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Mr Joseph O'Reilly, Rapporteur
Ireland EPP/CD

2nd February 2022

Dear Mr O'Reilly,

Re: Report – Addiction to Prescribed Medicines. (Provisional Version 01 December 2021)

I am writing as Chair of the International Institute of Psychiatric Drug Withdrawal (iipdw.org), on behalf of our Board.

I am also co-author of 'A systematic review into the incidence, severity and duration of antidepressant withdrawal effects' (Davies, J., Read J. 2019. *Addictive Behaviours,* 97**,** 111-121), which was commissioned by the UK's *All Party Parliamentary Group For Prescribed Drug Dependence.* The review informed Public Health England's seminal 2019 Prescribed Medicines Review, which we strongly recommend as a valuable basis for decision and policy making in this area. The report's recommendations for withdrawal support services and a 24 hour help line for people trying to come off antidepressants are particularly valuable and are likely to be implemented in the NHS soon. [https://www.gov.uk/government/publications/prescribed-medicines-review-report]

The IIPDW is comprised of researchers, mental health professionals and people with experience of withdrawing from psychiatric medications. It was established in 2016, with aims which include supporting the human right to informed choice with regard to psychiatric drugs, and contributing to evidence-based practices for reduction of, and withdrawal from, psychiatric drugs, and facilitating the inclusion of such practices in general practice guidelines worldwide. We therefore have a specific interest in your report and would like the opportunity to make some suggestions for improvement for your consideration.

The issue of patients becoming dependent on certain prescribed medicines has over the past few years come more into focus, and thus your report is timely and welcome in its aim to make provision for this group of people. What is noticeable reading your draft, is that its focus is predominantly on prescribed opioids and those drugs which lead people to a form of addiction similar to that which occurs as a result of taking illegal or street drugs. However, you have, quite rightly, included antidepressants in this document, as you have clearly recognised that taking antidepressants can lead to iatrogenic harm via a range of debilitating withdrawal symptoms.

The IIPDW would like to draw your attention to the fact that your report would better recognise and support all intended patient groups if it clearly differentiated antidepressant dependence from "nefarious addiction", and differentiated antidepressant patients from those prescribed narcotic painkillers.

We respectfully suggest the following:

1. Use the term "dependence" or "physical dependence" in relation to antidepressants

The IIPDW's position is that no person prescribed an antidepressant would recognise as in any way relating to them the European Monitoring Centre for Drugs and Drug Addiction's definition of addiction - "*a repeated powerful motivation to engage in a purposeful behaviour that has no survival value, acquired as a result of engaging in that behaviour, with significant potential for unintended harm*". It has been established that antidepressants do not cause cravings to take more, and that many people do not realise they have become dependent until reducing or stopping their drug and developing

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withdrawal symptoms. In addition, they become tremendously distressed if they are perceived as "addicts" and their only support is a drug misuse centre (which most refuse to attend).

Equally no person prescribed an antidepressant would recognise as relating to them the statement: "*In the case of addiction to prescription medicines, it is usually the result of an insidious and gradual process of giving up control of one's own life for the sake of relief provided by the medicine, typically to counter physical or psychological pain.*" At the point of prescribing, patients given an antidepressant are frequently told, erroneously, that their symptoms are due to a chemical imbalance in the brain. They are told that the drug has been chosen specifically to rebalance serotonin, and its role is similar to that of insulin to correct diabetes. Whilst we know that this narrative has no basis in science, it nonetheless provides a powerful rationale and leads people to believe they are taking an essential medication to correct a biological disease, rather than the suppression of symptoms.

We recommend that the report addresses these differences by using the terms adopted by Public Health England in its Evidence Review into *Dependence and withdrawal associated with some prescribed medicines* (2019) to distinguish between dependence and addiction. Further information on this is in the attached Appendix.

2. Amend recommendation 2.2 to read:

"*Encourage the relevant Council of Europe bodies to work closely with the World Health Organization (WHO) in this area, including on the possible drafting and issuance of guidance on prevention, identification, management and treatment of addiction to/dependence on prescribed medicines, including support to withdraw carefully and safely, at global and/or Council of Europe level."*

As identified in para 41 by your Danish contacts, *"if one addictive medicine is phased out, another one is bound to go up (eg: replacing benzodiazepines with antidepressants").* We have seen recent evidence of this in the UK where, following concerns about the rising rates of opioid prescribing, NICE guidelines on the management of chronic pain in primary care now, unfortunately, recommend antidepressants as the first line of pharmacological management. Antidepressant prescribing will continue to rise with very limited support services available to differentiate prescribed medication dependence and withdrawal from illicit drug misuse.

3. Antidepressants and withdrawal

We note that in para 17, antidepressants are not included in the list of medicines associated with withdrawal syndromes (as outlined in para 19). They should definitely be included.

We appreciate that para 19 addresses the withdrawal symptoms for antidepressants in some detail. We suggest, however, one correction:

> *The dose of antidepressant needs to be lowered in a way that gradually and evenly decreases its pharmacological effects.37*

should more accurately be:

> *The dose of antidepressant needs to be lowered very gradually, usually over several months or longer, with the final stages of withdrawal requiring particularly small reductions.*

Reference 37 seems to be a mistake as it is to a media story about Covid. You may want to make reference, instead, to the new guidelines from NICE or the Royal College of Psychiatrists, or the research of Dr Mark Horowitz et al. on this matter of hyperbolic withdrawal.

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This response is co-written with Stevie Lewis who is a Board Member of the IIPDW, and a person with lived experience of protracted antidepressant withdrawal.

She is a co-author of "*The Patient Voice: patients who experience antidepressant withdrawal symptoms are often dismissed, or misdiagnosed with relapse, or a new medical condition*" published in Therapeutic Advances in Pharmacology in 2020.

Thank you for taking the time to read our comments. Should you require any further information or clarification, I would be happy to discuss this with you.

Yours sincerely,

Professor John Read

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APPENDIX

Definitions of Dependence and Addiction from Public Health England's Evidence Review into Dependence and withdrawal associated with some prescribed medicines https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940255/PHE_PMR_report_Dec2020.pdf

Dependence *An adaptation to repeated exposure to some drugs and medicines usually characterised by tolerance and withdrawal, though tolerance may not occur with some. Dependence is an inevitable (and often acceptable) consequence of long-term use of some medicines and is distinguished here from addiction*

Addiction *Dependence plus a compulsive preoccupation to seek and take a substance despite consequences*

The IIPDW is concerned that, as written, the Addiction to Prescribed Medicines report conflates "dependence" and "addiction", leading to consequences that reverberate throughout the report and may adversely affect clinician-patient relationships and quality of care.

The definition of dependence has become confounded as different professional bodies sought to define it according to their own perspectives, sometimes involving political considerations (Nielsen et al., 2012).

However, the apolitical definitions in pharmacology texts such as Goodman & Gilman's *The Pharmacological Basis of Therapeutics* are most useful. The body and brain adapt to the presence of a drug to maintain homeostasis. If a hormone or transmitter is increased, then the relevant receptor will be up or down-regulated so as to reduce the effect of the change to the equilibrium produced by the drug (Hyman and Nestler, 1996). This is a natural physiological process, not psychological or under the individual's volition, and should not be associated with addiction. This disambiguation of dependence was incorporated into the DSM-5 (O'Brien, 2011).

It is important that both clinician and patient understand the natural process of adaptation leading to physiological dependence (sometimes called physical dependence), so as not to suggest the patient has developed an addiction and further, to communicate to the patient that some normal drug-related symptoms may arise and should be reported. When a psychotropic is taken regularly, certain clinically important phenomena related to the dependent state commonly emerge, such as loss of beneficial effect (tolerance) (Hyman and Nestler, 1996), inter-dose withdrawal, and withdrawal symptoms should dosing be irregular or reduced, as outlined in Monti, 2010 and Lerner and Klein, 2019 (latter authors associated with the US FDA).

Patients should understand why they might have any of these symptoms and be urged by the clinician to report them promptly so they may be addressed appropriately (Steinman, 2013).

References re Dependence

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Prof David Taylor, PhD
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