The misuse and harms of gabapentin and pregabalin

ACMD Call for evidence

Deadline 13 October 2025

Respondents should note that evidence submitted will inform the development of recommendations from the ACMD and could ultimately be published. However, in the interest of confidentiality and protecting commercial interests, any information submitted will be non-attributable.

All data submitted in response to this call for evidence will be protected by the ACMD Secretariat in accordance with the UK General Data Protection Regulation (UK GDPR). Furthermore, Section 43(1) of the Freedom of Information Act provides an exemption for information which is a trade secret, whilst Section 43(2) exempts information whose disclosure would, or would be likely to, prejudice the commercial interests of any person (an individual, a company, the public authority itself or any other legal entity).

Q1(a) Please indicate which is applicable:

- ***My submission should be considered a personal response reflecting my professional experience in this area***
- ***My submission should be considered as representative of the organisation I work for***

Q1(b) Please describe either the nature of your organisation and your role or your personal expertise within this area:

Q1(c) (For healthcare professionals only)

Please tell us about the setting in which you work:

- ***Primary care (e.g. GP practice)***
- ***Secondary care (e.g. general hospital)***
- ***Tertiary care (e.g. specialist mental health or addiction services)***
- ***Community based services***
- ***Other (please specify):***

Q2(a) From your observations and what you've encountered, in what context / for what conditions are pregabalin or gabapentin usually prescribed?

Our services do not prescribe pregabalin or gabapentin directly. However, we support clients who may be prescribed these medicines or who use them illicitly. In our experience, gabapentinoids are most commonly prescribed to our clients by GPs or other healthcare providers for the management of chronic pain or to support mental health conditions, such as anxiety or depression.

Q2(b) What types of harms have you observed or encountered related to the use / misuse of pregabalin or gabapentin? (e.g. physical, psychological, social, withdrawal effects). Please provide specific examples where you can.

We have observed several harms associated with the use and misuse of pregabalin and gabapentin. These include an increased risk of overdose (including death), particularly when the drugs are used alongside other substances such as opioids or when illicit supplies are contaminated. Dependence and withdrawal are also significant concerns. At present, there is limited evidence to guide substitute prescribing for individuals seeking to withdraw from illicitly obtained gabapentinoids, which restricts available treatment options. Support is generally limited to a gradual, stepwise reduction. Where gabapentinoids are prescribed legitimately, the reduction process is managed by the prescriber, but substance treatment services like ours often provide additional support throughout the process.

Q2(c) Have you encountered or observed pregabalin or gabapentin being prescribed with other drugs (such as opioids, other central nervous system depressants, and / or other drugs with a potential for misuse)?

We frequently encounter cases where gabapentinoids are used alongside illicit opioids. This combination is often intended to enhance or potentiate the effects of opioids, which significantly increases the risk of harm, including overdose and respiratory depression.

Q2(d) Have you observed or encountered pregabalin or gabapentin being used with other drugs? If so, which combinations in your experience are most prominently observed (e.g. opioids, benzodiazepines)?

Co-use of pregabalin or gabapentin with other substances is common, particularly among individuals who use opioids illicitly. Gabapentinoids are frequently used to potentiate or enhance the effects of opioids. In addition, we have encountered

anecdotal reports of individuals using illicitly obtained gabapentinoids as a means of self-managing mental health symptoms, such as anxiety or insomnia, or to address chronic pain where access to formal treatment is limited.

Q2(e) What effects have you observed or encountered from the co-use of pregabalin or gabapentin with other substances?

The co-use of pregabalin or gabapentin with opioids is associated with a significantly elevated risk of overdose. Among our client group, such patterns of use have been linked to higher levels of physical dependence and poorer overall health outcomes.

Q3(a) From which region was the information you are providing mainly sourced / observed?

From across our UK-wide services.

Q3(b) Where you have encountered or are aware of instances of pregabalin or gabapentin misuse, from your observation, were they usually obtained through prescription, illicit means, or other sources including online pharmacies?

We have encountered instances of pregabalin and gabapentin misuse originating from both prescribed and illicit sources. Within community settings, these substances are frequently obtained through illicit supply chains, including diversion from legitimate prescriptions and, in some cases, through informal peer networks. In prison settings, we have observed that pregabalin and gabapentin are often prescribed for pain management or mental health conditions, but diversion and misuse are common.

Q3(c) Have you encountered instances of those misusing pregabalin or gabapentin having obtained them from someone who was prescribed them legitimately?

Yes. Diversion of legitimately prescribed gabapentinoids is a frequent occurrence in prison settings, and often results in them being snorted, increasing the risk of both physical harm and disciplinary consequences. Clients accessing community drug and alcohol services also report obtaining gabapentinoids from these sources.

Q3(d) How prevalent do you believe the illicit market for pregabalin or gabapentin is? Please provide as much detail as possible.

While it is difficult to quantify the scale of the illicit market for pregabalin and gabapentin, our experience suggests that it is significant and increasing. A substantial

number of people presenting to our services report polydrug use involving gabapentinoids, most often in combination with opioids. This pattern indicates that illicit supplies are both accessible and in demand among people who use drugs.

Within the prison environment, gabapentinoid misuse has been a persistent issue. In our experience, prescribing and monitoring arrangements within both prison and community primary healthcare settings are often inconsistent, which can contribute to diversion and unregulated use.

Q3(e) Have you encountered any notable regional differences in the use, misuse, or harms associated with pregabalin or gabapentin? Please describe any regional trends or variations you have observed – for example, have you observed increased use in deprived areas?

Q3(f) Have you encountered any notable trend in patient demographic (e.g. age, race / ethnic group, gender) amongst those using pregabalin or gabapentin illicitly?

Q4(a) Do you think the classification of pregabalin and gabapentin as Class C Schedule III has affected the prevalence for misuse / abuse? If so – how?

From a service provider perspective, the reclassification of pregabalin and gabapentin as Class C has had a modest impact on prescribing practices and supply control. The change appears to have slowed the rate of new prescriptions and encouraged more cautious prescribing among healthcare professionals.

However, it has not led to a noticeable reduction in misuse or harm. Pregabalin and gabapentin continue to be widely misused, particularly among people who use opioids, where polydrug use substantially increases the risk of overdose and drug-related death. Diversion within both community and prison settings remains common, and national data indicate that deaths involving gabapentinoids have continued to rise since reclassification. This suggests that while the legislative changes have improved oversight, they have not addressed the underlying drivers of misuse or the availability of illicit supplies.

Q4(b) Do you believe the current classification and scheduling are appropriate? Please explain your answer.

We consider the current classification and scheduling of pregabalin and gabapentin to be appropriate but insufficient as a standalone measure. The move to Schedule 3 has

contributed to improved prescribing oversight and raised awareness of the potential for misuse among clinicians. However, the persistence of high levels of harm demonstrates that legislative measures must be complemented by stronger implementation and support measures. These should include enhanced safeguards around co-prescribing with opioids, improved monitoring of prescriptions, and targeted harm reduction measures for people at greatest risk. Within high-risk environments such as prisons, stricter management of prescribing and dispensing practices is essential to prevent diversion. A greater emphasis on practical interventions, including education, prescription monitoring, continuity of care between custody and community, and wider naloxone distribution is likely to achieve more meaningful reductions in harm than further changes to classification.

Q5(a) What types of support or treatment for pregabalin or gabapentin misuse have you encountered / are you aware of? (e.g. medical, psychological, social support). Are you aware of any pregabalin or gabapentin misuse-specific services or targeted interventions?

Within the prison environment, there is very limited targeted support for individuals misusing pregabalin or gabapentin. Clinical management of gabapentinoid misuse is often inconsistent, and there are few structured pathways for withdrawal or recovery. In our experience, GPs in prisons frequently take the approach of asking individuals to choose between continuing opioid substitution treatment (OST) or remaining on gabapentinoids, rather than offering an integrated plan to address dependence on both substances. This approach does not adequately address the physiological dependence or withdrawal symptoms associated with gabapentinoid use.

Often prisoners choose to discontinue OST while continuing gabapentinoid use, as they are aware that reinitiating OST in the community is relatively straightforward. In contrast, community prescribers are less likely to continue or initiate gabapentinoid prescriptions where there is evidence of misuse. This dynamic contributes to an ongoing cycle of unmanaged gabapentinoid dependence within the prison system, with little continuity of care on release.

There is limited evidence for substitute prescribing and it is not currently accepted practice. In some in-patient or monitored settings it is not uncommon to see benzodiazepines being prescribed for a limited period to mitigate risks of seizures on complete cessation of illicit gabapentinoids. There is limited evidence for how to reduce and stop illicit gabapentinoid use. (There are a number of studies that have looked at approaches to stop prescribing gabapentinoids and there are some regimes that have some acceptance for deprescribing gabapentinoids if they have been prescribed). There is limited access to inpatient detoxification (other than privately funded) for illicit gabapentinoid use when used in isolation and not used with other

illicit drugs (such as opioids).

Q5(b) How do you think the risk of pregabalin or gabapentin misuse can be most effectively mitigated / managed?

We believe the risk of pregabalin or gabapentin misuse can be more effectively mitigated through cautious prescribing practices, including increased monitoring by medicine management teams which can be helpful in overseeing GP prescribing. Clinicians should avoid open-ended prescribing and should be aware of the risks associated with long-term use, particularly for individuals with a history of drug dependence or mental health challenges. Increased monitoring via MMX teams as appropriate can be helpful overseeing GP prescribing

Q5(c) What types of monitoring and support do you believe are necessary during and after pregabalin or gabapentin prescribing? In your view, there any gaps in the current support systems or clinical guidelines?

Monitoring and support during and after gabapentinoid prescribing are essential to reduce harm. Rapid or poorly managed deprescribing can be harmful and may inadvertently push individuals toward riskier use, including reliance on illicit supplies. Guidance should explicitly address the balance of risks between continued prescribed use and withdrawal, particularly given the contamination of illicit gabapentinoids with substances such as nitazenes, as identified through drug testing services like WEDINOS. Comprehensive monitoring should include regular review of dosage, assessment of co-prescribing with opioids and proactive identification of signs of misuse or dependence.

Q5(d) In your experience, have you encountered any changes in behaviour or mental health shortly after starting or after stopping therapeutic pregabalin or gabapentin treatment? Where you can, please give examples for both short-term (such as post-surgery) use or long-term use.

Q5(e) How should the transition periods shortly after starting and after stopping pregabalin or gabapentin treatment be best managed in your view?

The cessation of gabapentinoid use, should be managed with increased monitoring and targeted support. Where people are experiencing difficulty during dose reduction, a short course of adjunctive medications to manage withdrawal symptoms, combined with psychosocial support, can help reduce the risk of relapse or engagement with illicit supplies. Close follow-up and continuity of care, particularly when moving

between prison and community settings, are essential to safe management.

Q6(a) Do you feel patients and prescribers are generally appropriately informed on the risks of misuse when prescribed pregabalin or gabapentin?

Awareness of the risks associated with gabapentinoid prescribing varies considerably across regions. Where local resources and guidance are available to support clinicians, there is evidence of safer prescribing practices and increased awareness of the potential for misuse.

Q6(b) What recommendations would you make to improve the management and prevention of pregabalin or gabapentin misuse? Are there any specific policies, guidelines, or educational materials that you believe would be beneficial?

To improve the management and prevention of gabapentinoid misuse, it would be useful to collate additional evidence on the role of substitute prescribing as a strategy to support people using gabapentinoids illicitly. Understanding the balance of benefits and risks in this context would inform more effective clinical interventions.

Additionally, the development and dissemination of clear guidance for patients and educational resources for clinicians can help support safer prescribing decisions, maintain awareness of misuse risks, and encourage proactive monitoring. Several ICB regions (such as Bristol, North Somerset, and South Gloucestershire) have begun implementing such resources, which represent a promising model for wider adoption.

Please include details of supporting information such as links to web pages, reports, or international projects in progress.

Would you be happy to be contacted for potential follow-up or to provide further evidence related to your submission? If so, please provide an email address by which we can contact you.

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