THE AFTERMATH

The decline of the benzodiazepines may just be clearing the way for a new generation of anxiety-beating, dependence-producing drugs. John Cooper reminds us of the legacy of the benzodiazepines – hundreds of thousands dependent, with the demand for help far outstripping supply – and calls for action now to prevent a new wave of psychotropic drug addiction in the '90s.

John Cooper

SINCE THEIR introduction to the medical profession and through them to the general public in 1960, the benzodiazepines have become, worldwide and in the UK, the most commonly prescribed type of psychotropic drug and one of the most widely prescribed drugs of any kind. They are credited with being "the most commercially successful drugs of all time",[1] and in the mid-1970s, when they reached the zenith of their popularity, were estimated to have sales worldwide of $1,000 million.[2]

As prescription medicines, benzodiazepines are considered to have five main uses: as anxiolytics (tranquillisers), sedatives and hypnotics (sleeping pills), muscle relaxants, anti-convulsants (for treating certain types of epilepsy) and amnestics (to relax patients before surgery). However, it is as tranquillisers or sleeping pills that the vast majority of benzodiazepines have been prescribed. Indeed, the most commonly prescribed benzodiazepines have become known to the general public by their manufacturer's brand name or their medically approved titles, eg, tranquillisers such as Valium (diazepam), Ativan (lorazepam), Librium (chlordiazepoxide) and Serenid-D (oxazepam) or sleeping pills such as Mogadon (nitrazepam), Euhypnos and Normison (temazepam) and Halcion (triazolam). Conversely, it is possible that many people do not know they are taking these drugs and so are unaware they may be at risk from dependence and withdrawal problems, particularly after extended use.[3]

Benzodiazepines represent only the latest drugs in a long succession of hypnotics, sedatives and tranquillisers, all of which, after many years of clinical use by doctors, consumption by patients and commercial success for manufacturers, have belatedly been found to have a range of adverse side effects. Not the least of these is their ability to produce physical or psychological dependence, with the associated problems of withdrawal. Drugs that have previously fallen out of clinical favour in this way include: chloral hydrate, methaqualone, meprobamate, and barbiturates, which since their decline in medical popularity in the early 1970s have become well established street drugs, a fate which seems to be befalling benzodiazepines.[4]

Another product which dropped dramatically out of the clinical limelight was the notorious sedative/hypnotic thalidomide. It is possible that damage to the unborn — less serious than that caused by thalidomide — may yet materialise as a consequence of the inappropriate use of benzodiazepines.[5]

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Up to 1 million dependent?

DHSS prescribing statistics refer to *all* types of tranquillisers, sedatives and hypnotics, not just the benzodiazepines. But benzodiazepines account for over 95 per cent of all tranquilliser and sedative prescriptions and 85 per cent of hypnotics,[6] so the statistics closely reflect the fate of the benzodiazepines. Total prescribing of all tranquillisers, sedatives and hypnotics has dropped from a record 42.2 million in 1978 to 30.3 million in 1985. As figure 1 shows, tranquilliser prescribing has declined most markedly, while prescribing of hypnotics has dropped very little over the same period of time, from 17.2 million to 16.0 million.[7]

But the situation regarding the repeat prescribing of these drugs — the problem which leads most directly to dependence — may not be so encouraging. In 1984, Professor Malcolm Lader — Britain's foremost medical expert on tranquilliser dependence — warned that repeat prescribing was a cause for concern, with 64 per cent of benzodiazepine prescriptions being issued as long-term repeats with the likelihood of a decrease in their therapeutic effect and an increase in the risk of dependence problems.[8] Even now, over 85 per cent of prescriptions for hypnotics and over 75 per cent for tranquillisers may be repeats.[9]

However, as Heather Ashton has pointed out: "It is not known, despite various estimates, what proportion of patients taking benzodiazepines become dependent, or what determines whether or not they do"[10] — a sentiment shared by other leading medical experts.[11,12] Nevertheless, it is possible to attempt to reconcile at least some of the estimates of chronic use and dependence.

Table 1 lists some of the estimates of people 'at risk' from dependence (ie, using for longer than four months). The first of these, the MORI survey conducted in 1984

Table 1. Estimates of the number of UK adults at risk of benzodiazepine dependence

Source	Definition	%	No.	Comments
Lacey R. *et al*, 1985, reporting MORI survey[28]	Using regularly for four months or more	8%	3.5 million	Refers to tranquillisers and hypnotics
Calculated from Balter *et al*, 1984[29]	Using regularly for four months or more in last 12 months	4%	1.6 million	Refers only to tranquillisers, not hypnotics
Lader M. *et al*, 1986[30]	Take benzodiazepines for more than one year	3.1%	1.25 million	Based on the Balter figures

Table 2. What the experts say about how many UK adults are likely to suffer benzodiazepine withdrawal problems

Source	Definition	Number	Comments
Trickett S., 1986[31]	Addicted to tranquillisers	1.25 million	—
Ashton H., 1986[32]	Addicted to Valium and other drugs in the diazepam family	1 million	
Turner D., 1984[33]	Physically dependent	600,000–700,000	—
Lader M., 1986[34]	Will develop withdrawal symptoms	250,000	Assumed 20% of long-term users develop dependence. Derived from Balter study, so excludes hypnotics.

Figure 1. Trends in family practitioner prescribing of sedatives/tranquillisers and hypnotics in Great Britain

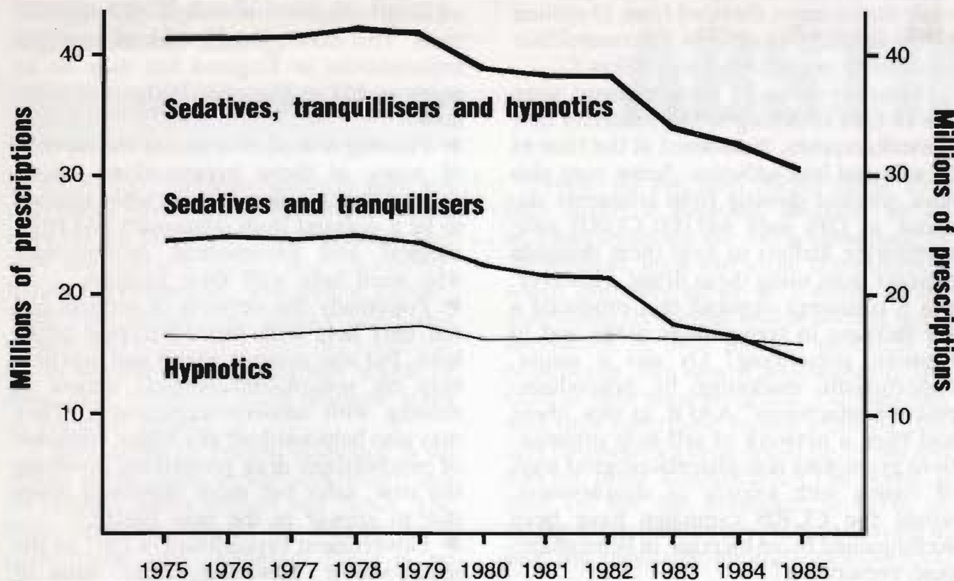
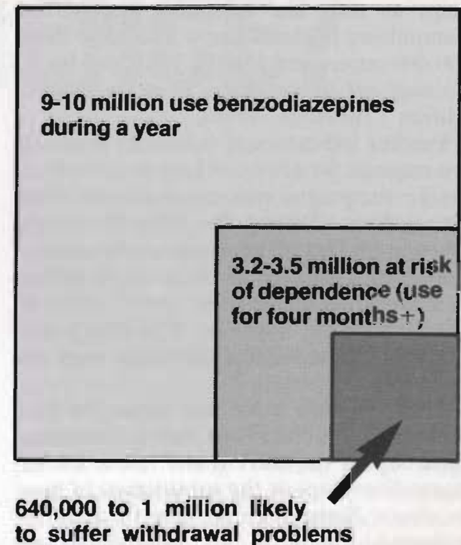


Figure 2. The probable extent of benzodiazepine use and dependence in the United Kingdom



by MIND and the BBC *That's Life* programme, produced an estimate of 3.5 million people using tranquillisers or hypnotics for four months or longer[13] — apparently twice the figure derived from the important Balter *et al* study conducted in 1981 and published in 1984.[14]

However, the Balter survey did not cover hypnotics — and these account for roughly half of all benzodiazepine prescriptions. Benzodiazepine hypnotics are prescribed on a repeat basis as often as tranquillisers and are just as likely to engender dependence, so estimates derived from the Balter study probably need to be doubled to take in hypnotics as well as tranquillisers. There were other methodological differences between the Balter and the MORI studies. However, some degree of compatibility can be arrived at if allowance is made for the absence of hypnotics in Balter's survey.

► MORI found 23 per cent of the population had taken tranquillisers or hypnotics. Doubling Balter's figure of 11.2 per cent (which excludes hypnotics) gives an equivalent estimate of 22.4 per cent having taken the drugs in the last 12 months. Together the studies suggest 9-10 million UK adults take benzodiazepines during a year.

► On chronic use, MORI found eight per cent used tranquillisers, sedatives or hypnotics for four months or more — precisely the percentage obtained by doubling Balter's four per cent. So both studies suggest 3.2 to 3.5 million people in the UK can be considered potentially at risk from dependence.

The crucial issue is: how many of these chronic users are actually dependent to the extent that they would suffer withdrawal symptoms if they stopped. Various estimates have been made (see table 2), based on estimates of the proportion of long-term users who suffer withdrawal. These range from 15 to 50 per cent, but most have been derived from people who have taken benzodiazepines for a very long time or in high doses, and do not relate directly to people who have used for four months or more.

If 20-30 per cent of the people who use benzodiazepines for four months or more might need help to cope with withdrawal problems — and the lower percentage is probably a conservative estimate — then some 640,000 to one million UK adults are to some extent dependent on benzodiazepines (see figure 2).[15] This leads on to the question of where a potentially large number of people with benzodiazepine withdrawal problems could go for help.

Help under-funded

Nobody really knows how many organisations there are in the UK offering help to benzodiazepine dependent people, where they are, or what sort of services they provide. Some of my own research has aimed to rectify this situation by establishing a national database of organisations and publishing the result as a directory. Funding for such an exercise has not yet been forthcoming, but provisional research has produced interesting findings. A search of the available reference sources supplemented by a questionnaire sent to Community Health Councils[16] revealed a total of 518 organisations in England which may offer such help. About 440 of these appeared very likely to provide some form of benzodiazepine service, of which 280 were known to provide tangible help, such as telephone counselling, advice leaflets, face-to-face or group counselling, etc.

What emerges from this provisional national sample is the importance of specialist benzodiazepine groups and similar organisations, NHS services, and MIND, as sources of help for people with benzodiazepine problems.

The results of a separate questionnaire survey sent to the readers of the Benzodiazepine Interest Group's (BIG) newsletter[17] suggest that hospital clinical psychology departments play a major part in the provision of NHS services for people with benzodiazepine problems.

The BIG survey also revealed that:

► Ex-users appear to play an important role in the provision of help for people with benzodiazepine problems. In about half the organisations surveyed ex-users were taking an active part in providing services for clients. They also ran office services and set up new self-help groups. This finding relates not only to groups such as specialised benzodiazepine self-help groups, MIND and to a lesser extent drug/alcohol agencies, but also to 40 per cent of the NHS psychology departments studied.

► Involvement of ex-users may have a profound effect on the services organisations provide, which tend to be more varied and more 'consumer orientated' or 'consumer accessible'. These services may include dissemination of printed advice leaflets, provision of telephone counselling, advice on step-wise reduction programmes, tapes on stress and relaxation management. There may also be more emphasis on group work of various kinds. This is true not only of organisations like MIND and self-help groups but of psychology departments as well.

► The organisations most in need of financial help appear to be the ones which deal with relatively large numbers of benzodiazepine dependent people, including specialist self-help groups and NHS services, particularly psychology departments, offering consumer-orientated and accessible services. These organisations, apparently carrying the brunt of consumer demand for services, are fostering a dynamic form of self-help involvement but receive little financial backing, particularly from central government sources. These organisations need to be evaluated, but funding is required now if many are to survive long enough to be studied.

Before leaving the question of what help is available for benzodiazepine dependent people, it is important to touch on two further sources. First, the recent emergence of a large number of advice leaflets, books or audio-tapes (at least nine since 1982) on the subject of benzodiazepine ▷

continued from page 9

dependence and how to cope with withdrawal — a development which, it can be argued, reflects consumer demand for help, as does the fact that the MIND tranquilliser leaflet has now sold more than 100,000 copies and Shirley Trickett's book *Coming off tranquillisers* is in its second edition (Thorsons, 1986).

Further indicators of consumer demand are requests for advice or help as a result of media campaigns concerned mainly with illegal drugs. During the 1986 TV South "Action on Drugs" campaign, callers mentioned tranquillisers twice as often as the next most mentioned drug, and 61 per cent of calls received during the 1982 LBC radio "Drugs and the Family" campaign were on the same subject.

Secondly, one must not forget the importance of GPs. They exert enormous control over the current and future use of benzodiazepines or the substitution of new products. Some may be able to assist in reducing the level of benzodiazepine prescribing[18] or deal with dependent patients.[19] However, if GPs have sufficient time and expertise to deal with anxiety and sleep problems, we have to ask why there was a proliferation of benzodiazepine prescribing in the first place.

The lessons of CURB

Problems in controlling the medical availability of sedatives, hypnotics and tranquillisers are illustrated by the CURB campaign, a brave attempt by doctors, funded by the DHSS, to persuade the medical profession to reduce the use of barbiturates as hypnotics — but one that raises many questions.

Between 1975 and 1977, CURB may have helped accelerate the decline in barbiturate prescribing. However, it did not reduce the use of hypnotics overall (a stated objective), for during the period of the campaign prescriptions for benzodiazepines as hypnotics rose.

Also, between 1971 and 1978 prescriptions for benzodiazepines as tranquillisers increased from 17 million to 30 million while barbiturates dropped from 13 million to five million — a *net gain* for tranquilliser prescribing overall of five million.[20]

Obviously some of these changes were due to GPs switching to the relatively new benzodiazepines, considered at the time to be safe and less addictive. Some may also have resulted directly from consumer demand, as GPs used 440,000 CURB antibarbiturate leaflets to help them dissuade patients from using these drugs. However, was it consumer demand that produced a net increase in tranquilliser usage and in hypnotic prescribing? Or was it astute, opportunistic marketing by benzodiazepine manufacturers? And if, as now, there had been a network of self-help organisations promoting non-pharmacological ways of coping with anxiety or sleeplessness, would the CURB campaign have been accompanied by an increase in benzodiazepine prescribing?

Should an exercise like CURB be repeated for the benzodiazepines? I believe there is a case for it, provided it does not panic doctors into indiscriminately and abruptly withholding the drugs, or result in the inadvertent promotion of a fad for new alternative drugs — a factor which would readily be exploited by pharmaceutical manufacturers. However, its organisation should be more catholic, involving not just doctors but representatives of benzodiazepine self-help groups, MIND, psychologists and other paramedics. Also, it is vitally important that the existing network of benzodiazepine organisations should be financed and publicised so they can play their part in such an exercise.

Summary and suggestions

► The problem of benzodiazepine dependence may be numerically large, involving 640,000 to one million people, many of whom may need advice or assistance with the sometimes protracted problem of withdrawal.

► Much of this help could be provided by existing statutory or voluntary organisations. This network comprises at least 280 organisations in England but may be as many as 613 in England, Wales and Scotland.

► Funding is needed to ensure the survival of many of these organisations, or to expand their services to meet what appears to be a demand from consumers and from medical and paramedical professionals who need help with their patients.

► Potentially this network of services can not only help with benzodiazepine problems, but also provide advice and practical help on non-pharmacological means of dealing with anxiety/sleeplessness. They may also help ward off any future epidemic of psychotropic drug prescribing involving the new, safer but more expensive drugs due to appear in the near future.[21]

► Government expenditure in 1987 on the media-visible 'Law and Order' issue of hard drug use was reported as £24 million.[22] The number of addicts was reputed to be 80,000,[23] meaning £300 per head was spent on people with illegal drug problems. In 1985, government spent between £200,000[24] and £500,000[25] on benzodiazepine groups. If one million people are dependent on benzodiazepines, this produces the ironic figure of £0.50 a head.

► Where could more money come from? The 'Limited List' was introduced on 1 April 1985, coincidentally increasing demand for help from people who had been abruptly taken off benzodiazepines without proper support and advice on withdrawal.[26] However, it is claimed that the NHS drugs bill has been cut by £75 million, £15,500,000 of which came from savings on benzodiazepine prescribing in a 12-month period.[27] What about reinvesting this large sum of money in providing services for people with benzodiazepine problems? □

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9. Confidential pharmaceutical industry data, 1987
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11. Lader M. and Higgitt A.C., *op cit*.
12. Tyrer P.J. "Benzodiazepines on trial". *British Medical Journal*: *288* (6424), p.1101-2.
13. Lacey R. *et al*, *op cit*, p.23.
14. Balter M.B. *et al*. "A cross-national comparison of anti-anxiety/sedative drug use." *Current Medical Research and Opinion*: 1984, *8* (suppl.4), p.5-20.
15. Lader M. and Higgitt A.C., *op cit*.

Drug Newsletter (Northern Regional Health Authority): 1985, (31), p.125-128.

16. Cooper J.V.W. "Benzodiazepine advice and self-help groups survey". *Benzodiazepine Interest Group Newsletter*: 1987 (5), p.4-7.

The survey of CHCs was conducted with the support of MIND. Although the response rate was disappointing (29 per cent in England, 18 per cent in Wales) it did help add to and verify the information extracted from the published sources.

17. Cooper J.V.W. "BIG survey of benzodiazepine organisations, their services, funding requirements, the numbers of people helped and the involvement of ex-users in providing services." To be published in *Benzodiazepine Interest Group Newsletter*.

A postal questionnaire sent to readers of the *BIG Newsletter* produced a 23 per cent response rate (40 replies).

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21. Buspirone (a new tranquilliser) has recently been successfully marketed in the USA (confidential pharmaceutical industry data, 1987). Beta-blockers, already in existence for the treatment of hypertension, angina, etc are growing in popularity as anxiolytics/tranquillisers (*Postgrad. Med. J.*: 1984, *60* suppl.2, 69). Glaxo appear to have a new 'wonder' drug at provisional clinical trial stage (*Daily Telegraph*, 18 Dec. 1986; *Times*, 20 Dec. 1986). These products may well be of clinical value to hard-pushed doctors or troubled patients. Benzodiazepines themselves, used wisely, are still valuable — but it would be sad to see a situation arise similar to their growth in popularity as barbiturates declined.
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29. Balter M.B. *et al*, *op cit*.
30. Lader M. and Higgitt A.C., *op cit*.
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32. Ashton H. quoted in *Sunday Post*: 23 March 1986.
33. Turner D. *Checkpoint*, BBC Radio 4, December 1984.
34. Lader M. and Higgitt A.C., *op cit*.