

# A Tale of Two Scandals

There were 1810 deaths from benzodiazepine overdose 1990–1996 according to Home Office Statistics and there are an estimated 1600 benzodiazepine-related traffic accidents with 110 deaths each year in the UK.  
C.H. Ashton, Emeritus Professor of psychopharmacology, Newcastle University

The current number of benzo addicts in the UK is estimated at one and a half million although no official figures exist. Many more people are ingesting benzos and are on their way to addiction. Many other ex-addicts have withdrawn but remain damaged. There is no treatment for benzo damage. Post-benzo sufferers are often left to struggle alone, stigmatised and excluded by the Health Service that made them ill.

Mick Behan, Parliamentary Researcher, Submission to the Health Select Committee Enquiry into the Influence of the Pharmaceutical Industry 2004

“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

## **Manslaughter by gross negligence**

“Negligence is generally defined as failure to exercise a reasonable level of precaution given the circumstances and so may include both acts and omissions. The defendants in such cases are often people carrying out jobs that require special skills or care, such as doctors who fail to meet the standard which could be expected from them and cause death. In *R v Bateman* (1925) 19 Cr App.R. 8, the Court of Criminal Appeal held that gross negligence manslaughter involved the following elements:

1. the defendant owed a duty to the deceased to take care
2. the defendant breached this duty
3. the breach caused the death of the deceased
4. the defendant’s negligence was gross, that is, it showed such a disregard for the life and safety of others as to amount to a crime and deserve punishment.”

## **Negligence**

“Failure to exercise the care toward others which would reasonably be expected of a person in the circumstances, or taking action which a reasonable person would not. Failure to exercise care, resulting in injury to others.”

On 23 February 2009 the Archer report on the 4,800 or so haemophiliacs who were infected with hepatitis C (and around 1,200 who were also infected with HIV) through blood transfusions in the late 1970s and early 1980s was made public. The report plainly sets out the pattern of negligence and injustices of successive governments.

The inquiry was privately funded by donations and received no support from government, either financial or through evidence. At the time of the inquiry’s launch, in February 2007, there had been 1,757 deaths and the number is increasing. The inquiry was set up by Lord Morris of Manchester and chaired by the former solicitor general, Lord Archer. The report runs to 113 pages and Lord Archer told the press conference that the infection of the haemophiliacs was “the worst treatment disaster in the history of the NHS” and a “horrific human tragedy”. But has there been an even greater disaster with nearly fifty years of tranquilliser over-prescribing by doctors?

As with tranquillisers, the blood scandal campaigners have been religiously rejected by the Department of Health over the years and although some have received a small degree of compensation (tranquilliser victims have received none), little has in fact been done to help them or their families. Some UK families have had nothing because their HIV-infected breadwinners died before 2003. Others live anxious and needy lives because they have been unable to work. Canada and Ireland on the other hand acted much more quickly with more generous financial help and assistance with mortgages and

insurance. The report has urged the government to offer a more substantial compensation package with survivors and their families but the Department of Health has so far offered only sympathy and a promise to look at the findings. No-blame assistance could be given though it is nearly 20 years since Virginia Bottomley, as health minister, promised that the needs of haemophiliacs would be kept under constant review. That review has sunk without trace.

The Department of Health also looked at the findings of the 2004-5 Health Select Committee report on the Pharmaceutical Industry, which included criticism of the provision for prescribed Tranquilliser addicts, but then rejected almost all of them. Sympathy is cheap but action and recognition costs money and impacts on the image of the NHS and politicians. The DoH is blame averse and addicted to the avoidance of responsibility and the recognition of avoidable scandals. Charles Dickens summed it up very well:

'Regard our place [The Circumlocution Office] from the point of view that we only ask you to leave us alone and we are as capital a Department as you will find anywhere...It's like a limited game of cricket. A field of outsiders are always going to bowl in at the Public Service, and we block the balls...Clennam asked what became of the bowlers? The airy young Barnacle replied, that they grew tired, got dead beat, got lamed, got their backs broken, died off, gave it up, went in for other games.'

Charles Dickens, *Little Dorrit*, pp 736, 737

## **The reality of Benzodiazepines**

Benzodiazepines are much more than a question of harm done by the medical profession. There is the crucial fact that successive governments of both parties allowed them to do it. Government and medical dismissal of patient experience as relatively minor and short-term is nothing more than a repetition of false assertions, the original source of which (if it was ever known), has been lost.

What cannot be rationally doubted, is the fact that benzodiazepines are frequently seriously damaging—something which might not be immediately apparent, judging by the truly enormous quantities that doctors have prescribed over the years, both in the UK and in other countries. There were warnings from very early in the life of these drugs that this was so, but the drug companies successfully fought off the findings for nearly thirty years until benzodiazepines were old news.

Benzodiazepines might well help some people in the short-term, owing to their properties as hypnotics, anticonvulsants, muscle relaxants, amnesics and anxiolytics. But benzodiazepines have potentially incredibly serious adverse effects made even worse by polypharmacy, excessive dosages and long-term use. Benzodiazepines were largely sold to doctors as being much less toxic than their predecessors the barbiturates but they are a long way from being safe drugs. High doses of benzodiazepines lead to over-sedation. Benzodiazepines impact on the ability to think, make decisions, and to remember. They make it much harder to learn new information. There are people who have withdrawn from benzodiazepines who find they have lost whole years and decades of their lives. In the elderly, these effects can lead to a false diagnosis of Alzheimer's disease. In spite of this fact, many occupants of old people's homes and in the community are regularly prescribed benzodiazepines.

The primary effect of benzodiazepines is one of addiction. With regular use for only a few months or even weeks the body comes to depend on them both psychologically and physically for normal functioning. As a consequence of this dependence, tolerance develops, so that larger doses are needed to produce the same initial effects. There is clear evidence showing that hypnotic effects are no longer effective after a few weeks and anxiolytic effects after only a few scant months. People unknowingly continue taking them mainly to prevent withdrawal effects. If dosage is insufficient once tolerance has developed, or if the drug is completely stopped, withdrawal symptoms then develop. This is an important reason why the long-term prescribed feel so ill all the time. The Department of Health stubbornly and perversely ignores this basic scientific truth and has illogically introduced an instalment prescription plan. Quite how doling out prescriptions over days will benefit addicted patients is a question it refuses to answer. It looks like action and to government that is probably enough of a recommendation, but doctors tempted to give it a try, may well find the 'problem' becoming much more noticeable in their surgeries as a result.

At present there are over a million long-term prescribed benzodiazepine users in the UK. Several studies, including those carried out by Newcastle University, have shown from computerised prescribing records, that there are 180 or so such patients in every GP practice. These long-term patients, while continuing their drug use, often suffer from adverse effects and from withdrawal effects afterwards—for a sizeable proportion this is permanent. Long-term use is commonly accompanied by increasingly diverse illnesses.

“Withdrawal symptoms can last months or years in fifteen percent of long-term users. In some people chronic use has resulted in long-term, possibly permanent disability.”

C.H. Ashton 2003

Professor C.H. Ashton, unlike those who advise government behind the scenes, ran an effective benzodiazepine withdrawal clinic from 1982–1994 at Newcastle University. She has described the morbidity in the first 50 consecutive patients who attended. They had been taking prescribed "therapeutic" doses of benzodiazepines for between five and twenty years and had decided to withdraw because they did not feel well while taking the drugs. Of these, 20% suffered from agoraphobia and/or panic attacks, 10% had had neurological investigations (three for Multiple Sclerosis) and 18% had had gastrointestinal investigations. Backing up the argument that long-term benzodiazepines lead to other prescriptions, she said that 62% of the first group had been prescribed other psychotropic drugs since starting benzodiazepines, the most common being antidepressants. In addition, 28% had been prescribed two benzodiazepines, thereby doubling the addiction potential and the possibility of side-effects.

Professor Ashton has said categorically that the symptoms which led to the investigations and the polypharmacy, were not the reason for starting benzodiazepines, but developed during long-term use. She has said on several occasions, that there is a likelihood that health for everyone does not necessarily return to normal after prescriptions cease.

“From the current evidence it appears that the symptoms that are most likely to be long-lasting are anxiety and insomnia, cognitive impairment, depression, various sensory and motor phenomena, and gastrointestinal problems. Tranquilliser drugs undoubtedly cause thought deficits and impair coping abilities. There may be an extended period after the taking of benzodiazepines has ceased when former patients find stressful situations difficult to deal with, though of course many still taking the drugs have the same experience as well. Something as basic as queuing in a shop, or answering the phone, can often seem a frightening and stressful situation. Complete recovery may require the individual to learn new strategies to replace the years of coping through drugs. For some people whose economic and social circumstances, have been severely impacted, this learning may prove to be inordinately difficult and sometimes impossible.”

C.H. Ashton, 2003

On any patient leaflet you will find advice saying that anxiety occurring after withdrawal is due to pre-existing symptoms recurring. Indeed it is normally cited by the profession as a reason why most doctors continue prescriptions. Patients who were not prescribed the drugs for clinical anxiety (and that is the majority) know that the self-serving 'symptoms recurring argument' is untrue. This can be a Catch 22 situation. Depression is common in long-term benzodiazepine users and patient experience points to the drugs being the cause. Depression also appears when patients withdraw. There may be pharmacological reasons for this but who would not be depressed by the realisation of what had been done to them by what they thought was a safe medicine? Depressive symptoms may appear for the very first time after withdrawal—often some weeks later, and may be severe and protracted for a long time. Suicide has been reported in some studies. Government maintains a supreme indifference to this benzodiazepine research. Instead it continues a parrot-like repetition of the need to prevent addiction occurring in the first place, ignoring the plight of many thousands of people disabled through medical prescribing.

It will be difficult for most people to believe that members of a highly regarded profession could inflict such damage, but the fact is that most doctors have an affinity with potions, and with the rise of drug company influence, they developed an affinity with the manufacturers of them.

"Doctors prescribe by nature. I had a patient who told me that her doctor had warned her that if she came off her medication she might die. I just saw another patient who was on seventy tablets a day. There are doctors out there who are absolutely committed to prescribing, and if the patient doesn't get better, they just up the dose."

Dr Robert Lefever, Director of the Promis Recovery Centre in Kent

It was the psychopharmacological era beginning in the late fifties that led to the explosion of medically-induced ill health. Benzodiazepines were pushed by their manufacturers as appropriate for virtually anything. Doctors followed the logic of this advert religiously:

"In the face of ill health there is anxiety and where there is anxiety either as a complicating factor or as a cause of illness itself, there is a place for LIBRIUM."

Today, in spite of this undeniable fact, the UK Department of Health rigidly maintains an illusion that the drugs are always prescribed for clinical anxiety and therefore suffering patients fall within the psychiatric sphere of responsibility. That way, it can say that any psychological problems while taking benzodiazepines or following withdrawal, are due to pre-prescription symptoms returning. They will not engage with the fact that patients, who were given the drugs for other reasons, are as likely to experience the same psychological difficulties as those who were given them for clinical anxiety. Physical side-effects are ignored.

It has been claimed that benzodiazepines are the most researched drugs in the world but much of the early research was basic and superficial to say the least, and would not meet today's standards. Long-term research has never taken place, either then or subsequently. Patients who took the drugs for years—many for decades—therefore have their claims of health damage ignored and rejected in the face of zero scientific evidence that it did not happen.

Between the introduction of benzodiazepines and 2004, Home Office and other figures suggest 17,000 deaths associated with benzodiazepines but as with all official statistics, they may well be an underestimate. In reply to a question from the Parliamentary Health Committee in 2004, Professor Alasdair Breckenridge, the Chairman of the UK drugs regulator stated that he thought there had been approximately 170 deaths. As Professor Heather Ashton said at the time, this represented 1% of the total and was a gross under-representation on the part of the regulator.

There are people who have taken the drugs and claim to have experienced no untoward effects or problems during ingestion or in withdrawal. On one side of the argument about the benefit of benzodiazepines and possible symptoms, there is Professor David Nutt of Bristol University, who believes the downside of benzodiazepines has been over-emphasised and that medics are being unduly constrained in their use. Nutt outlines his position on benzodiazepines in his paper "The Psychopharmacology of Anxiety". He recommends prescribing practices that directly contradict the 1988 CSM Guidelines on prescribing and what the Department of Health says is its position. Professor Nutt takes every opportunity to air these views, most recently in a lecture to students and medical staff at Newcastle University.

Professor Heather Ashton agrees that some people can withdraw from benzodiazepines with few if any symptoms and that there are probably many reasons why. Personality may play a part and this ultimately has a physical basis, shaped by genetics and environment which determines the "wiring up" of the brain—e.g. the synaptic connections which mediate the ways that individuals have learnt to cope with anxiety and stress. There is evidence that anxious people have fewer GABA/benzodiazepine receptors in the emotional areas of the brain than more stolid people—so perhaps those without withdrawal symptoms had more GABA receptors to utilise. They may not develop so much benzodiazepine tolerance (down-regulation of GABA/benzodiazepine receptors) and so suffer less rebound of GABA under activity related to withdrawal symptoms. The distribution and sensitivity of these receptors may vary so that some people may have more physical symptoms in withdrawal while others experience more psychological symptoms. She also says that the nature of withdrawal may depend partly on the type of benzodiazepine used. Withdrawal symptoms are usually worse in those using short-acting and/or potent benzodiazepines such as lorazepam, alprazolam, and clonazepam even if these are withdrawn slowly.

A crucial ingredient, seldom if ever, ever mentioned in relation to benzodiazepine withdrawal, is the factor of polypharmacy, which Professor Ashton agrees may also play a part. She says that over 60% of the long-term dependent she saw in her National Health Service Withdrawal Clinic, had also been prescribed other drugs, usually antidepressants, along with the benzodiazepines. Antidepressants, antipsychotics, and morphine-based painkillers, all have side-effects themselves—with symptoms not dissimilar to benzodiazepine withdrawal. Any discussion by anyone on the subject of benzodiazepine

withdrawal is therefore necessarily incomplete, if it does not take into account the fact that for many people, benzodiazepine prescriptions led to other drug prescriptions—many of them producing physical dependence. It is often a situation of withdrawing from multi-drug use, rather than single drug use.

So, the experience of people who have taken (or who are still taking) benzodiazepines and indeed other mind-altering drugs, varies. There are a number of reasons for the individuality of response, not least, differences in human physical make-up, length of prescription and differences in personal circumstances. A person working in a job, which does not require high-level intellectual thought, or constant decision-making, for instance, may find it altogether easier to avoid the impact of benzodiazepines on cognition.

But there needs to be some sort of true representation for the stories of the very large numbers of UK citizens whose existence has been needlessly harmed and sometimes destroyed by prescribed benzodiazepine addiction. Benzodiazepines are not the only treatment to destroy health and lives as the recent Vioxx disaster and the haemophilia scandal testify. There are strong common elements between the stories—pharmaceutical company deceit, regulatory inaction, and dogged medical belief in benefit, is common to all. But it is the scale of benzodiazepine prescribing and its longevity that makes this story unique. Benzodiazepines have been prescribed in their billions to millions of patients, based on a jigsaw of poor and non-existent research, pharmaceutical power, amateur regulation, medical ignorance and disdain, and organised government cover-up.

How are statistics of large benefit and little harm arrived at? What rigorous investigation is it based on? Is it, for instance, based on the absence of complaint to doctors, regulators or drug companies? Is it based on collected endorsements from patients? Or is based on neither of these? Is it, in fact, not a statistic at all—merely another plank in the house built by the indoctrinators? But the desire to believe is strong. It is a sad but observable fact that we look beyond positive claims and assurances only after we have personally met the hidden downside of drugs that ‘help millions’, through our own experience.

### **Socio-economic cost of benzodiazepine addiction**

Benzodiazepines have been a near 50 year horror story for tens of thousands of people in the UK but this medical disgrace has never been addressed. Weak, belated and spasmodic warnings have been issued over the years and they have had the unfortunate side-effect for patients, of allowing government and the benzodiazepine manufacturers to further draw a veil over the historic and ongoing impact of inappropriate prescribing in the public mind.

It is possible to make an argument that much of the medical profession does not fully realise what it has done, given the speed of consultations, the failure of regulators to pass on the horror stories they have been told, and the distance between the patient in the doctor's surgery and the patient's actual life outside it. But above all, it is the chemical ability of benzodiazepines to produce apparent mental instability and engender a belief, not only in doctors but also in patients, that this drug-produced harm is genuine illness that has led to the greatest medical damage. The belief has been fostered among doctors (and unwittingly by the patients), that the drugs and consequent ones have been necessary.

It is simply not true that benzodiazepine injury has ever been addressed. There are still far too many prescribed addicts in the UK and thousands of former addicts who took the drugs long-term, and as a result are living with ruined health which cannot be rebuilt. Many are living in poverty because of the effects of benzodiazepines. Whole lives have been lost and cannot be relived. Families have disintegrated, never to reunite.

The real severity of benzodiazepine damage has never been officially recognised. In the face of it the Department of Health believes that repeated utterance of statements such as ‘we take the problem seriously’ or ‘our priority is to prevent addiction occurring in the first place’ makes it true for actual and former patients and is adequate support for those badly in need of it.

The debate on benzodiazepines has largely centred on addiction versus efficacy, but addiction can be seen as only part of the picture—mostly important in relation to the fact that once addicted,

patients keep taking them—the far more serious side of the issue centres around what continued addiction often leads to, and its dire effects on general health, thinking abilities, and life.

There are extensive costs to the patient and to society, caused by benzodiazepines but not studied by medicine, because their nature is not seen as medical. There are costs produced by benzodiazepines which are medical but which have never been researched, and which are therefore not recognised by medicine.

There are costs to the National Health Service of medical investigations for symptoms which are in reality a result of the effects of benzodiazepines. These costs must be very high indeed, if patient reporting is taken into account, but they are officially unquantified. Investigations for MS, ME, IBS, Arthritis and Thyroid deficiency and other 'ghost illnesses' are common—usually the results are negative.

For people taking benzodiazepines and particularly the elderly, there is a much increased risk of accidents. The cause of the accidents, whether occurring in the home, on the road, at work or in a care home is routinely not recognised, but has a cost for the individual beyond the cost to the NHS.

There is a great deal of evidence that the unborn are severely affected by the addiction of the mother. The link between benzodiazepines and foetal harm was denied in Parliament in 1999 but it undoubtedly occurs.

"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 in London, 'Face the Facts', BBC Radio 4 1999

Prescribed benzodiazepines can lead to loss of control over actions which means in practice that drug-induced violence occurs in the home involving partners and children. Unwanted pregnancies are another side-effect of the drugs. Inhibition reduction leads to anti-social acts such as theft and vandalism. People end up in gaol because the impact on thought and emotion is not recognised. As Professor Ashton says:

"Benzodiazepines can occasionally cause paradoxical aggression and have been associated with baby-battering, wife-beating and grandma-bashing. They can also cause depression and can precipitate suicide in depressed patients. They should not be used in depression although they are still commonly prescribed long-term for depressed and anxious patients. They can also cause emotional blunting and apathy, with inability to cope with the needs of children and family, an effect bitterly regretted by many long-term users."

Benzodiazepines cause job loss either whilst taking them or while attempting to withdraw. Not everyone loses their job of course but a significantly large number do, and it is not surprising, given the deadening effects of the addiction and the high number and severity of possible withdrawal effects. This effect on the individual and on families is totally ignored by government. In 2004 the Chief Medical Officer, Professor Liam Donaldson, reminded doctors of their continuing over-prescribing. He referred to the cost to the NHS of the drugs themselves, but made no mention of the costs to the individual.

There is a large financial impact to the state generally, which benzodiazepine addiction is responsible for. People who are unable to work pay no taxes or national insurance. Their spending power is curtailed and therefore they pay less VAT. Addicted and unemployed the benzodiazepine-dependent make very little contribution to the economy. Although many iatrogenic benzodiazepine addicts are to all intents and purposes disabled, few receive disability benefits. Thousands do receive incapacity benefit at a lower figure, because of the length of their 'illness', and this is of course a drain on the national economy. Many iatrogenic victims have not worked for decades.

Perhaps the biggest loss for a proportion of the dependent (and who knows how big this proportion is) is the loss of choice. They cannot choose to buy a house or might lose a house because of the drug effects. They cannot take holidays or buy a new car. They cannot socialise or take up hobbies because of induced anxiety and the inability to concentrate and think clearly. Some discover after they

have withdrawn from the drugs that they never left the house or indeed a room, for years because of benzo-induced agoraphobia—prisoners because of drug prescriptions.

There is much exhortation from government these days about the need to build up personal pensions to maintain a secure lifestyle in retirement—we are all living longer and the state is becoming more hard-pressed to finance pensioners. There are thousands, addicted for decades to benzodiazepines, who feel assaulted anew when they hear that message. Through state avoidance of responsibility for health protection, they had no chance to build up a personal pension, leaving them entirely dependent on the state for the future. What a supreme irony it is then, that at a time when the state is telling everyone that the state pension is completely inadequate and that they should save for a personal one, there are many condemned to poverty through state inactivity and denial.

The most insidious effect of the drugs in the estimation of many is the effect the drugs have had on their family. The family was not prescribed the drugs but it was as certainly and indelibly marked as the taker. The lack of emotional response due to benzodiazepines is something a child does not understand and may never understand, even as an adult. The life chances of children of the unemployed and sick iatrogenic addict are necessarily reduced and their emotional needs may remain unsatisfied, leading to problems for them later in life. It can be very difficult afterwards to re-establish relationships between a formerly addicted parent and children.

Where does the patient find closure in the face of orchestrated denial, lack of government recognition and help, and a spirit within the medical profession that sees each new drug as a wonder drug, taking decades each time before it exercises control? The three components of continuing good health are psychological, physical and social. Benzodiazepines have a three-pronged negative effect on health—the effects of taking of them, the realisation afterwards of the impact they had on a life and the realisation for the individual that they are powerless to achieve recognition. It is a deep and genuine kind of grief which is not in the annals of medicine. Within the present political, legal and medical structures, there is little hope of closure.

### **A Selection of Informed Comments on Tranquillisers**

"Thousands of people could not possibly invent the bizarre symptoms caused by therapeutic use of benzodiazepines and reactions to their withdrawal. Many users have to cope, not only with a frightening range of symptoms, but also with the disbelief and hostility of their doctors and families. It is not uncommon for patients to be "struck off" if they continue to complain about withdrawal symptoms. Even when doctors are concerned and understanding about the problem, they often have little knowledge of withdrawal procedure, even less about treatment..."

Trickett S, Withdrawal from Benzodiazepines, Journal of the Royal College of General Practitioners 1983; 33: 608

"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, The Lancet, 22 September 1984, 706

"There's certainly a problem, the NHS are concerned. The NHS spends about £40 million per annum on these drugs. There are a substantial number of people who do suffer from this problem long-term. I know that the withdrawal symptoms can be agonising for some people and can be very difficult indeed."

John Patten, Health Minister, 1984

"In the UK, 11.2% of all adults take an anti-anxiety drug at some time during any one year. But over a quarter of these people (3.1% of all adults) are chronic users, taking such medication every day. Even at a conservative estimate, 20% of these will develop symptoms when they attempt to withdraw. That means a quarter of a million people in the UK. The sooner the medical profession faces up to its responsibilities towards these iatrogenic addicts, the sooner it will regain the confidence of the anxious members of our community."

M.H. Lader, Anna C. Higgitt, Management of benzodiazepine dependence, Update 1986, Brit J Addiction, 1986, 81, 7–10

"The benzodiazepines are probably the most addictive drugs ever created and the vast army of enthusiastic doctors who prescribed these drugs by the tonne have created the world's largest drug addiction problem."

Dr Vernon Coleman, 'The Drugs Myth', 1992

Dear Mr Haslam,

Thank you for your recent letter regarding Benzodiazepine Tranquillisers.

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.

This is something we will be returning to both in the House and in terms of our own future policy development. I am passing your letter to Paul Boateng who, as the legal affairs spokesman, has specific responsibility for the litigation side of what is a national scandal.

David Blunkett MP, Shadow Secretary of State for Health,  
24 February 1994

"...the risks [of benzodiazepines] were always obvious and...the providers of medicine between them, readily let this happen."

Charles Medawar, Social Audit, Power and Dependence 1991

They [benzodiazepines] are very effective at relieving anxiety, but we now know that they can be addictive after only four weeks regular use. When people try to stop taking them they may experience unpleasant withdrawal symptoms which can go on for some time. These drugs should be only used for short periods, perhaps to help during a crisis. They should not be used for longer-term treatment of anxiety.

The Royal College of Psychiatrists, July 2001

"Benzos are responsible for more pain, unhappiness and damage than anything else in our society."

Phil Woolas MP, Deputy Leader of the House of Commons and Local Government Minister, Oldham Chronicle, February 12 2004

## Parallels

"My family believe my brother was murdered, and I stick by that."

Brother of Blood Transfusion Victim, Daily Telegraph, February 23, 2009

Interviewer: I don't want to sensationalise this Susan but, in the last couple of minutes, you've actually accused doctors of murder.

Campaigner Sue Bibby: Well I think that they do have a case to answer – it would be very nice if one or two of them would actually stand up and speak.

Talk Radio UK Interview on Tranquillisers with Mike Dicken and Susan Bibby  
December 5, 1998

Is one scandal greater than the other, a larger case of inertia and unconcern? A scandal is a scandal, both are sizeable and have involved a large number of deaths, both have involved government inaction, but the 48 year benzodiazepine scandal must be seen as the greater if only for its longevity and absence of recognition. The heyday of vast tranquilliser over-prescribing took place in the 1970s and 1980s. The 4,800 or so haemophiliac victims received their contaminated blood at that time. But the tranquilliser scandal rolled on and new addicts are still, without warnings, being created today.

"The Department of Health fails even to collect figures that might be considered unpalatable."

Alice Miles, The Times, July 4 2007

"[Benzodiazepines] have been prescribed for sports injuries, muscle spasms, premenstrual tension, exam nerves, depression, general malaise and much else..."

Professor C.H. Ashton, Bristol and District Tranquilliser Project AGM, October 2005

The benzodiazepine story has many unique qualities and the Department of Health has developed a policy of no-admission and steadfast denial. Instead of action it has:

- Routinely insisted that its priority is "to prevent addiction occurring in the first place" in the face of much evidence of injury and the fact that those injuries have been occurring for nearly half a century. Crucially, it also maintains that doctors must be free to exercise clinical judgement, even when that judgement (as in the case of David Nutt) is likely to increase addiction and harm.



- It has made no effort to commission research into the wide variety of injuries reported by patients and sticks rigidly to the message that tranquilliser addiction is a mental health problem when in fact it is a problem of chemical addiction with physical responses to that addiction.
- It has left campaigners to provide detailed information on the scale and nature of the problem but has not accepted it; neither has it made any attempt to investigate and provide its own data.
- It has always insisted that treatment and withdrawal assistance is available when it has been shown to be non-existent and in the knowledge that prescribers who addicted patients have little interest in the addiction or the expertise to assist.
- It has consistently evaded all responsibility for the situation, preferring historically to blame it on prescribers, though lately it has moved towards the blaming of patients and stigmatising them as drug misusers.

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

In 1988 the Committee on the Safety of Medicines issued 4 week prescribing Guidelines to doctors but these were never seriously followed up and the CSM had no remit to discover whether they were being followed. There was no plan to audit the number of patients on individual prescriber lists who had already exceeded the Guidelines and offer withdrawal assistance. Hence there are tens of thousands of people today who have been taking tranquillisers for decades without knowledge that their life is being harmed.

"GPs will be asked to trawl through their patients' records to identify those most at risk of developing cardiovascular disease and call them in for an assessment, the National Institute for Health and Clinical Excellence proposed today.  
The Guardian in June 2007

Hearing the victims of the haemophilia scandal speak is like a rerun of the tranquilliser scandal:

"I would just like to see someone apologise, but they won't do it because they think they will be subject to criminal actions."

"One of the reasons the government had been so successful in keeping the whole thing silent was because there were so few people willing to stand in public and campaign."

"People say move on with your life, but that's hard if you have had no resolution and you are surviving on £59 a week."

"We need an apology, just the acknowledgement that this happened and it shouldn't have happened. I don't think they realise how much that means to people."

"People need to be able to live comfortably without having to go cap in hand to the local authority or a fund whenever they need the slightest thing. All we are asking for is to be able to live with decency and dignity."

## Tranquilliser victims

"[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

Tranquilliser victims have received no recognition, no support, no apologies, no compensation and no closure—and this in spite of the fact that so many of them cannot work, have no pensions or security and live with ruined health because there is no agonist for the damage inflicted. Many victims do receive state benefits and the government refuses to investigate how many of those on benefits are there because of the drugs, but benefits are not large and do not represent security. In fact because the Department of Works and Pensions, reliant on Department of Health information, does not take benzodiazepine injury seriously, the victims live constantly with the fear of losing those benefits. The Archer report acknowledges how the extraordinary financial burden of long term ill-health had been placed upon people who had lost their jobs, lost their insurance and, as has so often been the case, lost the breadwinners in their families. There has been no such acknowledgement in the case of tranquillisers. In this horror story the victims have been left to their own devices.

- 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.

## Tranquilliser Quotes

"...apart from people's physical health going down (although luckily, some people seem to be able to stand up to that), they are described by their families as being "Jekyll and Hyde". Agoraphobia (not being able to go out) is a very, very common symptom which very few people actually have before they're given the drugs – sometimes they might have it, but mostly they don't have it until they've been put on the drugs. This of course makes them [the patients] incapable of doing anything much. They can't go out to the local shops, they can't look after their children properly; they are very distressed by this and feel it's their own fault. Usually they go back to the GP and the GP will say: "Oh you're an anxious personality and that's what's wrong with you," and they usually give them more benzodiazepines, or other antidepressant drugs as well.

Sue Bibby Talk Radio UK Interview with Mike Dicken and Susan Bibby  
December 5, 1998

"In fact the drug was poisoning my central nervous system. Emotionally I felt numb...Those pills cheated me of my adult life – I lived like a robot..."

"...After 30 years of tranquillisers mixed with a variety of anti-depressants, 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..."

"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."

Hendon & Finchley Times August 2003

"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.”

The Tranquilliser Trap, May 2001

“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.”

The Tranquilliser Trap, May 2001

“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.”

The Tranquilliser Trap, May 2001

“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.”

The Tranquilliser Trap, May 2001

Colin Downes-Grainger

25 February 2009