

BLAMING THE PATIENT

**Prescribed Tranquilliser Addiction
Denial and Avoidance of Responsibility**

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Drugs responsible for more pain, unhappiness and damage than anything else in our society

"If any drug over time is going to just rob you of your identity and be an ironic reaction to early effectiveness. To long, long term disaster, it has to be benzodiazepines."[sic]

Dr John Marsden, Government Adviser on Drug Addiction, psychologist and senior lecturer in addictive behaviour at the Division of Psychological Medicine and Psychiatry, Institute of Psychiatry, senior editor of the scientific journal *Addiction*. Britain's Deadliest Addictions, Channel 4, November 1 2007

"It is easy to overdose on prescription drugs, partly because your consciousness is impaired and it can be difficult to remember how many you've taken...**and however legal these drugs might be, their misuse carries the same consequences as illegal narcotics: the familiar, dispiriting tale of the addict losing their family, friends, job, home, and, sometimes, their life.**"

Dr Howard Markel, professor of paediatrics and psychiatry at the University of Michigan, February 10 2008

"We are in danger of not having learnt from the benzodiazepine story. People are saying we're going through the same cycle with anti-depressants. The prescription rate is rising fast, and it worries me."

Dr Mike Shooter, former President of the Royal College of Psychiatrists and chairman of the children's mental health charity Young Minds, 2007

"We moved to the treatment of drug offenders. Everyone struck sympathetic poses. No one said the unutterable and suggested that if NHS budgets are squeezed it should surely be people who become ill through no fault of their own—rather than self-harming drug addicts—who come at the top of the spending pile."

Quentin Letts, on previous day's Parliamentary debates, Daily Mail, 19 March 2008

"I could take members of the Committee to Oldham people who have been benzo addicts for 20-40 years...so much for efficacy! The only reason they are still taking their drugs is to keep withdrawal symptoms to a minimum."

Barry Haslam, Beat the Benzos campaigner, 2005

"It is estimated that 1.5 million people's lives have been destroyed by involuntary tranquilliser addiction leading to long periods of mental ill health. A man whom I met recently had been on tranquillisers for 45 years. Those people want to work, but cannot do so. As far as I am aware, the only primary care trust that has introduced a withdrawal programme is Oldham. Will the Secretary of State encourage his Department and the Department of Health to study the Oldham model with the aim of getting some of those people off prescription drugs and back to work? That would improve their quality of life, and would reduce the benefits bill as well."

Jim Dobbin (Heywood and Middleton) (Lab/Co-op)

Hansard 31 March 2008

Tranquilliser Myths

If you are told or read that the tranquilliser scandal is something that happened many years ago and has been addressed with lessons learned, and that doctors have all the facts about the consequences and nature of the addiction, you are entitled to sound a hollow laugh. If they assure you that doctors know better now, you may shake your head in wonder. The facts speak otherwise, but it seems that human nature being what it is, by and large the only ones with consistent and long-term concern, are those who have experienced the facts at first hand. DoH watchers have much the same feeling as those who voted in the Zimbabwe elections in 2008, an election where the results failed to appear. Real action on tranquillisers has similarly been long awaited but has never happened.

People have their belief systems and fight against those beliefs being challenged by unpalatable reality. The idea that medicine has killed, maimed and deprived, needlessly and avoidably, uncounted numbers of healthy people over fifty years through the unfettered prescribing of dangerous tranquilliser drugs, is not something most people want to think about. Belief in medicine as life-saving and pro-patient is strong and forces the mind to cast around for justifications and defences which in relation to benzodiazepines do not in fact exist. It is unfortunate that those in government who could have prevented this inexcusable tragedy from occurring and who allow it to

continue now, appear to be no different to anyone else. There has been and is no closure for the thousands of victims of unscientific prescribing, political posturing and regulatory inadequacy.

What is most striking about investigating the nature and history of benzodiazepine tranquillisers is the almost total lack of science behind political and medical statements about limited side-effects. Those effects have been down-played by regulators and by politicians and doctors without any recognition that it is pharmaceutical companies who have underwritten those judgements. The Department of Health and its agencies have not felt the consequences of their assertions—these have been confined to the patients who have experienced them. Knowing as they do, that enormous numbers of people were prescribed benzodiazepines over the years—many for inordinate lengths of time—they have no motivation for discovering the reality regarding a multitude of side-effects or the true cost of the damage. Often it is difficult to know where the self-deception ends and deliberate mendacity begins. On 19 March 2008 the Daily Telegraph said this:

“Richard Mawrey QC finally lost his temper with ministers’ arrogance as he ruled that Labour had organised a conspiracy across Birmingham to win the local elections by rigging postal votes. His trial found “fraud that would disgrace a banana republic”, while ministers were in “a state not simply of complacency but of denial.””

You might not immediately think that this description has anything at all to do with the benzodiazepine scandal but it has. What the judge described as a ‘state of complacency and denial’ fits the government response to injured patients perfectly.

Examine a voice-over statement made on a BBC Horizon programme on drug classification in February 2008:

“Benzodiazepines if taken illegally can lead to memory loss...”

No mention of the fact that tens of thousands of patients have been prescribed identical drugs for years and decades of their lives, rather than the official maximum guidance of four weeks. The best that can be said about this omission is that the programme was designed to look at the Home Office classification of drugs used illegally. This you might feel was fair enough, but the examination of drugs used legally for nearly half a century by doctors and illegally on the streets for much less than that, failed to highlight the crucial point which government and medicine consistently refuse to appreciate—**the drugs are the same**. If you are going to regard benzodiazepines on the street as illegal—presumably because they do harm, then in logic it follows that they do equal if not greater harm when prescribed to patients every day for limitless lengths of time. The connection is never made by government and it is appropriate to wonder who decides not to make it. There is a suspicion worth mentioning that judging by patient reports, many of them have been prescribed benzodiazepines in far larger quantities than those taking them illegally—but it is this latter group of illegal users who are seen by government as being in danger and in need of help and protection. The myth is always maintained that if a drug is prescribed as a medicine then it must have been safely done for positive benefit and it must have been prescribed out of necessity. No deeper analysis is made. This is the greatest fantasy of all.

Do doctors monitor patients, prescribe safely and prevent harm? Many doctors have prescribed recklessly for years in the face of regulatory advice. How has that prevented harm? Would it not be truer to say that medicine inflicted injury and bore little responsibility for having done it? Does that give medicine a reason to downplay the effects of over-prescription? With the NHS as a political creation, closely linked to the Treasury, does it give politicians a reason to blame patients and not the manufacturers and prescribers of the drugs? When the regulatory bodies set up by government to oversee drug safety are heavily influenced by pharmaceutical companies and have failed in their duty, is that another reason to blame the patient and avoid commissioning or insisting on drug company investigation into patient claims? Is it really informed to maintain that a drug which is illegal on the streets is totally safe as a prescription?

I sent this letter to the Department of Health on 23 February 2004, though it did not receive a reply—very few letters ever do. The DoH, like the NHS itself, seems to believe that a public which questions is an irritant. Both it seems are only too willing to believe in a “green ink brigade”, and are more interested in finding reasons to leave concerns unaddressed:

Ms Rosie Winterton, Minister of Health

The latest numbers from the UK charity TRF show that there were 1,070 cases of date rape in the UK between January 2003 and January 2004. In 1990 the number of cases was 39. Very few cases ever reach court because of a lack of evidence and memory loss. Bournemouth police have introduced a scheme to raise awareness but have emphasized that while people think of GHB (gammahydroxybutrate) and Rohypnol as the only date rape drugs, the whole range of benzodiazepines is used, including nitrazepam (mogadon), diazepam (valium), lorazepam (ativan) and

the new Z drugs—zopiclone, zaleplon and zolpidem. All the drugs, it is emphasized, have the same effect—especially if mixed with alcohol.

The TRF figures show the highest number of cases over the last 5 years—1,832—originated in pubs, but could occur anywhere. It is not the intention of the drug rapist to incapacitate the victim (though that can happen), rather to induce complete loss of inhibition and an unreal sense of confidence. The effect of Rohypnol and all other benzodiazepines, GHB and Z drugs used to 'date rape' is exactly the effect produced in patients through prescriptions. In medicine the memory loss is seen as beneficial in those about to undergo operations or in a state of crisis because of some life problem—often misinterpreted by doctors as psychological illness. But what may be advantageous in the very short term, is extremely disadvantageous in over-prescription. Stories of missing years in the memories of addicted patients are commonplace. Patients who have beaten the addiction are horrified to discover that what they had thought of as themselves while addicted was a drug induced reality.

The euphoria (an effect denied by Roche for decades), false gregariousness and unnatural confidence—deliberately induced by the administrators of benzodiazepines in date rape, are part of the picture of how benzodiazepine addicts, created by doctors, find that their lives have been made infinitely worse by over-prescription. Many former iatrogenic addicts find that as a consequence of the false picture of life that benzodiazepines produced in them, they are afterwards faced with financial burdens and a variety of other social and economic consequences, which were the direct result of inappropriate drug-induced decision making.

All the benzodiazepine drugs referred to above are available from a private or NHS doctor. They all work in the same way. They are a controlled substance when used illegally, but doctors who use them legally but without the knowledge of their social, economic and health effects are in practice uncontrolled.

In view of the impact benzodiazepines have had on many former patients' lives, would you be kind enough to say whether the Department of Health has any plans to consult with the relevant department to implement a scheme where those affected can at least have a small degree of security provided through disability benefits as a necessary obligation?

The last sentence in the letter, though justified, would have given a strong reason for the DoH to ignore it. Comments made by politicians in the past have made it clear that they believe two things about benzodiazepine campaigners—that they are motivated by money and that the evidence they present is selected to make their case.

Benzo statements

"The medical profession took nearly 20 years from the introduction of benzodiazepines to recognise officially that these minor tranquillisers and hypnotics were potentially addictive. The 'happiness pills', which had been propping up a fair proportion of the adult population since the early 1960s, were found to have an unexpectedly bitter aftertaste: doctors and patients alike were unprepared for the problems of dependence and withdrawal that are now known to be common even with normal therapeutic doses."

Editorial (Anon), 'The Benzodiazepine Bind', *Lancet*, 22 September 1984, 706

"The Medical profession, I think, is fairly ashamed of what has happened. It has allowed this very untrammelled prescribing to go on. My estimate is that there's something between a quarter and half a million people in this country, at this moment, who would have problems trying to stop their tranquillisers. They would need help to do so and there's been a sense that they're difficult to treat, difficult to deal with and a lot of these patients are just kept on their medication indefinitely. No real attempt is made to help them come off...the Government should tackle this problem face on. There are thousands of people out there who are not receiving treatment, hundreds of GPs who don't know really how to treat these patients. There are self-help groups who are crying out for funding just to keep going at a very low level. I think the Government should now acknowledge the problem and set funds aside, because if the Government doesn't do that, these people will go to their graves with their tranquilliser bottles beside them."

Professor Malcolm H. Lader, 'Face the Facts', BBC Radio 4 1991

"Benzodiazepines cause a more significant withdrawal for the newborn baby than either heroin or methadone. When a baby is withdrawing, they have a state of irritability, they are hyper-responsive, which means that they tremor at the slightest noise, even when quiet and they cry with a cry that is

very distinctive—it's much higher pitched and it's much more of a distressed cry as if the baby is in discomfort. They basically are miserable, unsettled babies."

Dr James Robertson, Arrowe Park Hospital, Liverpool, 'Face the Facts', BBC Radio 4, 1999

"The developing foetus can be congenitally malformed; it can have heart attacks in the womb. We also know that the newborn baby born to somebody taking benzodiazepines will have difficulty breathing and they would have floppy muscles—what doctors call a 'floppy baby' and they may be unduly cold because the temperature regulation, which is so important to a baby, is disrupted..Well I think if any doctor is prescribing benzodiazepines to a pregnant woman, he should check his indemnification status because it is in fact illegal prescribing."

Robert Kerwin, Professor of Psychopharmacology at the Maudesley Hospital, London, 'Face the Facts', BBC Radio 4 1999

"This is a worldwide problem [benzodiazepine dependence] and I think one of the big factors is they're cheap. GPs are now under a great deal of pressure to prescribe inexpensive drugs. Now, a thousand 2mg Valium tablets...diazepam tablets...cost around £3 which is not very much. If you are prescribed 60 and you pay the six quid prescription fee, the government makes a nice little profit out of you."

Dr John McCormack, General Medical Council, on BBC 'Face the Facts', March 1999

"Doctors who prescribe benzodiazepines continuously are courting disaster. What we need to realize is that benzodiazepines are addictive...the drugs should not generally be prescribed for longer than a few weeks. You use them clinically when it is indicated for short periods of time. Short-term use is certainly less than three months. In general practice I wouldn't be using them for more than two to three weeks...it is a drug that takes a much longer detox procedure than almost anything else."

Drug-addictions expert Dr. Garth McIver, The Vancouver Province, December 31 2001

"There's still a significant continuing problem with benzodiazepines in this country. We would have liked if it was solved 20 years ago, but it still exists. We continue to work as a College with prescribing groups around the country to try and continue to raise awareness of this issue and reduce the prescribing of these drugs to appropriate use, but it is a very long struggle...I think it should be a significant priority for this country. It's potentially a million people who are on drugs which only maybe is a tiny percentage of them need to be on, and that is not good for this country. It's also a waste of resource. We are ploughing money into these drugs and into support services for patients for a situation that we **may** have created ourselves."

Dr Jim Kennedy, Royal College of General Practitioners, 'The Tranquilliser Trap', BBC, May 2001

"It is difficult to defend that we have such a huge problem of benzodiazepine prescription and long-term use and therefore dependence."

Professor Louis Appleby, National Director for Mental Health, 'The Tranquilliser Trap', BBC, May 2001

"**Some** people have been on the drugs for many years and it is very difficult to get them off because they are very addictive. We can nibble away at the problem—but it is a very time intensive thing to have to do."

Dr Peter Fellowes, Chairman, BMA Prescribing Committee, March 2004

"The medical profession should take much responsibility for allowing the present situation to arise. They have been guilty of decades of thoughtless prescribing which persists for benzodiazepines despite national and international guidelines, recommending that benzodiazepines are indicated for short-term use [2–4 weeks] only."

Professor C. Heather Ashton DM, FRCP, Bristol and District Tranquilliser Project AGM, October 2005

A family doctor in Reading in 2007 expressed a not uncommon, caring medical view when he said that patients increasingly expected to be given medication rather than other therapies:

"Antidepressants seem to have lost the stigma they once had and now most patients seem to want to take them."

He might have said that this was due to the ignorance of patients on the facts behind the drugs but he did not. This flew in the face of the fact that deaths due to adverse drug reactions had risen by over 500% since the early 1990s according to a Tomorrow's Doctors Report in 2006. In that same year Professor Jeffrey Aronson, from Oxford University and president-elect of the British Pharmacological Society, commenting on rapidly rising drug injury, said:

"I think that any dangers that occur could be prevented by careful prescribing, by careful use and by increased knowledge on the part, both of doctors and nurses and pharmacists who are prescribing drugs, and the patients who are using them."

The General Medical Council unsurprisingly did not agree with the first part and commented:

"We refute the suggestion that medical undergraduates are failing to learn to prescribe properly. It is clearly stated in our guidance that medical students must be taught to prescribe safely and effectively, and we regularly check medical schools to ensure they are following our guidance."

Again unsurprisingly, the Department of Health said:

"The reform of junior doctor training, Modernising Medical Careers last August means that all junior doctors now have to prove they are skilled in prescribing before they are able to move up to the next level of training. Skills junior doctors must demonstrate include being able to prescribe drugs appropriately, take accurate patient drug histories and recognise the sources of medication error and ways to minimise it."

Gelling nicely with a defensive philosophy that patients are only given what they want, in the findings of a survey of 870 family and hospital doctors conducted by Doctor Magazine in January 2008, 60% of doctors believed that NHS treatment should be withheld from patients who were too old or who were leading unhealthy lives. Paul Mason, a Dorset GP said:

"The issue is: how much responsibility do people take for their health?"

Benzodiazepine victims wish fervently they had kept responsibility for their own lives and health and not passed it to their doctors. As a result of not doing that, many are left with poverty and permanent ill health as a legacy.

On 10 February 2008, The Observer printed a report on the findings of the All Party Parliamentary Group on Drug Misuse under the headline "GPs have got Britain 'hooked on painkillers'". That the story appeared and the APPG had recognised the great harm over-prescribing by GPs has inflicted on trusting patients, was welcome news and much needed publicity. Campaigning group Beat the Benzos had submitted information to the committee and the chairman Dr Brian Iddon MP received a copy of my book Prescription for Injury which examines the politics behind state sanctioned tranquilliser addiction.

The report highlighted key facts:

- Some doctors (and the number is worryingly unknown) are 'mis-prescribing' drugs such as painkillers, sleeping tablets and anti-anxiety pills 'leading to addiction and dependence'.
- They are fuelling the growth of the number of citizens hooked on prescription drugs by giving them dangerously high doses of medicines that can prove highly addictive. Among these drugs are benzodiazepines and 'Z' drugs.
- GPs ignore the advice from the Committee on Safety of Medicines and subsequent advice that patients should take benzodiazepine tranquillisers and hypnotics for no more than four weeks. They issue repeat prescriptions without even seeing patients in their surgery.
- Home Office figures suggest the misuse of benzodiazepines has caused 17,000 deaths since their introduction in the Sixties.

"It was extremely concerning for the inquiry to receive so many testimonials of people still being negligently prescribed these drugs by their GP. The guidelines now in place recommend that benzodiazepines are not taken continuously for longer than four weeks, but there were many cases of GPs continuing to prescribe the drug for a lot longer—sometimes even allowing repeat prescriptions without having the patient in for a consultation."

"Some GPs are addicting people by giving them repeat prescriptions without checking to see how long they've been on the drugs in the first place. They are not stopping patients from getting any more of them after the set amount of time."

All Party Parliamentary Group on Drug Misuse, February 2008

As it was reported in the Observer, the story then lost some credence, beyond the fact that dangerous prescribing of benzodiazepines was happening. It did not mention that this had been happening for almost half a century, in spite of attempts by campaigners and affected patient survivors to stop it. Doctors, the correspondent reported,

were **unwittingly** fuelling the growing number of people hooked on prescription drugs. The question of when doctors should have ceased to be unwitting and to act unwittingly was not explored.

The meanings of unwitting are defined as:

1. Unintentional: not intentional; "the offence was unintentional"
2. Not aware or knowing
3. Ignorant, unaware because of a lack of relevant information or knowledge

Unwittingly is defined as: without knowledge or intention

Is mis-prescribing i.e. prescribing benzodiazepines to the wrong person or for too long a period, unintentional? Should any prescriber be uninformed? This is what the Committee on Safety of Medicines said twenty years ago in 1988 in their guidance under the heading: CURRENT PROBLEMS 1988; Number 21: 1-2 BENZODIAZEPINES, DEPENDENCE AND WITHDRAWAL SYMPTOMS

The Committee on Safety of Medicines recommends that the use of benzodiazepines should be limited in the following ways:

1. Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness.
2. The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate and unsuitable.
3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress.

DOSE

The lowest dose which can control the symptoms should be used. It should not be continued beyond four weeks.

Long-term chronic use is not recommended.

The advice was sent to all doctors in the UK and the Department of Health says that further guidelines were issued in 1994 and in 1998 to GPs and health authorities. What place does 'unwitting' hold here? What don't extensively trained doctors understand about the 1988 Guidelines on benzo prescribing? The advice was quite clear, though it took the UK regulatory authorities nearly thirty years to issue it. For some doctors today and most yesterday however, the guidance might never have been issued. The situation with benzodiazepines, 'Z' drugs and SSRIs is a clear illustration of the limitations of guidance when a doctor can operate with the belief that his own practice, experience and clinical judgement is more reliable than regulatory warnings and the reports of adversely-affected patients. The DoH says that the number of tranquilliser prescriptions has fallen over the years in England and Wales but there are two points which are not commented on:

1. Z drug prescriptions and antidepressant prescriptions have taken up the slack.
2. No attention at all is paid to those who will never recover—a total constantly added to even under the present prescription levels. Professor Heather Ashton estimates this at a possible 15 percent in long term patients.

It is worth noting however that in Scotland prescriptions of diazepam have increased by 60% in the past decade, from just in excess of half a million per year in 1996 to more than 800,000 in 2007.

Medical defence and comment

"Patients who are addicted to prescription drugs can be extremely manipulative in their efforts to get GPs to prescribe them more drugs."

Dr Steve Field, chairman of the Royal College of General Practitioners, February 2008

Dr Field, in saying that the Royal College would 'take on board' the findings of the APPG, then followed the usual line of avoiding the question of how patients become addicted to tranquillisers in the first place and mitigated any responsibility for doctors by referring to patient abuse of prescription drugs and lumping this together with addiction through over the counter drugs.

These days the purchase of drugs on the internet is emphasised in any report of the 1 million plus iatrogenic tranquilliser addicts in the UK. This is a recent phenomenon, is a complete red-herring, and has nothing to do with the indisputable fact that hundreds of thousands of unsuspecting patients since the beginning of the 1960s were

never warned about what could happen to them, either by their doctors, or by leaflets accompanying their prescriptions. Neither were they effectively protected by government and regulators who were consistently and regularly told by campaigners and patients that doctors in the NHS, in large numbers, were ignoring the four weeks advice and were prescribing as they had before.

Medical and government defence of the benzodiazepine scandal has moved through several stages, not necessarily in this order and not necessarily one at a time. Sometimes previous positions are resurrected:

- The drugs are not addictive
- And if they are, it is because of an addictive personality
- Patients ask for them
- Patients bully doctors into prescribing
- The drugs are cheap to provide for government
- Doctors have no time to assist in withdrawal/doctors find it very difficult
- There are no alternatives to pills in UK healthcare
- Aware or former iatrogenic addicts are merely seeking compensation
- It's all down to defective genes
- It's all in the past, it was regrettable but we have learned lessons
- Patients abuse the drugs and must be controlled
- Benzo campaigners select their evidence

The view of patients being the authors of their own demise and deluded victims of their own pre-existing psychological condition began with the pharmaceutical companies and the experts who were linked to them. Until 1988 there was no UK regulatory recognition that benzodiazepines were addictive and should be used with caution. There had been a statement in 1980 by the Committee on the Review of Medicines that "there was little convincing evidence that benzodiazepines were efficacious in the treatment of anxiety after four months' continuous treatment." Since tens of thousands of people before and after were prescribed them for decades, the conclusion you might think is that although they might not work, they were fairly harmless. Large numbers of doctors disbelieved the first and agreed with the second.

But there was evidence, some of it long before 1980 that benzodiazepines were addictive and had severe side-effects—it was merely a case of not proven in the eyes of regulators. Benzodiazepines had from the beginning a large placebo effect on those who prescribed them and those who regulated drugs.

"How the dependence potential of the benzodiazepines was overlooked by doctors...is a matter for amazement and casts shame on the medical profession which claims to be scientifically based..."
Professor C. Heather Ashton DM FRCP, Bristol and District Tranquilliser Project AGM, October 2005

And as Mick Behan of Beat the Benzos wrote to the House of Commons Health Committee inquiry into the pharmaceutical industry in 2004:

"Most of the benzodiazepines—Valium, Librium, Mogadon, were on the market before the Medicines Act of 1968. These drugs were issued "Licences of Right". The Licences of Right were a registration procedure and involved no assessment of safety or efficacy. Assessment was deferred to a future review by the CRM. Significantly, those reviews did not occur until 1983/84. By then the damage was done, the huge benzo addict population had been created and still exists to this day."

There has been much learned discussion over the years amongst scientists and lawyers about precisely when doctors should have known about the addiction potential of tranquilliser/hypnotics. They should have known from the beginning, since nearly every chemical that medicine had ever used to influence the mind had turned out to be addictive. But in medicine it seems, until either an overwhelming mass of new independent scientific evidence or rare pharmaceutical company admission alters the view of a drug, damage done to patients and reported by them does not exist. That is the single most depressing fact about this age of drug company controlled medicine—ostensibly for the benefit of patients and the alleviation of suffering—only those with a positive experience to report are believed. If the positive is accentuated for long enough however, it becomes impossible, it seems, to admit what has happened, take direct action to stop it continuing, or help those affected.

"The scale of the problem is so large...that is beyond the grasp of many politicians and people in power to solve it...you have this huge problem with a huge number of people involved and yet we seem as a society to be incapable of acting on it. We can only cope with problems that are so big...we can't cope with this one."
Phil Woolas MP, Croydon Benzodiazepine Conference, November 2000

Benzodiazepines became a huge experiment on the population. It is possible but not likely that Roche and subsequent 'me-too' manufacturers had no idea at first that that was what was to happen, but their marketing tactics were certainly aimed at expanding the market as wide as sales tactics and permitted control of research information, could make it. The experiment in profit generation without responsibility for human injury, certainly worked and it drew in vast numbers of people who were not mentally ill and who had no organic disease. Subsequently many of them became very ill, many losing homes, families, jobs and future—things which cannot be given back and remain unacknowledged to this day. Benzodiazepines, contrary to the message coming from government and drug companies, were only in the minority of cases prescribed for clinical anxiety—they were as Professor Heather Ashton rightly says, prescribed for everything:

“[Benzodiazepines] have been prescribed for sports injuries, muscle spasms, premenstrual tension, exam nerves, depression, general malaise and much else. Because they make some people feel good at first...these prescriptions tend to be continued long-term.”
Bristol and District Tranquilliser Project AGM, October 2005

The manufacturers have always maintained the line that tranquillisers had invariably been prescribed for clinical anxiety but what degree of anxiety would even justify the injuries that benzodiazepines can inflict? Rather than for clinical anxiety however, tranquillisers have been prescribed, and led to addiction, for everything from the death of a pet to vertigo. The Department of Health has never wavered from the same line too, and has formulated a message of all reported patient adverse effects being caused by a pre-existing mental health problem. In their view such things as brain atrophy, severe muscle and joint problems, gastro-intestinal disturbances, distorted nerve sensations and a whole host of other physical symptoms are produced by some undiscovered (but always undemonstrated) psychological condition. Such assertions would disgrace a fantasy pot-boiler, but are all too readily parroted in the political world of pharmaceutical/medical defence. Government relies on a variety of allies in its denial but above all on the fact that most of those affected never make the connection between their ill health and the prescriptions. Why would they, unless they research the facts—patient leaflets and doctors avoid all mention of serious side-effects; doctors because they accept what regulators and drug companies do not tell them and leaflets because regulators see it as their duty to rubber stamp the crafted pharmaceutical message they contain.

Interestingly, although he made few public pronouncements on the drugs he created, Roche scientist Leo Sternbach always insisted it was not the drugs, but the doctors prescribing them, who were responsible for the damage. He had a point, but the general message simply does not stand up in the real world where the drugs were prescribed. Although doctors over-prescribed and mis-prescribed, for which they were certainly culpable, the sales arms of Roche, Upjohn Wyeth and others with their messages of benefit without side-effects had underscored what they did. No drug company told doctors to prescribe for a limited period in the interests of safety. No drug company warned doctors that the drugs were addictive in excess and for years they fought the truth that they were.

The UK Government will tell you anything it thinks sounds right and seemingly doesn't care if the statement is obviously bogus and illogical. They will tell you for instance that abolishing parking charges for visitors and patients to hospitals in England, as Wales intends to do in 2008, cannot be done because 'forcing hospitals to stop charging would breach the Government's drive to cut carbon emissions by encouraging car use.' They will tell you that their actions on reducing benzodiazepine prescribing have worked, are working and that they 'take the problem seriously'. That they ignore what the problem is, refuse to help the severely afflicted and avoid thinking about the fact that the problem has existed for nearly 50 years, demonstrates the untruth of what they say. At any time, the Department of Work and Pensions which does not officially recognise most benzodiazepine symptoms and which oversees social security benefits, may withdraw incapacity benefits from the severely affected who do not tick the boxes. Many of those suffering from symptoms which government refuses to acknowledge and which many doctors do not recognise because they have never been told they exist, live in fear of benefit withdrawal, adding a further impact on their lives, beyond the effects benzodiazepine drugs have previously inflicted.

Ministers have no expertise in the work of most departments they find themselves in charge of. Ministers in the Department of Health are no exception. They are therefore reliant on advisers who are deemed to be unbiased and expert. Ministers have no way of estimating how expert and unbiased they are and perhaps no motivation. Such advisers are the ones the minister asks for a view on any issue raised by patients and campaigners. When former health minister Hazel Blears told a campaigner that she believed benzodiazepine activists used 'selective evidence' that view would have originated from her advisers. The fact that campaigners know this is not true gives them no ability to demonstrate it.

The existence of ministers gives complete immunity to the flawed beliefs and actions of advisers and civil servants as they act in their name. Advice on psychotropic medicines comes from the psychiatric sphere of medicine—a sphere that it has been said owes its claim to scientific knowledge simply by virtue of its alliance with pharmaceutical manufacturers and their drugs. With some notable exceptions, such psychiatrists have no motivation to divorce themselves from the benefit message of manufacturers whose financial support and influence

has often fostered their careers. Advisers are as a rule, those whose involvement with the pharmaceutical industry has propelled them to their positions. They claim to be the holders of scientific 'truth' and the Department of Health accepts it, producing policies based on pharmaceutical company 'expertise' and 'evidence'.

The benefits of light touch regulation

After 4 years of regulator (MHRA) 'investigation' into whether GSK hid trial results concerning the effectiveness and suicide risks associated with the SSRI Seroxat, the government announced in March 2008 that GSK had indeed been aware of these facts from 1998 and had not given the trials data to the MHRA until May 2003. In a breathtaking statement on this crucial fact, new health minister Dawn Primarolo said that GSK would not face criminal prosecutions because the law on when or even whether drugs companies should inform the regulator is not clear enough. GSK and the undisclosed trials illustrate perfectly how in the UK we have a No Responsibility health system. Prescribers have no responsibility and neither does the regulator, the Medicines and Healthcare products Agency, which does not have the power or inclination to discover truth. Politicians rather than face responsibility, refuse to pick up on the real import of what happens in medicine.

New legislation, according to Primarolo would be introduced by the end of 2008 placing a greater obligation on companies to disclose results of trials, though there is no detail on the proposal. The MHRA has said it would press for a law change in the U.K. and eventually Europe to compel the reporting of negative clinical data no matter where trials are conducted. GSK are currently being sued in the US by families of under-18s who committed suicide while on Seroxat. The families claim the drug increased their children's suicidal thoughts and GSK knew about the dangers. Since it was first prescribed in Britain in 1990, the tablet, which makes GSK £1billion a year, has been associated with at least 50 suicides, both adult and child.

Suing the same company over the same drug in the UK is likely to be a great deal more problematical than in the US. Obtaining legal aid funding for court cases in the UK is virtually impossible and those injured by the government and its agencies are forced to prove beyond any scientific doubt in civil cases that the drug caused the injury. Given the secrecy surrounding drug data, the absence of independent science on claims and the overwhelming financial power of drug companies, the UK legal system is a picture of almost total denial of justice.

The GSK situation regarding Seroxat is of concern to us all. Patients take drugs on the advice of doctors and doctors get their information about effectiveness and safety from drug companies, such as GSK, and from uninformed and some would say ineffective and unconcerned regulators. Consider these statements on the MHRA decision:

"I personally believe that there is an ethical dimension to this and it is very important that companies realise that if they have information, whether or not there is a legal obligation to do so, they should pass it on to us."

Kent Woods, Chief Executive MHRA, BBC Newsnight, 6 March 2008

"Because the drug was never actually licensed for children though, a loophole in the law means the company can't be prosecuted. In the absence of tighter legislation though, trust is all there is and there is nothing to say other drug companies haven't been misleading the public about other medicines that are currently assumed to be safe."

Shelley Jofre, BBC Newsnight, 6 March 2008

"Unless there is a mandatory publication of all results I can't see how we can trust drug companies at this point to just disclose voluntarily."

Dr Tim Kendall, Royal College of Psychiatrists

"The MHRA made clear yesterday it was convinced GSK was aware of the dangers of Seroxat to children some time before the company told the regulator. But not only was it unable to prosecute GSK under the existing laws, it was also prevented from revealing what it had discovered under secrecy rules related to the commercial confidentiality arrangements. So at the end of an investigation in which the MHRA's investigators negotiated on 103 occasions with GSK lawyers over obtaining documents, and accumulated one million pages of evidence, the situation remains as it was in 2003. Nobody outside GSK and the MHRA officially knows who knew what and when."

The Guardian, 7 March 2008

The MHRA had found that GSK had not told them about crucial trials results affecting patient safety but that was not illegal in the UK. But then as the UK pharmaceutical trade association the ABPI told the House of Commons Health select Committee in 2005:

“The pharmaceutical industry is a business, with obligations to its shareholders. The regulator should expect it to use any legal means to provide a return on investment.”

“Our goal—to bring to patients life-enhancing medicines—is not only necessary but noble, and there is no reason why the industry should not use all legitimate means to advance it.”

As has been found regarding children and Seroxat, not revealing data to the MHRA in a timely fashion has been legal and presumably therefore was seen as legitimate. This is nobility in action.

What concern had ever been and was being shown for benzodiazepine or more recently, SSRI patient safety? What is the value of a human life to government? The MHRA in the person of Kent Woods had discovered an ethical dimension to drug manufacturer and regulation. They had discovered, because they could not at last publicly avoid discovering it, that what campaigners and independent doctors had been telling the regulator for years was true—that drug company motives are primarily profit focused and they employ ever more devious (though perhaps legal) tactics to secure that profit at the expense of patients (but not the economy). The MHRA is amateur, not expert, because of its ignorance, and as Charles Medawar says, places a 'naive and absurd' level of trust in drug companies. Benzodiazepine campaigners and patients have been rejected for years by a body which has no evidence, does not seek evidence and believes in those who hide the evidence.

"The deviousness companies employ when promoting their drugs and minimising their side-effects is really quite extraordinary."

Charles Medawar, Medicines Charity Social Audit, 7 March 2008

At this point it is worth reproducing the comment by Dr Steve Field, chairman of the Royal College of General Practitioners:

“Patients who are addicted to prescription drugs can be extremely manipulative in their efforts to get GPs to prescribe them more drugs.”

No acknowledgement here of the tactical control of medicine by pharmaceutical companies, merely a repetition of the patient is to blame message. GPs and regulators are the main target of drug companies, but as usual it is the uninformed patients who bear the consequences. It is the patients who are blamed for the situation they find themselves in.

What truth was being demonstrated about the drugs regulator, the level of its expertise, its willingness to police drug companies and its ability to pronounce on the safety of drugs? The MHRA describes its responsibilities as “protecting and promoting public health and patient safety by ensuring that medicines, healthcare products and medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and are used safely.” But after this forced public disclosure how successful is the regulator? What value to place on government statements that drug companies are a success story? Is it now more likely that ongoing and historic patient claims of drug harm (including benzodiazepines) are valid? How should we assess regulator and government claims that the claimed drug injuries are not backed up by science? As a matter of record, on 24 February 1994, David Blunkett, opposition Labour MP, who became Home Secretary in the Blair government, told Barry Haslam of Beat the Benzos:

“Dawn Primarolo and myself have been taking up cases and have advised on how best the groups involved might organise a parliamentary lobby and keep attention on these issues. We have also tried to assist through both Parliamentary Questions and raising the matter on the floor of the House, in pushing the Government to accept its own responsibilities and to take action now to ensure that it does not happen again.”

Dawn Primarolo is the health minister in 2008 making the announcement about tightening the law on disclosure (11 years after her party came to power) but one is entitled to doubt if any attention at all will be paid to the ‘issues’ of benzodiazepines. Here are some of her answers to questions asked in parliament on the subject:

3 March 2008

Jim Dobbin: To ask the Secretary of State for Health how many of those previously addicted to prescribed tranquillisers have suffered long-term impairment as a consequence of their addiction.

Dawn Primarolo: The Department does not currently collect information that enables us to provide an estimate of the number of patients who are addicted to prescription drugs.

11 March 2008

Jim Dobbin: To ask the Secretary of State for Health

- (1) How many and what proportion of babies born with a tranquilliser addiction have a permanent impairment as a consequence of their addiction; [190209]
- (2) How many babies were born with an addiction to tranquillisers in each year from 1999 to 2006; [190273]
- (3) What treatment the NHS provides to babies born with an addiction to tranquillisers. [190275]

Dawn Primarolo: Information is not collected centrally about the number of patients with a prescription drug addiction, nor is information available either about the number of individuals with a permanent impairment as a consequence of their addiction.

14 March 2008

Jim Dobbin: To ask the Secretary of State for Health what services are provided to pregnant women to assist withdrawal from (a) voluntary and (b) involuntary or prescribed tranquilliser addiction. [191167]

Dawn Primarolo: The maternity services standard of the 'National Service Framework for Children, Young People and Maternity Services' states that women who have substance misuse problems are at greater risk of problem pregnancies and their care should be provided by an integrated multidisciplinary and multi-agency team. All National Health Service maternity care providers and mental health trusts should have in place joint working arrangements for maternity and mental health services, including arrangements for direct access by midwives, general practitioners and obstetricians to a perinatal psychiatrist.

27 March 2008

Jim Dobbin: To ask the Secretary of State for Health what steps are being taken to tackle addiction to prescribed selective serotonin reuptake inhibitor antidepressants.

Dawn Primarolo: There is no conclusive evidence that antidepressants such as selective serotonin reuptake inhibitors (SSRIs) are addictive, in that they do not appear to lead to tolerance or dependence-forming, hence the Department has not implemented any policies to deal with this issue. However, we know that some patients will experience withdrawal reactions on stopping or reducing their use of SSRIs, and in some cases the withdrawal reactions may be severe and disabling.

These comments from more informed sources are relevant:

"When SSRIs first came out, people like me were telling our patients, "These are not like tranquillisers, you can't get hooked on them." But while they don't get hooked in the sense that they crave them or mortgage everything to get more of the drug, they do get hooked in the sense that when they try to stop taking them, they have trouble."

Professor David Healy, The Observer, 3 February 2002

"As I mentioned before, the benzodiazepines had been accepted as being dependence-producing, or addictive, on the basis of their withdrawal effects. Now there were clear withdrawal effects from SSRIs. In a scramble to prove that SSRIs were not addictive, psychiatrists changed the definition of drug dependence."

Professor CH Ashton, October 2005

"After the trial ended they said: "Can we continue on these tablets because we feel we've got to have them because they seem to be so effective", but more concerning to us was the fact that they were saying: "I cannot tolerate the symptoms when I stop it"."

Professor Peter Tyrer, Head of Psychological Medicine, Imperial College, London

Government advisers are honourable men and women is the never varying establishment message but they are only as expert as their philosophy, connections and information allow. The true experts on drug impact are patients—people without a philosophy to defend, no pharmaceutical connections and with the most important information in the world—personal experience.

On March 2 2008, the UK newspapers were plastered with the apparent news (Dr Irving Kirsch et al review of published and unpublished SSRI trials) that SSRIs were not as effective as government and its advisers and therefore doctors had previously said they were. In fact for mild and moderate depression they were little better than a placebo and of course carried the risk of severe side-effects—something else the government and its advisers have apparently yet to learn. This news was not news to psychiatrists such as Professor David Healy, who have been saying it for years. But the media did not address the real scandal which is that for 20 years Pharma had been hiding the results they did not like and the severe side-effects they knew about. Neither did the media

address the fact that government policy on the drugs had been based on MHRA advice on safety, when in fact they had never seen the hidden data and what data they had seen had been in summary form. Ivan Lewis, the mental health minister had taken what was described as 'the unprecedented step' of calling on the drugs companies to give the data to the body that will review the current depression guidelines, the National Institute for Health and Clinical Excellence. He said that 'a failure to do so would leave the inevitable impression they had something to hide'. Benzodiazepine campaigners have been saying this for decades but no-one who could change things has yet listened with any degree of concern.

The UK government sees the drug companies as vital to the British economy and therefore its priority. Pharmaceutical companies, particularly GSK, have regular access to government, thereby giving them the ability to form health policy. In many ways, their influence is so great, that they are almost a part of government. When the Department of Health, the drugs regulator, NICE, doctors, the Department of Work and Pensions and patients are basing their actions on positive and partial information provided by manufacturers, why is it so easy and acceptable to deny patients' injury claims? Drug manufacture and regulation and hence prescription is not a leisurely and gentlemanly game but is played as though it is. Regulators deny, deny, deny until they are forced publicly into some degree of confession, but before that happens unknown numbers of those outside the rules of the game have their lives destroyed and their injuries made invisible.

Anyone looking at the Department of Health website under 'What's New', as the news about GSK and Seroxat was being examined in the media, would have found something which you might think in the circumstances was less than appropriate:

'Moving beyond sponsorship: Interactive toolkit for joint working between the NHS and the pharmaceutical industry.'
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082840

"In February 2007, the Ministerial Industry Strategy Group published its Long-Term Leadership Strategy for medicines. To encourage joint working between the NHS and pharmaceutical industry it recommended that the Department would develop an interactive toolkit to support this.

The purpose of this toolkit is to:

- encourage NHS organisations and staff to consider joint working as a realistic option for the delivery of high-quality healthcare
- provide the necessary information and have easy access to the tools which will help to enter into joint working."

There is not only a revolving door between the pharmaceutical industry, regulatory bodies and government,

"The relationship between the industry and the MHRA is naturally close. There are regular interchanges of staff, common policy objectives, agreed processes, shared perspectives and routine contact and consultation. Many of the senior staff of the MHRA have previously worked with the industry..."

March 2005 House of Commons Select Committee on Health Fourth Report

but also between politicians in the health department, other branches of government, and industries who value their connections.

In 2007, health minister Lord Warner left the DoH. The Rt Hon Lord Warner of Brockley PC was previously Minister of State for NHS Reform. In March 2007 he became chairman of a body known as the London Provider Agency, a body which he had a great deal to do with the setting up of. Commenting on the appointment, Ruth Carnall, Chief Executive of NHS London said:

"We are very fortunate to have been able to recruit Norman Warner who has such a tremendous knowledge of London coupled with his unrivalled experience of central and local government as both a public servant and Minister. London will derive huge benefit from his wisdom and unique insights."

The London Provider Agency seeks to persuade hospitals to adopt what are loosely termed "modernisation" measures. Further appointments have followed with companies which have an interest in his policies as a minister. He has become an adviser to Private Equity Group Apex which part owns General Healthcare, a group which had won several independent sector treatment contracts from government. Lord Warner was in charge of the government IT programme for four years and he has now joined Xansa, Deloitte and DLA Piper who all benefited

from government contracts. The anti-bacterial gel producer Byotrol, are also going to employ him, presumably because of his “unrivalled experience of central and local government” and presumably his contacts.

In January 2008, it was announced that Patricia Hewitt, former Secretary of State for Health had been appointed "special consultant" to the world's largest chemists, Alliance Boots. She is also to become the "special adviser" to a private equity company Cinven, which paid £1.4billion for Bupa's UK hospitals. In March 2008, it was announced that Hewitt will join the British Telecom Group board as a non-executive director. Like Lord Warner, Hewitt is an advocate of private enterprise and its role within the UK healthcare system.

Lord Sainsbury, science minister for eight years under the pharmaceutical company enthusiast Tony Blair is an example of how political donations can apparently lead to power in government. Since 1997 he has given £16 million to the Labour party. Like Lord Warner he brought to his appointment as science minister an agenda which his official position gave him the opportunity to advance. He has been a long-term supporter of GM crops and was financially involved with their development before becoming a minister. His ministerial position necessarily gave him a unique opportunity to promote his interest.

Paul Drayson, another Labour donor who became a minister and was elevated to the Lords, co- founded PowderJect Pharmaceuticals in 1993 which specialised in the production of vaccines and was Chief Executive until 2003. Not surprisingly you might think, PowderJect was awarded a £32million government smallpox vaccine contract in 2002—without competition, shortly after Drayson donated £50,000 to the Labour party. There was a parliamentary inquiry but no wrongdoing was found. After he was made Baron Drayson of Kensington in 2004 he gave the Labour Party £500,000.

Quis custodiet custodians?

Campaigners and patients must be forgiven for believing that they will never be adequately protected while the economic benefit conferred by drug company activities takes precedence in the mind of government, and the job prospects of former ministers and maintenance of an interdependent and philosophically aligned system appears to be the priority. Perhaps that is why the government places little emphasis on this informed assertion from the Health Select Committee:

“Trust is critical in the relationship between regulators and industry. However, at the heart of this inquiry are the concerns of those who believe that the MHRA is too trusting. Trust should be based on robust evidence; it should be earned rather than presupposed. The evidence indicated that the MHRA examined primary (raw) data on drug effects only if it suspected some misrepresentation in the summary data supplied. It was argued that such trust in regulated companies goes too far: reliance on company summaries is neither sufficient nor appropriate, in the absence of effective audit and verification of data that companies provide.”

And as they also said:

“If pharmaceutical companies only publish clinical research that is positive and hold back on publishing clinical research which is negative, then patients may well be given treatments which, unknown to either the patient or the doctor, are likely to do more harm than good.”

“Although much has changed in drug regulation and prescribing practice in the last decade, the over-prescription and subsequent widespread adverse events and 'therapeutic' dependence on benzodiazepines is perhaps a good illustration of the dangers of drug promotion by the pharmaceutical industry and under-regulation or over-reliance on industry self-regulation.”

“A large-scale legal action was brought against the manufacturers of Ativan (John Wyeth) and of Valium, Mogadon and Librium (Roche) in 1986. By 1992, over 12,000 claimants were involved in this litigation. However, most claimants were funded under the Legal Aid scheme and the Board withdrew this funding in 1996. To date, no redress against the companies involved has been made, and the legacy of an influential promotional campaign in the 1960s continues.”

“There is a lack of support and rehabilitation services available for people still addicted to benzodiazepine drugs, many of whom may have been first prescribed them in the 1970s or 1980s. Not a single NHS benzodiazepine rehabilitation clinic exists in the UK to this day.”
2005 House of Commons Health Select Committee Fourth Report

Understanding Addiction

The Department of Health and the medical establishment persist today in a wrong-headed and indefensible misunderstanding of the process of addiction. In statements they give the appearance of believing that there is no difference between the iatrogenic tranquilliser addict and someone addicted to the same drugs bought on the street. The Department of Health makes much of what it calls an instalment prescribing facility for addicted patients. As Professor Ashton, Beat the Benzos, as well as myself and others have told the department, this is a misconceived response to Involuntary Tranquilliser Addiction (ITA). It is based on a self-serving belief that the cause of addiction is the patient and not the drug—patients are abusing the drugs and damaging themselves. In fact the primary cause of ITA is mis-prescribing by prescribers and the extreme addictive potential of the drugs.

According to its pronouncements, the Department of Health seemingly finds it impossible to get its collective head round the meaning and mechanism of addiction. It admits that tranquillisers are addictive and then with no logic at all insists that patients, who over the years had no warnings about the potential for addiction, in fact are **with personal responsibility and misuse aforethought**, abusing the prescriptions and therefore primarily in need of control by those who addicted them. At the same time while hundreds of millions of pounds are spent on illegal drug addiction, tranquilliser addiction due to prescriptions receives little acknowledgement and even less help. Local Primary Care Trusts, the National Treatment Agency and drug action teams do not spend their drug treatment budget on involuntary tranquilliser addicts, it being argued that there is treatment available through GPs and in psychiatric hospitals. At present, according to Beat the Benzos, there is one specialist trained nurse in Northern Ireland and one in Oldham in the north of England who deal with involuntary addicts. But mental health services are entirely inappropriate since tranquilliser addiction has an external physical cause and has nothing at all to do with mental illness.

The difference between the damage done to thalidomide children and the damage done to iatrogenic benzodiazepine users is that the injury done to the former was undeniable—you could not avoid seeing it and it could not be steered into the realm of psychiatry. The damage claims of benzodiazepine victims have never been scientifically investigated and, because the injury hides beneath the skin, can be readily denied, particularly if research and discussion are confined to a limited area. Blindly insisting that benzodiazepine claims of physical damage should be confined to the realms of psychiatry is an excellent way of not verifying whether the symptoms reported are real or not. Patients know that the symptoms exist and are caused by the drugs but they are merely reporters of personal experience of course. How easy it is for science and politicians to ignore them and the very few individuals who speak for them.

Historically, dependence on drugs was seen as a personality flaw—that an addicted individual could not live up to accepted standards of responsibility. Later, addiction came to be seen as something from which a person suffered, but it was still an individual-based disease and still implied personal responsibility.

Medicine has used many addictive substances acting on the brain, including alcohol and opium, and science shows that because of this the individual has had a continuing need for more. Scientists are still debating however whether it is ultimately substances that addict people or people who are addicted to substances—or both. While this esoteric and cosy debate goes on, patients continue to be addicted through the medicine bottle and pack, without warnings or adequate protection.

Drug addicts are seen by the majority of the population as personally responsible; after all, they chose to use drugs in the first place. But the pattern of prescribed addiction is pretty plain and straight forward and has nothing to do with personal responsibility or abuse. The majority of people who became addicted to tranquillisers prescribed by doctors had never been addicted to mind-altering substances before and most ex-addicts are not addicted to anything afterwards. The official line seems to say that many hundreds of thousands of people with addictive personalities presented themselves to their doctors and in defiance of medical advice, proceeded to abuse the prescriptions and addict themselves. Apart from anything else, this scenario would imply that doctors have no role as gatekeepers, something which I believe to be manifestly untrue. Thousands of those harmed were in fact unborn babies and the gate-keeping role should have been obvious.

The DoH view is a complete nonsense and there is no evidence for it at all. How on earth it can maintain a morally repulsive misunderstanding of the history of iatrogenic tranquilliser addiction is beyond the ken of ordinary mortals. If PILS leaflets said in big black letters **THIS MEDICINE IS HIGHLY ADDICTIVE—DO NOT TAKE IT FOR LONG** and patients ignored that, the DoH view would be more understandable, but the leaflets don't and they won't—supposedly because it will frighten needy patients. However, it appears that addiction is easily understood by government and the medical profession when the subject is illegal ingestion, perhaps because the chemicals do not come from a state sanctioned source. It is an old, old story with benzos. No one apparently gets it but the unwitting victims. That the drugs are fine and that people destroy themselves in defiance of their supposedly unwitting doctors is a ridiculous message. Medical statements about patient attitudes and the unwitting role of doctors are indefensible. Of course some patients are manipulative—because they are addicted! There will be very

few who set out to exploit doctors and this is a modern phenomenon with no bearing on those who have been addicted for many years.

What did doctors not understand about the 1988 and subsequent Guidelines on tranquilliser prescribing? What do a conveniently unknown number of doctors not understand now? How many times does the fact that doctors are ignoring safe prescribing guidelines need to be 'taken on board' by their professional body and by government? Why is it a polite discussion for 'stakeholders' other than the affected patient?

The brain disease explanation of addiction says that people become addicted to a substance because they like the way it makes them feel. Some people it is claimed may never become addicted but the majority do have that susceptibility and therefore should be protected. This is currently the most widely held view of addiction among the scientific community. Survival it is explained is based on a rewards system and dopamine is released by the limbic system to produce a pleasure feeling. Benzodiazepines at first make you feel less threatened, worries fade into the background and sleep is enhanced. Since patients like the way they feel, not surprisingly they learn to repeat the behaviour. All addictive substances cause the brain to release high levels of dopamine. But the difference between illegal users of benzodiazepines and those receiving prescriptions is that prescriptions are seen as medicines by patients. They are not seeking to abuse drugs.

Because of dopamine release and its impact on the brain's reward centre, benzodiazepine users learn very quickly to keep taking them. They learn this much faster and with more intensity than other activities producing dopamine, since the release of dopamine is so much larger. Because of the abnormal release of dopamine, the brain struggles to return to chemical balance after the tranquilliser dose wears off. This produces withdrawal symptoms. Prolonged use of tranquilliser/hypnotics causes the brain to stop maintaining natural dopamine levels. This creates further withdrawal or tolerance, leading to physical dependency. Addicted patients need to escalate the dose just to feel normal. This of course is a cycle that can be difficult to break. Once addiction and tolerance set in the brain alters its priorities. A further prescription becomes the be all and end all of life. The benzodiazepine has taken over thought and the addict is no longer in control of his or her life.

If a person reaching this stage had not received benzodiazepines from a doctor but had acquired them on the street he can perhaps rightly be described as a substance abuser. However the Department of Health, overseeing the UK health system likes to use this description for addicts created by doctors as well. This scandalous assertion was addressed in a letter from psychopharmacologist Heather Ashton to an aggrieved patient in January 2007. She referred to:

"...the hard-headed ignorance of the Department of Health who seem to be concerned only with illicit drug abusers."

She described how in the letter from health minister Caroline Flint to the patient:

"...long-term prescribed users are being fobbed off as usual with weasel words that are not relevant to their case."

She was criticising the fact that the Department sees nothing wrong with tarring patients with the same brush used for illegal users and that it is wrong in maintaining that methods used to target and assist illegal users are appropriate for use with patients. For instance, in spite of campaigners trying to tell the Department that it was an unjustified move, it has introduced what it calls an 'instalment dispensing facility'. The instalment dispensing facility, in the logic of the DoH and I quote Caroline Flint, the health minister in 2006, is intended for:

"Prescribing diazepam in cases of dependence, which enables these to be dispensed daily, or by less frequent instalment. It enables prescribing professionals to use this mechanism to increase the safety of such prescribing should it be necessary. Prior to this being introduced, prescribers had to write multiple short-term prescriptions to achieve this. The facility had already been available for a number of other controlled drugs for use in the management of dependence for some time prior to its introduction for diazepam."

This demonstrated beyond any doubt that not only was the DoH unwilling to understand iatrogenic addiction, but had no grasp of the ethical issues involved.

Everyone involved with a benzodiazepine addict is marked by the addiction—even those who did not take the drugs. Everyone involved is trapped outside a bubble, with the addict inside it shut off from reality. There is no common understanding of what is happening to both of them. The Benzo affected live by the day. After withdrawal, if it takes place, many former addicts still live by the day. Some of these people are in poverty, without jobs and security, some experience daily ill health with a variety of unrecognised symptoms—some feel the impact of both.

Science has described behaviour which is symptomatic of addiction. These symptoms are divided into two types: physical and behavioural.

PHYSICAL

Tranquilliser addicts find they need additional, greater or more frequent prescriptions to achieve normality. The addict will also experience withdrawal symptoms when he or she attempts to stop use of the drug. The possible withdrawal symptoms for benzodiazepines are many and varied and for some people go on for months or years or are permanent. Unlike heroin where the withdrawal period is around a week, the prescription benzodiazepine addict may find it takes up to two years or more, and some find it impossible to withdraw.

BEHAVIOURAL

For the prescribed tranquilliser addict, behaviour centres on avoiding the effects of withdrawal and the experience of the effects of ingestion. The long-term iatrogenic addict may try to stop taking the drug on many occasions without success. Looking back, if he succeeds, he will see the prescription growth over the years. Because of lack of advice and personal knowledge of what was happening he will see that life was focused on the prescriptions and the victim may observe how his health deteriorated during that time. He will have spent the years putting in requests for repeat prescriptions or visiting the surgery, without realising that addiction was running his life and often dictating the level of his health. He will remember that his behaviour radically altered during the period of ingestion—things that he once did and found pleasure in doing fell by the wayside. Responsibility for his life, including personal responsibilities e.g. going to work or supporting a family became unimportant. He became controlling, isolated, perhaps self-harming, self-deceiving and being prevented by the drugs from feeling responsibility, willing to sacrifice the needs of his family. The harm stemming from benzodiazepine dependency is much more than a measurement of how the addiction harms the body. It is also the way it affects an individual's mental and social health and the consequences for family and employment.

The addiction usually disturbs a person's perceptions and attitudes and often disrupts their personality. Drugs such as diazepam and lorazepam certainly interfere with natural brain chemistry. The whole experience of the situation has a deleterious effect on thinking and feeling. The addicted patient suffers great isolation and draws inward—something which if taken to a doctor is described as agoraphobia when it is not. There is often little ability to cope with life, and it is the addiction that causes it. To deal with the feeling, more of the drug is needed. The relationship with the drug excludes people, so human relationships fall away. The result is increased isolation, which is of course a Gordian knot. The feelings experienced in prescribed addiction revolve around the knowledge that as an individual, you are not in control of what you do—of being involved in an inexplicable mess that is destroying your life. There is also the sense of shame and guilt, though it was not the patient's fault. These feelings often persist long after withdrawal and may be permanent. It is hard to live with the knowledge that you spent years behaving in a way which was totally alien to your true personality.

There is no greater loss than losing the ability to think rationally and even to remember. The thought patterns you used for years or decades are defensive and work to guard the addiction. Some are responses to the stress due to the addiction. Some are the results of the damage done by the chemical. The addicted patient becomes negatively dependent on the family and pertinently on the doctor, who is regarded as some kind of fixer. The patient believes that his own thought patterns are true and that all around him should fall in with his often unreal and grandiose ideas. He becomes obsessive, often paranoid, and his behaviour and thought denies reality. Such twisted thought patterns, with illogical actions seeming logical, become a way of life.

But the addict is not the only victim of the large scale addiction that the government in its denial and in place of action, still insists it wishes to prevent happening in the first place. There are social, emotional and physical effects on the family involved in tranquilliser addiction, quite separate from the effects on the patient. As the patient becomes increasingly isolated and inward looking, so does the family, and with the complete lack of knowledge of what is happening and why, they are unable to take constructive actions. Instead they are ashamed and mystified.

Living with a tranquilliser addict is incredibly difficult and involves a learned sense of hopelessness and helplessness. It has been observed that families of addicts have poorer health. My own wife I remember, when she had reached the end of her tether, went to the doctor only to be offered a tranquilliser as a means of coping. Anxiety, depression, headaches, migraines, digestive disorders and heart problems have all been reported as consequences of living with an addict. Ironically this often means medical prescriptions for people who would, but for the iatrogenic addiction of another, have been healthy. Moreover the family becomes so focused on the behaviour of the addict that they are unable to concentrate on themselves, on anything other than low-level, limited living. The family experiences its own kind of addiction impact.

The lack of concern and the responses coming from the Department of Health (particularly now it has moved the goal posts again so that prescribed victims are to be seen as drug abusers) is an assertion that the position the iatrogenic addict finds himself in is at root his own fault—that he volunteered to become addicted. Even if this were true which it patently is not, behavioural psychologists point out that addiction is much more than personal choice.

In the case of prescriptions leading to addictions, it is primarily a case of health protections failing to act and inform decisively and effectively.

As Professor Heather Ashton commented on the introduction of instalment prescribing for tranquilliser addicts created by doctors:

“The ‘instalment dispensing facility’ is a gross insult to prescribed users.”

On the services for withdrawal which the department deems appropriate but which are seldom available to medically created addicts she said:

“Mental health centres and specialised drug services are [in any case] inappropriate, and often disastrous, for prescribed benzodiazepine users who are a quite different population to illicit drug users.”

But the department never does listen or understand, and refuses to engage with the argument that going to a doctor, relying on his expertise and becoming addicted to something you did not know was addictive, is a very long way from going out onto the street, buying from drug dealers and then becoming dependent. Tranquillisers and sleeping pills have been given to people by doctors as medicine for nearly 50 years. The relevant civil servants in the Department of Health, including those in the Substance Misuse team, the MHRA, GPs and others in the health establishment, all stick rigidly to the scripted belief that patients misuse benzodiazepines, opiates, hypnotics, Z drugs—in fact all the mind-altering drugs. This belief ignores the addictive nature of these substances and the phenomenon of tolerance withdrawal. It is not patients who misuse these addictive substances—it is the manufacturers, regulators, doctors and government who have been misusing patients for over four and a half decades. Above all it is government and regulatory authorities who have been abusing the trust placed in them by the population to safeguard their health. Benzodiazepines are a more addictive substance than heroin. They take far longer to withdraw from than heroin. The physical and mental after-effects of months, or years of dependence, can continue indefinitely.

The Dependency Culture

“[But] for a large proportion of those on incapacity benefit—half of them claiming for five years or longer—the benefit is a (cheap) compensation for the fact that they have no future. And never will have...”

Yvonne Roberts, Where's the Benefit? The Guardian, February 6 2008

I doubt if the writer had any idea but she was describing the situation of benzodiazepine victims exactly. A great deal of government action is currently being proposed under this term but the term dependency culture is doubly ironic for iatrogenic tranquilliser patients. Their dependency on medically prescribed tranquillisers turned them into state benefit dependents. What the government means is that a faulty system has allowed hundreds of thousands of individuals to become reliant on the state but what state sanctioned addicts mean is that the state allowed them to be addicted to state-licensed medical drugs and then left them to swim in a benefits stew they had never wanted or sought.

This year has seen a great political effort by the Labour party (in an effort to appear tougher than the Conservatives who have pushed this agenda and the Liberal Democrats who accept it) to formulate a message in the minds of voters who believe that the words ‘benefit claimant’ equal exploitation of the hard-working by the work-shy. Such people were greeted at the beginning of February 2008 with enthusiastic headlines such as:

“1.9m ON BENEFIT ‘SHOULD GO BACK TO WORK’”

David Freud, an investment banker who had been hired by the new Work and Pensions Secretary, James Purnell, gave it as his opinion that the disability tests used to award state aid were “ludicrous” and something effective should be done to save the state money. Of course it should, there will be those who milk the system, but I would guess that most people are victims and would not by choice exchange the freedom that a job and income bring for levels of benefit which are very low indeed. Victims of medical drugs, including benzodiazepines, will be caught up in this political fervour. Having been marginalised (perhaps for decades) many, along with everyone else, are by the magic of politics to be scrutinised, rejuvenated and quite possibly told by private companies (which will be put in charge of finding jobs for the long-term unemployed) that they really should be working. As Freud has said:

“If you're disabled, work is good for you, and not working is bad for you.”

Who could argue with that?

Since government refuses to recognise the severity of illness experienced by the addicted and many formerly addicted patients, there is little chance that the private sector will suddenly discover it, particularly as they will be offered up to £62,000 to return an individual to the work force for three years. If you refuse to co-operate you will have your benefits "sliced". Perhaps the inability to demonstrate the reality of your drug-induced illness will be seen as not co-operating.

Freud says simplistically and erroneously that:

"You get more money [than unemployment benefit] and you don't get hassled, you can sit there for the rest of your life. It's ludicrous that the disability tests are done by people's own GPs—they've got a classic conflict of interest and they're frightened of legal action."

In fact benzodiazepine victims and others injured by medical drugs are periodically put under the microscope by the Department of Work and Pensions' doctors and it is they, not GPs, who conduct disability tests. If he can get that wrong, what else has he got wrong?

But the points to be remembered are these:

- Government has allowed health, social and economic destruction through addiction to take place and still allows it.
- Government knows what has happened and avoids recognition of it.
- Government has left many to wither on benefits and has made no attempt at rehabilitation.
- Government now believes as part of its political struggle with other parties that such people can continue to remain unrecognised and can be viewed in exactly the same light as every other benefit claimant.

"Working can make a real difference to people's health and quality of life."
James Purnell, Secretary of State for Work and Pensions, 17 March 2008

"We know that staying in or returning to work is generally good for patient's health, whereas unemployment is progressively damaging. Being unemployed can lead to problems such as more sickness, mental illness, disability, increased use of medication, higher hospital admission rates and shorter life expectancy."
Secretary of State for Health, Alan Johnson, 17 March 2008

There is no understanding or recognition in either of these statements that medicine has consigned large numbers of benzodiazepine patients to the scrap heap and that it is the impact of the drugs that has kept them from working. The problems cited as possible through not working, are, for such patients, in addition to their drug-induced incapacities.

Dame Carol Black, National Director for Health and Work, has in 2008 produced a report for government which has discovered the cost of sickness to the British economy to be over £100billion a year. The cost of benefits and lost taxes is calculated at £63billion. As a result of the report the DoH is touting the idea of 'well notes' from doctors rather than sick notes. Well notes set out what tasks a worker can perform instead of certificates automatically signing someone off. GPs would be expected to offer patients advice about what they can do to get fit for work. There is great irony in the expectation regarding GPs. The sole advice from doctors that would have prevented very large numbers of patients from becoming sick and disabled is this:

"These pills must not be taken for more than two weeks. It will take at least another two weeks to withdraw from them safely. That is the advice of the Committee on the Safety of Medicines."

Alec Jenner, the medical man with a mission

Dr Alec Jenner is not untypical of the scientific mind in action. Apparently he read in passing in a newspaper how a circus trainer was sedating tigers with a new drug. He wondered whether the same drug would work on the people of Sheffield where he was employed. He subsequently approached Roche the makers of the drug which became known as Valium and carried out research on humans. The following are quotes taken from an article titled "Alec Jenner: the man who helped to create Valium", published in The Guardian, on November 22 2000:

"When I was an ambitious doctor, I did not even think of Valium's addictive potential—although I now wish I had."

"I feel naive but not guilty. What seemed so good about the benzodiazepines when I was playing with them was that it seemed like we really did have a drug that didn't have many problems. But in retrospect it's difficult to put a spanner into a wristwatch and expect that it won't do any harm."

'In 1986, 17,000 people brought a group action against benzodiazepine makers Wyeth, Roche and Upjohn. Although the action collapsed in 1994, when the legal aid board stopped paying legal fees that had already reached £35m, the sense of injustice felt by the victims is as strong as ever. At a "Beat The Benzos" conference earlier this month, calls were renewed for compensation for benzodiazepine victims and a full inquiry into how the drugs were prescribed, despite their having been listed as drugs of dependence by the World Health Organisation.'

'After his early pioneering trials, Jenner did little further work for Roche. But, in 1990, he received a letter from the company's solicitors asking him to give his scientific opinion on the files of dozens of the group action Valium users complaining of addiction and memory loss, epileptic fits, vision problems, mood swings and extensive cognitive deficits. His assessment was that, generically, the users' problems were as likely to be due to "addictive personalities" and "neurotic" or "pre-morbid" diagnoses as Valium addiction and damage. Roche used Jenner's analysis in its defence.'

"I have sympathy for the people involved, some of whom may have a case. But the issue for me was to demonstrate scientifically whether their complaints were because of the effects of Valium. This was not the case. And, in legal cases, the benefit of the doubt is always with the accused. Having said this, much of the research is contradictory and **we are not certain of very much in psychiatry. Allegations of damage could turn out to be true—in the same way as we did not originally think of the possibilities of addiction but now recognise this to be so.**"

Whatever his motives, here was a psychiatrist who had in his own words 'played' with a drug which has never been trialled long-term and had dismissed claims of physical damage when there has been no research into physical damage. He felt no guilt about never having considered addiction in his research. Neither apparently did he have qualms about the fact that his expertise was quite possibly not expertise at all, but a further darkening of the smokescreen around tranquilliser damage.

If you read this list of withdrawal effects by Professor Jeffrey Richards, at the University of Ballarat in Australia, you might well wonder what business a psychiatrist has ever had providing cover for the makers of benzodiazepines.

<http://www.med.monash.edu.au/non-cms/mentalhealth/benzos/>

Common Withdrawal Symptoms

- Abdominal pains and cramps
- Agoraphobia
- Anxiety
- Breathing Difficulties
- Blurred Vision
- Changes in Perception
- Depression
- Distended Abdomen
- Dizziness
- Extreme Lethargy
- Irritability
- Lack of concentration
- Lack of coordination
- Loss of balance
- Loss of memory
- Muscular aches and pains
- Nausea
- Nightmares
- Rapid mood changes (crying one minute and then laughing)
- Fears (uncharacteristic)
- Restlessness
- Feelings of unreality
- Severe headaches
- Flu-like symptoms
- Shaking
- Heavy limbs

Seeing spots
Heart palpitations
Sore eyes
Hypersensitivity to light
Sweating
Indigestion
Tightness in chest
Insomnia
Tightness in the head (feeling a band around the head)

Less Common Withdrawal Symptoms

Aching jaw
Numbness in any body part
Craving for sweet food
Outbursts of rage and aggression
Constipation
Diarrhoea
Paranoia
Depersonalisation (a feeling of not knowing who you are)
Painful scalp
Persistent, unpleasant memories
Pins and needles
Difficulty swallowing
Rapid body changes in temperature
Feelings of the ground moving
Sexual problems
Hallucinations (auditory and visual)
Skin problems
Hyperactivity
Hypersensitivity to sound
Speech difficulties
Sore mouth and tongue
Suicidal thoughts
Incontinence or frequency or urgency
Increased saliva

Rare Withdrawal Symptoms

Blackouts
Bleeding from the nose
Burning along the spine
Craving for pills
Discharge from the breasts
Falling hair
Haemorrhoids
Hypersensitivity to touch
Rectal bleeding
Sinus pain
Seizures
Sensitive or painful teeth

Continual Impact

But withdrawal symptoms are just one side of the coin. What happens to people when they are taking the drugs is often what destroys them. Benzodiazepines really can be 'damned when you take them and damned when you stop' drugs. These excerpts are a sample of the horror stories appearing in the media over the years. They are only the tip of the iceberg—a representation of what happens to individuals when prescribers are ignorant, regulators are compromised and government sees the protection of an industry which provides jobs and large-scale revenue as being more important than health protection. According to scientists like Jenner, these people were suffering from "addictive personalities" and "neurotic" or "pre-morbid" diagnoses. Maybe though, he could be wrong—he said that.

The first are from 'The Tranquilliser Trap', a BBC programme broadcast on Sunday 13 May 2001:

"I was prescribed Lorazepam at 16. I am now aged 44 and have been off tranquillisers for two years, after a GP suggested that I had perhaps been on them too long! After suffering most of my life with Agoraphobia and Panic Attacks, I cannot believe that this drug is still manufactured. It is high time the drug companies were held accountable and something positive was done. How many people have to lose their quality of life and battle so hard, with little help to regain it, before someone says stop."

"I have been on this medication for 34 years, yes 34 years, and all because I had a small concern in 1967. All doctors told me was to keep taking the meds. One year ago I started to find out that I didn't need it. BUT to get off it is a serious job, people need help and advice. I nearly died of going into convulsions as I didn't know enough about how to withdraw. I'm still in a very serious condition called derealization, the doctor said it was like stopping smoking! I nearly killed myself."

"My doctor prescribed Librium continuously for 10 years in the 70–80s after a minor bout of anxiety. My memory is permanently impaired over that period."

"I was on those drugs for 10 years and I don't remember any of it. When I finally got off, it was like waking up. What happened to me was horrendous and it has affected my whole family. I'm still living with the effects."

Barry Haslam, Benzodiazepine Campaigner and Consultant

"I have been on Valium for 37 years and still no help. Doctors don't care for your health."

"I have been taking Nitrazepam for 20 years, I can't stop taking them. When I was given them by a hospital doctor I was told that they were to relax me so that I could sleep. I was not told anything about them being addictive. Obviously I have found out that they are highly addictive. If I do not take them my whole body shakes to such an extent that I cannot hold a cup of tea in my hand. I also get terrifying dreams, there is much more that I can tell you about them."

"If the government knows these drugs to be harmful why are they allowing them to be dispensed? Why have they not implemented resources to help patients come off the drugs? It takes more than a guideline...the problem will not go away...indeed it will not 'die' off which is one method some GPs are using to reduce their prescriptions, i.e. they are waiting for those patients who have been addicted for 20+ years to die because it is easier to give a 2 minute prescription rather than seeing a demanding patient for 20 minutes a visit every day until they get what they demand."

"My uncle was prescribed Ativan over 25 years ago. The doctor then prescribed practically every other drug that was mentioned on your fantastic insight in to this brushed under the carpet crime. He is agoraphobic, intense mood swings and all the symptoms the programme mentioned."

"I was left unmonitored on benzos for 17 years. Withdrawal was a nightmare—hallucinations and mania. I am appalled that the drug companies are not taken to task and forced to pay compensation. All medical experts now agree that they are addictive. No person, regardless of their initial mental health problems deserves the horror of benzodiazepine withdrawal."

"I believe I am one of the longest addicts of Lorazepam, I started taking them in 1974 following a car accident and finished taking them in 2000 (26 years). I was 18 when I was first prescribed them and the effect upon my life has been devastating, like others I thought I was going out of my mind, a fact my doctor was only too willing to agree with...I am forty five and I can't remember what it was like when I was 18, I can't remember a time when my life was not governed by fear. I may function in society, but that does not mean I can lead a normal life. However I find that the medical profession believes that now I no longer take these drugs that I am back to full fitness...I was offered no support from anywhere and yet if I was a Heroin addict, I would have had masses of help and support."

"It is rare to find any useful help out there from the same doctors that prescribed these things to millions of people over the years, including me. I have been working at getting off these for two years off and on and it is the hardest thing I have ever done."

"All that was missing was a more complete presentation of the dreadful after effects of withdrawal from dependency on prescription drugs such as diazepam. I was fed diazepam and a cocktail of other pills for thirty years and five years ago voluntarily stopped following advice in an article reprinted from an American medical journal. Five years on I have chronic pains in my legs which apparently defy diagnosis by UK GPs but is documented in the USA. In my opinion far too little work has been done in this area and it will be difficult to get people to withdraw unless they know that support is in place to cope with the after effects."

"Many people in their 30s, 40s and 50s have now worked out that prescribed chemicals killed their parents and/or grandparents! The hidden cost to the world and its peoples in physical, mental, emotional and financial terms is inestimable!"

These experiences were recounted on 'Face the Facts', BBC Radio 4, March 16 1999:

"I went to my doctor's and said: "Do they make you lose your memory?" And he said 'No.' My memory went down and down. I can't remember what I did yesterday and I don't think about tomorrow. There's no tomorrow—all there is, is now..."

"I used to be a dancer and I got medals for dancing but I couldn't go back to dancing again and I just feel that I couldn't mix...I will never be the same person I was because I just feel I've been damaged."

"It was one Saturday—my dad phoned me up and said: "You'll have to come to the hospital with your mum, she's had a fall." I made an excuse saying: "I'm going out but I'll give you a ring back to see how she is." Basically I just couldn't go out of the house. My son who was 21 at the time had to do the shopping for me. I couldn't even go to the corner shop."

"She's gone from a very bright, athletic girl—a very intelligent, attractive girl, into almost a recluse and she looks ill all the time and she says she feels ill all the time. She doesn't go out, she doesn't do anything, she has no future, she has no career prospects, she has no life."

"There are people out there...who are hooked, unknowingly, unwillingly, and they feel that society has 'chucked them overboard'. They feel they no longer belong anywhere. They feel they've lost such a lot, that they can no longer regard themselves as fully human."

"You can say it in one really—I feel as if my own self—at some stage—was removed. I gradually went missing. My personality gradually went missing."

This was related by Ray Nimmo the founder of www.benzo.org.uk on the BBC Radio 4 programme, 'You and Yours', July 16 2002, 'Benzodiazepine Guidelines routinely ignored':

"I was just left on repeat prescriptions of these drugs. I was told that I was the problem—that I needed to stay on these drugs. I just became suicidally depressed, so anxious, agoraphobic, lethargic. I just didn't want to go out of the house. I didn't want to answer the door or the telephone. I was just like a zombie—living in this twilight world of paranoia and fear. It was dreadful...By March 1986 I just had to give up work. I couldn't cope with life let alone a career or a job of any kind. My family were just completely at a loss. My wife managed one day at a time—trying to look after me, managing all the household, doing all the shopping, looking after our young son. My son is 20 next month. I really don't even remember him for all those years. It's as if my whole memory is blotted out. It's as if all those 14 years happened to someone else..."

These are a selection of experiences recorded in print media over the years:

"In the past forty years I haven't had a life...No one can say they've seen me go up the street on my own, or take my children out on my own, or go on a bus. When my daughter was at primary school, her teacher told her she couldn't understand why I never came to parents' evenings. If my mum hadn't been there to look after them, they would probably have been taken into care."
Unhappy Anniversary of Valium, Observer, February 2 2003

"She finds it difficult to concentrate and is crippled by a devastating fatigue that cuts short her activities and blights her life. The fall-out from weaning herself off the drugs has affected her husband Bob, 53, and other members of her family. "We have all suffered. I feel so sorry for Bob—I am surprised he has stuck with me," she said. She started off taking Valium and ended up being prescribed a whole cocktail of different drugs to combat the many side-effects. And when she came off them, Val's problems just seemed to escalate. "There have been times when I have wished I could die. The pain has been so bad and I just don't seem to get any better. "Nobody can tell me why this has happened to me and worse still they can't tell me if it will ever end," she said."

'I wanted to die',
Southampton Daily Echo, April 18 2006

"After 30 years of tranquillisers mixed with a variety of antidepressants, the mother-of-six says the drugs have left her physically and mentally handicapped. Over the years Mrs Dixon's health has deteriorated and she has suffered a host of problems including panic attacks, muscle weakness, mood

swings, bowel problems, nausea and severe pelvic pain. Her condition has left her unable to leave her home for the past 10 years and watch her children and 20 grandchildren growing up..."
'Grandma's tablet warning', Newcastle Evening Chronicle, May 27 2004

"One Barnet woman, who wanted to remain anonymous, says she was left housebound after being addicted to benzodiazepines for more than 20 years. She was originally prescribed the drugs for a stomach upset, but now suffers thyroid problem, asthma, ME and leg pain so severe she can hardly walk—all of which she attributes to the drugs."
Tranquilliser addiction is 'damaging our health',
Hendon and Finchley Times, August 21 2003

"Jennifer describes her life as a living nightmare—a hellish version of reality that was brought on after withdrawing from 31 years of daily Valium use. She describes herself as a shadow of the woman she was before she started to come off the common tranquilliser more than two-and-a-half-years ago. "This isn't a life—I have no life of my own," she said. "I live my life like a hermit. I used to travel all over the world with my job. Now I can only just make it down the road to Abergavenny. Everything I enjoy in life I can't do anymore because of the depression. I have panic attacks if I'm left alone...It seems the only way out of this is death. I feel so hopeless."
'Tranquilliser Hell still haunts patient after 31-year addiction',
The Western Mail, March 17 2003

"I started off on Valium in 1973 when I was 18." he says. "I had gone to the GP because I felt a bit shy and introverted. I was not a very outgoing fellow and there was some personal stuff in my childhood. I had anxiety, tension and stress. The doctor gave me Valium. I took it and felt that it was great. I felt very attached to it." So attached, that it was to dominate the next 14 years of his life. "For all that time, I was living in a haze. I lost my job and did not care. Once I had it I could float around. I stopped for a very short time and felt that the world was a frightening place...I did not realise that this was worse than a heroin addiction. It's very secretive as well. It's like putting on a mask. Behind it all you are a shell, dying inside."
Sunday Tribune, Ireland, March 2 2003

"The children spent their early years in and out of nurseries because I couldn't cope, and I missed out on so much of their childhood. They all deserve so much more, but I felt powerless to change. I vaguely remembered what I used to be like and wished I could get back to being my old self, but I couldn't stop taking the pills and I was scared I'd feel worse without them. Whenever I tried to come off them, I turned into a physical as well as an emotional wreck. I'd shake and sweat would pour off me. My body couldn't cope—I was addicted. Roy was desperate to help but my doctors couldn't offer any alternatives to the repeat prescriptions."
'I had to be drugged up to the eyeballs to function',
Best Magazine, February 20 2001

"Michael, 56, was first prescribed the tranquilliser Ativan, a benzodiazepine used to treat anxiety and insomnia, in 1977...He estimates he has 69 side-effects, including extreme sensitivity to light, sound and temperature, chronic bowel and intestinal problems, muscle aches, vertigo and insomnia. He can barely walk and hasn't left his home since August. The pain in his legs is so intense, that he can't bear anything to touch them."
Man's life 'blighted by pills', York Evening Press, October 30 2000

"Ann Tallentyre was first prescribed benzodiazepines 32 years ago—and has been taking them ever since. 'I do not live, I exist,' she says. 'I can't go out because I have agoraphobia. I am totally dependent on others—my daughter has to do the shopping.'
'Benzodiazepines can ruin lives', More addictive than heroin yet prescribed to one in four adults.
Sunday Express Magazine 1999

"Mr Morris was first given a tranquilliser at Royal Oldham Hospital after suffering a panic attack when his father died. His then GP continued the prescription for nearly six years. Mr Morris has since had 70 electrocardiograms for chest pains. He says: "I can't sleep, I am constantly sweating. I can't go out. I can't associate with people properly...The Royal Oldham would not comment on Mr Morris' case but said **the CSM guidelines were for advice only. Doctors were free to make clinical decisions.**"
'Valium Father to sue', Mail on Sunday, June 22 1997

"The practice of "switching the patients out with the lights" is causing increasing concern among medical and charitable organisations, according to the report by the Royal College of Physicians. More than 90 per cent of residents of the homes are prescribed drugs, and nearly half are taking major

tranquillisers and other sedatives..."I fear that in some homes these drugs are being used like a chemical ball and chain to keep patients quiet. These are very frail physically and mentally ill people and virtually the entire lot are on medication, with a large proportion on sedatives. It is a growing cause for concern."

[Dr Michael Denham, Consultant Geriatrician at Northwick Park Hospital and chairman of the working party that produced the report]"

'Sedative cocktails fed to the elderly', The Independent, May 7 1997

"Gwen Howard claims that tranquillisers have completely ruined her life. 'I was prescribed them for 17 years' says Gwen, a pensioner from Nottingham, who has started a support group for fellow sufferers. 'It changed my personality, ruined my life and destroyed my marriage. I was so ill I had to stop working 10 years ago, when I was only 54.'"

'I'm not asking for charity—just justice!' Best Magazine, March 21 1995

Additional Comments:

"I'm writing to you (on my now redundant notepaper) because it is important you recognise that I had a successful career, marriage, quality of life etc...I was prescribed Bzs for coach travel queasiness (trivial) in 1970 and became ineluctably physiologically addicted over the next 20 years. I've been suffering bzs post withdrawal syndrome (PWS) since 1990, and am still quite poorly."

Letter to the author from sufferer and campaigner who had read Prescription for Injury, 12 April 2008

"Benzo's will kill you. I'm 43 months off benzo's and my life is ruined. I may be physically still here but I'm dead."

YouTube Comment February 2008

"I had a successful teaching job once and my wife could have had a successful teaching career. Now at 61 and 59 years of age respectively, and after a thirty five year experience of benzodiazepines, it has become obvious that the best we can look forward to is a fundamentally insecure and impoverished old age, after a fundamentally insecure and impoverished previous three decades."

The Author, benzodiazepine victim and campaigner

Conclusion

Politicians have always been easily converted by the rich and powerful and their objectives. Health ministers remain stubbornly naive about the motivations of the pharmaceutical industry and its lobbyists. They are only too easily impressed by the blandishments and arguments of those seeking to build even greater profit margins from involvement in the NHS.

The trouble with accusing the UK government and its agencies of incompetence is that it might be seen to excuse its motives. Despite the gloss of reason that the DoH puts on the benzodiazepine situation, it has had ulterior motives from the start. Its concerns are political and are to do with economics, preserving the status quo and the image of medicine. The avoiding of a true assessment of what patient evidence on the drugs actually means, and the nonsense of its stated position makes any belief in incompetence or ignorance highly doubtful. Things were meant to be this way. The Labour party has pursued policies to do with privatisation and an ever deeper involvement of the pharmaceutical industry in the NHS for ideological reasons. For government, the historic injury and ongoing injury to benzodiazepine patients due to the activities of Pharma, has no real merit or priority.

Patient evidence on tranquilliser damage does not stop health ministers from seeming to accept it while doing nothing to stop it. In their minds they cannot stop it. They have to cover up for a deliberate decision that controlling benzodiazepines directly should be avoided, not least to skirt around the reality that tens of thousands of British citizens have had key elements of their lives destroyed—health, social and economic. The decision was taken because of a doctrinally driven determination by the new Government in 1997 to promote their vision of healthcare, something which would be significantly dented by any real recognition of how pharmaceutical companies actually operate. The DoH clearly understands that its political duty is first and foremost to minimise harmful perceptions of the dire consequences of half a century of tranquilliser impact on people it is supposed to be protecting. The process of denial is long-standing, and efficiently if immorally carried out. Who in their right minds would put forward the view that patients receiving medications without adequate warnings for ridiculous and contra-indicated amounts of time from their doctors should be lumped in with illegal users who get their drugs from dealers? Without making a prior decision to think it, who would think that innocent people injured by drugs badly and inappropriately prescribed, should look for help in drug misuse centres and psychiatric hospitals?

The Government has shamelessly ignored torrents of stories in the media and from patients and campaigners directly about the impact of tranquillisers and hypnotics in the real world. Those who are truly knowledgeable about benzodiazepines reflect daily on how well the assertions of the DoH have protected them and what should happen to those still in parliament who remain responsible for inflicting continuing damage on a new generation of the innocent, under the banner of "preventing addiction occurring in the first place".

The bitter truth is that for years the government has spurned and avoided proper debate on the largest and longest running health scandal in NHS history. It should never be forgotten that ministers have always had the power to intervene in the over-extended story of benzodiazepine destruction. But then that is why the MHRA exists—to deflect the responsibility away from politicians, and the regulator has yet to accept how insidiously damaging the drugs are. On a BBC programme Brass Tacks in October 1987, Professor Michael Rawlins, member of the Committee on the Safety of Medicines and Chair of its Subcommittee on Safety, Efficacy and Adverse Reactions said however:

"There's no scientific evidence to indicate that one particular tranquilliser is worse than another. To act just against one would be wrong because there is a problem with the whole group."

In the real world, which is the world patients live in, there is no moral justification for failing to take effective action over a class of drugs which the regulator has long known there is a serious problem with. Instead what has happened is that regulators have continued their game of risk/benefit based on theoretical prescribing practices and not on actual ones. Politicians, realising what has happened to multiple thousands of people who were not ill before they took the drugs have fought a determined action to avoid responsibility through meaningless assurances and regular switches of assertion. They have farmed out responsibility to doctors and local health authorities and have watched while the responsibility has been avoided and ignored. Their current acceptance of a lumping together of illegal drug users with iatrogenic ones has been both craven and immoral. In the meantime the manufacturers have grown rich, inviolate and free to continue the damage.

Science may not be able to explain many of the side-effects reported by patients and these mutually assured interests of medicine and politics may have little incentive to investigate or acknowledge them, but they do exist, they do destroy. They have existed and harmed patients for fifty years. What does this say about health protection and the ability of those outside establishment systems to secure change in the UK democracy?

Prescription figures over the years. All figures are in Millions.

Benzodiazepines 1980–1988 in UK:

1980	29.1
1981	29.5
1982	29.7
1983	28.7
1984	28.0
1985	25.7
1986	25.3
1987	25.5
1988	23.2

In 1988 the CRM's successor, the Committee on Safety of Medicines (CSM) had said that tranquilliser dependence was increasingly worrying. But this was the prescription level **one year after** the Guidance:

1989 22.1

Twelve years after the CRM expert opinion, and **four years after** the Guidance issued by the CSM this was the prescription level:

1992 15.8

Fifteen years after the CRM expert opinion, and **seven years after** 1988, the level was still far too high:

1995 14.027

Twenty two years after the CRM expert opinion, and **fourteen years after** the CSM Guidance for doctors, Department of Health data showed that 30% of these prescriptions failed to adhere to it.

Twenty five years after the CRM expert opinion, and **seventeen years after** the guidance from the CSM, the figures were still at a completely unsafe level:

2005 11.252

2006 10.769

Mortality from overdose, suicide and accidents.

“A recent study estimated that benzodiazepines cause 1600 traffic accidents and 110 driving-related deaths each year in the UK.”

“Between 1990–1996, over 1800 deaths have been attributed to benzodiazepine overdose in suicides, accidents and undetermined causes. In about two thirds of these cases, benzodiazepines were taken alone; in one third with alcohol or other drugs. Benzodiazepines are taken in 40% of self-poisonings. Temazepam, the commonest hypnotic used today, is the most toxic. The risk of a fatal outcome is greatly increased in the elderly and people with lung disease, and benzodiazepines increase the risk of fatality if taken with many other drugs that depress respiration. The combination of benzodiazepines with opiates causes about 100 deaths each year among drug abusers in Glasgow alone.”
 Professor Heather Ashton DM FRCP, Oldham Benzodiazepine Conference 2004

Collected reasons for prescribing to patients leading to addiction

- | | |
|-----------------------------------|--------------------------|
| Nursing sick wife after operation | Childhood insecurity |
| Bereavement | Isolation |
| Emotional upsets | Family problems |
| After an operation | Floater in the eye |
| Husband's accident | Broken neck |
| Socialising | Changed job |
| Dental pain | Violent husband |
| After-flu virus | Infertility |
| Dry eyes | Fatal illness |
| Alcohol problem | Disc trouble |
| Alcoholic father | Divorce |
| Sex abuse | Menopause |
| Stomach trouble | Prison |
| Hysterectomy | Cystitis |
| Business problems | Cat died |
| Handicapped child | Lack of confidence |
| Shift work | Redundancy |
| Bankruptcy | Hay fever |
| Thyroid problems | Mother committed suicide |
| Demanding mother | Vertigo |
| Driving test | Jury service |
| Scared of dying | Palpitations |
| Asthma | Work pressure |
| Bad fall | Moving house |
| Rugby injury | Loss of hearing |
| Rape | Cooker blew up |
| Car crash | Claustrophobia |
| Headaches | Illness |
| Mastectomy | Post-natal depression |
| Interview nerves | Back pain |
| Retirement | Active/crying baby |
| Dizziness | Homelessness |
| Abortion | Coach travel sickness |
| Shyness | |

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Medicine inflicts widespread and routinely unacknowledged damage through tranquillisers and other mind altering drugs. This book examines the question of why so often dangerous drugs are sold to regulators and doctors as safe, only for patients to discover later that this is far from true. The history of tranquillisers has been pulled together to show that doctors are not as expert as they think they are when they prescribe, that drug companies routinely exploit and control the existing medical system in the UK, and that politicians and regulators fail to protect while saying that they do. The book questions whether the first duty of the state to safeguard its citizens has actually been carried out.

PRESCRIPTION FOR INJURY is available by contacting the author.
Price is £10.00 including postage. amad@downes-grainger.com

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