PE1651/SSSSSSSS
Royal College of General Practitioner's submission of 7 June 2018

Thank you for your letter dated 10 May regarding Public Petition PE1651, which is, *'Calling on the Scottish Parliament to urge the Scottish Government to take action to appropriately recognise and effectively support individuals affected and harmed by prescribed drug dependence and withdrawal'.* In relation to this petition, RCGP Scotland has been asked specifically for the College's views on the above action and for an understanding of the following points:

- To what extent GPs in Scotland recognise the issues raised in the petition;
- What guidance and training is available to GPs to support people to safely withdraw from drugs such as benzodiazepines and anti-depressants.

We are happy to provide the following response.

NHSScotland's Information Services Division (ISD) data shows that prescribing of hypnotics and anxiolytics (in which benzodiazepines are included) has remained largely stable over the past ten years.[i] The use of antidepressants prescription items has increased consistently over the past ten years, rising overall by 75.1% in that time (from 3.6 million items in 2006/07 to 6.4 million items in 2016/17).[ii]

RCGP Scotland recognises the breadth of diagnoses that both benzodiazepines and antidepressant medications are licensed to treat[iii]. For antidepressants this includes, but is not limited to, depression; panic and anxiety disorders; obsessive compulsive disorder . For benzodiazepines, this includes anxiety, muscle spasms and supporting symptoms for alcohol withdrawal.

The recognition of these types of diagnoses has increased in recent years and all have shown a notable increase in prevalence. With this, between 1-2% of the population has a psychotic disorder. Primary care provides around 90% of all patient contact with the NHS and about 1 in 3 of GP appointments have a mental health component. It is equally notable that the Scottish Government states that only 1 in 3 people who would benefit from treatment for a mental health illness receives that treatment[iv]. Moreover, those who suffer from a mental illness are likely to die 15-20 years prematurely because of physical ill health.[v]

One example of areas in which these medications assist is suicide prevention. With an increased use of antidepressant medication in the past 10 years, the rates of suicide have decreased among males from 25 per 100,000 (age/sex standardised) in 2008 to 18.1 in 2016 (most recent data). In females, over the same time period, the rate has decreased from 7.8 to 7.2 per 100,000.[vi] Trying to identify at a population level those who may be at risk of suicide is challenging. There are no reliable NHS tools to help, although there are known risk factors. For instance, we know that reducing access to lethal means, and better identification and treatment of depressive illness, helps to reduce suicide levels. From a general practice perspective, trying to find one person who may commit suicide with a depressive illness in a general practice population, when depressive illness is so common, is challenging and so optimising mental well-being for all is prudent. It may be seen that this approach has been effective in reducing population level suicide rates.

From a general practice perspective, the existence of 10-minute consultation times as standard presents a challenge to the kind of conversations that patients who have been harmed by prescribed drug dependence and withdrawal should have with their GP. RCGP Scotland has consistently called for an end to 10-minute consultations as a means of better supporting patients suffering from complex health problems. This is required for the provision of Realistic Medicine.

We note briefing papers previously published by the Royal College of Psychiatrists on the subject of the increased use of antidepressants in Scotland[vii]. With these types of issues at the forefront of general practice, we very much recognise their importance and understand the complexities involved in the management of mental health issues.

We note, too, the Scottish Government's *Mental Health Strategy 2017-2027*. We welcome the Strategy's ambition 'That side effects of psychiatric medication are appropriately monitored and, where possible, reduced.'[viii] Such research is to the benefit of patients and practitioners alike. The Strategy's further stipulation that, 'we must see, and be able to measure … [e]qual access to the most effective and safest care and treatment: [d]emonstrated by increasing the proportion of people who receive treatment for a mental illness, who would benefit from that treatment. This will also require improvements in prescribing and follow up care' is again to be welcomed for both patients and general practitioners and as a step towards dealing with the many ramifications of the Inverse Care Law, whether in an urban or rural setting.[ix]

Guidance and training to support GPs in the management of mental health issues is embedded within general practice. It forms a core part of the RCGP general practice training curriculum.[x] The management of mental health problems in primary care is supported by a broad range of professionals, both embedded within the primary care system and third-sector professionals, including GPs. The Scottish Government's *Mental Health Strategy 2017-2027* clearly sets out the importance of the breadth of this integration.[xi] This has been further reiterated in the 2018 *General Medical Services Contract* in Scotland[xii] which has supported continued and expanded mental health support to General Practice.

The withdrawal of medication must be carried out safely, ensuring the patient is adequately supported to cope with the rigors of this process. The efficacy of antidepressants is not disputed and indeed is well supported by evidence[xiii]. Being mentally 'well' takes social, psychological and medical support. As such, to simply remove a medical treatment, without ensuring all aspects of well-being are in place, may cause harm and should only ever be done with some caution. The lack of availability of psychological services within communities and the significant waiting times for these services where they exist present barriers for general practitioners when they are considering referring patients to such services.

There is published evidence to support GPs in the deprescribing of benzodiazepines, although this evidence is not always applicable to a Scottish population with a long-term dependency to these medications. There is some promising, recent, evidence-based research from Canada in a primary care setting which gives a well-formed structure to aid clinicians in the deprescribing of benzodiazepines[xiv]. However, there

exists no official guidance for the use of benzodiazepines in treating anxiety or for the use of opioids in managing chronic pain.

Support for GPs to consider the safe withdrawal of anti-depressants is available and an evidence based copy of a structured annual review and depression management flowchart is attached for your information. An academic study has also been carried out on the subject which has shown a reduction in prescribing[xv]. However, it is also notable that there has not been any long-term follow-up of the patients involved to assess whether they experienced any harms from the reduction in prescribing, such as the patient being at a higher risk of suicide, or to ascertain whether they returned to using medication.

Overall, the evidence to support the harms caused by long-term benzodiazepines is clear, whereas the evidence to support safe withdrawal is sparse. Regarding antidepressants, the burden of depression (and of those yet to be recognised as having depression) is clear and it has a significant impact on patients' health and wellbeing. The evidence to support safe withdrawal is poor and lacks any long-term strategy.

As with any decision to withdraw medical treatment, such a step must be considered on an individual, case by case basis, and should be undertaken in conjunction with a GP or mental health professional. It should also be noted that developing research informs any changes to clinical practise.

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[i] Information Services Division (ISD) NHS National Services Scotland, 'Medicines used in Mental Health' (2017) Available at: https://bit.ly/2JdXgKJ (Accessed 29/05/2018)

[ii] Information Services Division (ISD) NHS National Services Scotland, 'Medicines used in Mental Health' (2017) Available at: https://bit.ly/2JdXgKJ (Accessed 29/05/2018)

[iii] Joint Formulary Committee. (2018). *British National Formulary.* London: BMJ Group and Pharmaceutical Press

[iv] Scottish Government, 'Mental Health Strategy 2017-2027: Our Vision' (2017) Available at: http://www.gov.scot/Publications/2017/03/1750/3

[v] Scottish Government. 'Mental Health in Scotland – a 10 year vision' (2016) available at: https://consult.gov.scot/mental-health-unit/mental-health-in-scotland-a-10-year-vision/supporting_documents/mentalhealthstrategy.pdf

[vi] National Records of Scotland. (2017, August 2). *Probable Suicides: Deaths which are the Result of Intentional Self-harm or Events of Undetermined Intent*. Retrieved May 29, 2018, from https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/suicides

[vii] Royal College of Psychiatrists. (2014, October). *Briefing Paper on the Pharmacological Treatment of Depression in Scotland*. Retrieved May 29, 2018, from https://www.rcpsych.ac.uk/workinpsychiatry/divisions/rcpsychinscotland/briefingpapers.aspx

[viii] Scottish Government, 'Mental Health Strategy 2017-2027: The physical wellbeing of people with mental health problems' (2017) Available at: http://www.gov.scot/Publications/2017/03/1750/3

[ix] Scottish Government, 'Mental Health Strategy 2017-2027: Our Vision' (2017) Available at: http://www.gov.scot/Publications/2017/03/1750/3

[x] Royal College of General Practitioners Curriculum, '3.10 Care of People with Mental Health Problems', available at http://www.rcgp.org.uk/training-exams/training/gp-curriculum-overview/online-curriculum/managing-complex-care/3-10-mental-health-problems.aspx

[xi] Scottish Government, 'Mental Health Strategy 2017- 2027' (2017) available at: http://www.gov.scot/Topics/Health/Services/Mental-Health/Strategy

[xii] Scottish Government, 'The 2018 GMS Contract in Scotland' available at: http://www.gov.scot/Publications/2017/11/1343 (Scottish Government, 2017)

[xiii] Cipriani A, F.T. (2018) *'Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis'* available: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32802-7/fulltext

[xiv] Pottie K et al (2018) 'Deprescribing benzodiazepine receptor agonists: Evidence-based clinical practice guideline.' Canadian Family Physician 64(5) Available at: https://www.ncbi.nlm.nih.gov/pubmed/29760253

[xv] Johnson C, M.H. (2012) 'Reviewing long-term antidepressants can reduce drug burden: a prospective observational cohort study' British Journal of General Practice, 62 (604): e773-779 http://bjgp.org/content/62/604/e773

Recurrent depression pathway

Single episode pathway

No. of lifetime episodes of depression (including this one)

Two or more

How severe and/or difficult-to-treat was your most recent episode?

Short duration, uncomplicated

Do you have side-effects?

No

Aim to take antidepressant at the current dose for 24 months, before a gradual withdrawal over 1-3 months

If symptoms return, you should restart the medication and restart the time that you shoudl remain on medication

Yes

You are likely to benefit from taking an antidepressant for at least two years. Discuss the choice of drug with your doctor

If symptoms return, you should restart the medication and restart the time that you shoudl remain on medication

Severe, prolonged, or difficult-to-treat

Do you have side-effects?

No

Aim to take antidepressant at the current dose for 3-5 years (or longer), before a gradual withdrawal over 3-6 months (or longer)

Yes

You are likely to benefit from taking an antidepressant for two years or more. Discuss the choice of drug with your doctor and consider switching to a better-tolerated drug

One

Do you have side-effects?

No

Aim to take antidepressant at the current dose for 9-12 months, before a gradual withdrawal over 1 month

Yes

Have you taken medication for at least 6 months?

Yes

Discuss with your doctor - you might want to consider stopping the antidepressant if you can't find an antidepressant that suits you

If symptoms return, you should restart the medication and restart the time that you should remain on medication

No

Taking an antidepressant for a longer time may be helpful. Discuss switching to another, better-tolerated drug with your doctor

Continuing treatment with antidepressants reduces the risk of relapse by 70% compared to stopping. Benefits of continuation last for up to 36 months

Geddes, J. R., Carney, S. M., Davies, C., et al (2003) Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. Lancet, 361, 653-661. http://dx.doi.org/10.1016/S0140-6736(03)12599-8

"In adults with depression who have benefited from antidepressants, medication should not be stopped before 9-12 months after *recovery*."

WHO (2012) Q2: How long should treatment with antidepressants continue in adults with depressive episode/disorder? Geneva: World Health Organisation. http://www.who.int/mental_health/mhgap/evidence/resource/depression_q2.pdf

There is less evidence for long-term treatment in primary care. Decisions should be made on an individual basis, depending on personal risks of recurrence and tolerability.

Piek, E., van der Meer, K. & Nolen, W. A. (2010) Guideline recommendations for long-term treatment of depression with antidepressants in primary care - a critical review. European Journal of General Practice, 16, 106-112. http://dx.doi.org/10.3109/13814781003692463

"The evidence confirms the recommendation of NICE CG90 (to continue therapy for at least 2 years if at risk of relapse), although further research is needed to determine the optimal treatment regimen for relapse prevention."

National Institute for Health and Clinical Excellence (2009) CG90. Depression: the treatment and management of depression in adults. London: National Collaborating Centre for Mental Health. http://www.nice.org.uk/guidance/CG90
National Institute for Health and Clinical Excellence (2012) Depression: Evidence Update April 2012. London: National Collaborating Centre for Mental Health. https://www.evidence.nhs.uk/evidence-update-13

These are guidelines only. A number of factors might affect your decisions about how long to stay on antidepressants:
1. Previous good response to a particular treatment;
2. Tolerability of your current antidepressant;
3. Whether your most recent (or previous) episodes were severe, of long duration, or difficult-to-treat.
4. Other comorbid conditions (such as anxiety disorders) that may respond to antidepressant treatment, and which may increase the likelihood of relapse or recurrence if not treated.

All of the following situations assume the following: 1) your depressive symptoms are not changing (for better or worse) unpredictably or very quickly; 2) you don't have an increase in suicidal thoughts and/or behaviours; 3) you are tolerating the medication in a predictable manner.