PE1651/J
Petitioner submission of 20 June 2017

Benzodiazepines - a brief history

The history of benzodiazepines is important because it illustrates the failure by the medical profession and the UK Government to protect patients over many decades. Benzodiazepines such as diazepam (valium) were first introduced into the UK in the 1960s. They were hailed as a wonder drug and were widely prescribed by doctors for anxiety and insomnia. By the 1970s it had become clear that these drugs were highly addictive. Early critics of the drugs included Dr Vernon Coleman, former GP and Professor Malcolm Lader, King's College, London. (1) Dr Coleman states in a recent video that doctors ignored the evidence of addiction for many years. (2)

In 1988, the Committee on Safety of Medicines (UK Government) stipulated that benzodiazepines should be prescribed for 2-4 weeks only. (3) A number of TV documentaries such as *Brass Tacks* featured the immense difficulties faced by patients trying to withdraw. One man described the chemical fear as worse than fighting on the front line in the Second World War. Patients today continue to endure this extreme level of distress as they try to withdraw from benzodiazepines, antidepressants and antipsychotics.

In the 1990s, a class action was mounted by thousands of patients against the drug companies and the Department of Health. The case was thrown out by the Judge on a technicality. It is astonishing that prescribing rates by doctors continued to rise. Professor Heather Ashton formerly University of Newcastle ran the only dedicated withdrawal clinic for patients withdrawing from benzodiazepines. Her manual is the still the most widely used source of information by those withdrawing from benzodiazepines. (4)

Prescribing of benzodiazepines has gradually diminished over the past three decades but dedicated support services have never been established in any UK country, instead Government funding has been targeted at drug and alcohol addiction services. PDD patients are advised to consult their GPs. Yet, the RCGP in its recent evidence to the BMA stated that GPs are inadequately trained to deal with withdrawal from prescription drugs which cause dependency. (5) It is astonishing that GPs should be inadequately trained in PDD given the millions of patients consuming prescription drugs with the potential for dependence. The experience of patients attempting to withdraw confirms this assertion. A more recent documentary by Shane Kenny, former RTE radio presenter, has been televised in Ireland. He has been damaged by benzodiazepines. It features both Professors Lader and Ashton. The benzodiazepine disaster is compared to the Thalidomide scandal. As the online community of sufferers continues to grow, it is clear that the issue of PDD is one that requires to be addressed urgently. The BMA clearly agrees and has recently called for a UK-wide helpline and specialist support services. (6)

Antidepressants - a brief history

MAOIs and tricyclics were the first antidepressants developed, dating back to the 1950s. These drugs came with numerous side effects and sometimes strict regiments for taking the drugs. Because of this, researchers looked for an alternative with similar effectiveness but fewer side

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1 http://www.lader-ashton.org
2 https://www.youtube.com/watch?v=uWDiHFWTaMU
3 http://www.benzo.org.uk/commit.htm
http://webarchive.nationalarchives.gov.uk/20141205150130/http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con2024428.pdf
4 http://www.benzo.org.uk/manual/
5 http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a23_1/apache_media/H6IB5G1BL8SX1KJ7VY4MCRCXVG6EV7.pdf
6 https://www.bma.org.uk/news/media-centre/press-releases/2016/october/bma-calls-for-national-prescription-drug-helpline

effects and found this in SSRIs introduced from around 1987 (Prozac). More recently, researchers have developed another class of drugs, serotonin-norepinephrine reuptake inhibitors (SNRIs), thought to be even more effective but with similar side effects to SSRIs. (7) The problems with Benzodiazepines initiated a shift to more and more GP prescribing of antidepressants. This continues and they are still commonly believed to be 'safe and effective'. Unfortunately actual patient experience is now telling a different story ….

This recording https://soundcloud.com/user-581729117/lets-talk-withdrawal-interview-excerpts has been made specifically by a patient colleague James Moore (8) for the petition committee and contains brief relevant interview excerpts specifically about antidepressants, dependence and withdrawal. A CD is also provided: Podcast excerpts – David Healy/John Read/Joanna Moncrieff/Claire (18min duration)

And Unexplained Symptoms ….

People are encouraged to visit their GP for help with all manner of symptoms – many of which actually be self-limiting given time, appropriate support and perhaps some change in circumstances. However people want a quick-fix solution – so expect to leave the GP surgery with a prescription. This could be tablets for 'sleep', 'anxiety', 'depression', 'palpitations', 'panic attacks', 'indigestion', 'IBS' and so on (all typical symptoms of stress – alerting us that something needs to change as we 'can't go on like this').

People do not usually realise is that the medications (commonly antidepressants and benzos) prescribed for these common human alarm symptoms act directly on the central nervous system (CNS) and autonomic nervous system (ANS) – 'working' by interfering crudely with the functioning of the most basic and essential nervous systems which control all the vital functions of the body 9 &10 (digestive, cardiovascular, respiratory, endocrine, sleep, reproductive, immune and other systems) as well moods, feelings and complex human thought processes. Once people start taking medications – especially antidepressants which patients are told that they need to keep on taking 'for at least six months' or longer – their basic functioning has to cope with new additional systemic stresses. Many people develop new symptoms as the medicines interfere with physiological homeostasis. If patients do try to 'come off' the medication, they can run into further difficulties of systemic readjustment with confusing functional and psychological symptoms 9 & 10. These are generally played down or not acknowledged by the current GP guidelines.

The GPs, having to comply with their professional guidelines 11,12, 13 , become frustrated when the patients keep coming back with various 'functional', 'somatic' or 'Medically Unexplained Symptoms' (MUS) for which tests are carried out until it is established that there is 'no physical cause' – so the GP then, again following professional guidelines, tries to 'reassure' the patient that there is 'no disease' and that CBT and exercise – and perhaps 'acceptance' and 're-attribution' therapies are what is needed. Meanwhile the patient is very unwell with various bodily dysfunctions (and frightened, upset, and sometimes angry) and the doctor-patient relationship suffers as both parties become desperate with each other…. NHS resources are stretched beyond limits, patients become iller and actively damaged and functionally disabled and GPs become overstressed and ill too.

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[7] https://antidepression.wordpress.com/2008/10/22/history-of-antidepressants/
[8] James Moore's podcast http://www.jfmoore.co.uk/podcast.html
[9] Carvahlo A.F et al. (2016) Psychotherapy and Psychosomatics – V 85, No.5, 2016 http://www.karger.com/Article/FullText/447034
[10] Fava G.A. et al (March 2015) Psychotherapy and Psychosomatics https://www.karger.com/Article/FullText/370338
[11] Royal College of Psychiatrists (2011) Guidance for Health Professionals on Medically Unexplained Symptoms (MUS) http://www.rcpsych.ac.uk/pdf/CHECKED%20MUS%20Guidance_A4_4pp_6.pdf
[12] Burton, Chris (Ed) 2013. ABC of Medically Unexplained Symptoms Wiley-Blackwell/BMJ Books
[13] Patient.info NHS approved information for doctors and patients http://patient.info/doctor/medically-unexplained-symptoms-assessment-and-management http://patient.info/doctor/somatic-symptom-disorder

The October 2016 announcement by the BMA (14) has raised awareness that patients are experiencing terrible problems with these medications. The rising problem of patients experiencing 'MUS' (an essentially psychiatric diagnosis, also referred to as Somatic System Disorder, Conversion or Functional Disorder), resulting in huge costs to the NHS, may actually be partly explained by the inexorable increase in prescribing of antidepressants (especially) which can and do interfere with human functioning and lead to confusing and debilitating 'Functional Disorders' (9) & (10). Apart from very cursory references, the current GP guidelines skim over these medications as potential causes of MUS. It appears that GPs and patients are actually being misled – to the serious detriment of all concerned.

The accompanying 'patient journey' diagram charts the progression of events that we are frequently seeing and is further evidenced by the patient accounts that have been submitted to the Petition Committee. There is clear evidence that the 2013 prediction of Allen Frances published in the BMJ (15) is playing out (16) & (17).

[14] BMA (2015) - Prescribed Drugs Associated with Dependence and Withdrawal – Building a Consensus for Action and subsequent news announcement update October 2016 https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/prescribed-drugs-dependence-and-withdrawal

[15] http://www.bmj.com/press-releases/2013/03/18/new-disorder-could-classify-millions-people-mentally-ill

[16] http://www.bmj.com/content/346/bmj.f1580/rr

[17] http://w-bad.org/

M. BROWN : PEOILSI

A Patient journey – Antidepressants/Benzodiazepines

Life crisis (and/or trauma) – feeling overwhelmed etc.

Insomnia, anxiety, panic, weepy, anger, depressed, not coping ....

Visit GP — **OR** — **Visit eg. HG therapist**

Started on antidepressant (AD) &/or Benzo (BZ)

Sometimes change of AD/BZs or inc. in dose

GP says need to stay on **AD for at least 6 months** ...

Sometimes other symptoms develop

After a while – want to stop AD/BZ *

Dr advises too-fast taper

Patient experience w/d symptoms →

Dr says need to go back on AD/BZ

(Last 4 steps can be repeated ...)

Long-term AD/BZ effects. Not OK

Patient wants to come off AD/BZ

Slow taper .... Eventually gets to zero? (or not) ....

Withdrawal problems – somehow gets through it

Protracted withdrawal/discontinuation syndrome

Multiple physical symptoms over long time

Patient feels awful – anxious, depressed

GP says 'not to do with meds - is underlying MH condition'

Neurological damage – fibromyalgia, peripheral neuropathy

Burning brain, visual problems, MCS etc. Etc.

Many referrals & tests... all 'normal' ££££ to NHS

Diagnosed Medically Unexplained Symptoms/ Functional/Somatic System Disorder(s) →

No more tests

CBT & graded exercise (ADs?)

Patient not OK - disabled

Source: Joint Commissioning Panel for Mental Health >>> Guidance MUS Feb 2017 www.jcpmh.info

Visit eg. HG therapist
Tell story – feel heard
Psychoeducation, understanding
Breathing, Guided imagery
Trauma treated effectively

Get back to life – needs met – feel well >

"Clinicians need to add SSRI to the list of drugs potentially inducing withdrawal symptoms upon discontinuation, together with benzodiazepines, barbiturates, and other psychotropic drugs." (Source: https://www.karger.com/Article/FullText/370338 Fava G. A. et al March 2015)

Signs and Symtoms of withdrawal from SSRI

System involved	Symptoms
General	Flu-like symptoms, fatigue, weakness, tiredness, headache, tachycardia, dyspnea
Balance	Gait instability, ataxia, dizziness, light-headedness, vertigo
Sensory	Paresthesias, electric-shock sensations, myalgias, neuralgias, tinnitus, altered taste, pruritus
Visual	Visual changes, blurred vision
Neuromotor	Tremor, myoclonus, ataxia, muscle rigidity, jerkiness, muscle aches, facial numbness
Vasomotor	Sweating, flushing, chills
Sleep	Insomnia, vivid dreams, nightmares, hypersomnia, lethargy
Gastrointestinal	Nausea, vomiting, diarrhea, anorexia, abdominal pain
Affective	Anxiety, agitation, tension, panic, depression, intensification of suicidal ideation, irritability, impulsiveness, aggression, anger, bouts of crying, mood swings, derealization and depersonalization
Psychotic	Visual and auditory hallucinations
Cognitive	Confusion, decreased concentration, amnesia
Sexual	Genital hypersensitivity, premature ejaculation

WHAT IS MUS?

Medically Unexplained Symptoms (MUS) refers to persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology[1]. MUS are common, with a spectrum of severity[2], and patients are found in all areas of the healthcare system[3].

Patients with MUS are more likely to attribute their illness to physical causes, rather than lifestyle factors[16]. This can include symptoms such as pain in different parts of the body, functional disturbance of organ systems and complaints of fatigue or exhaustion[17].

Table 1. Functional somatic syndromes →

Symptoms (combination of)	Syndrome
Bloating, constipation, loose stools, abdominal pain	Irritable Bowel Syndrome
Fatigue (particularly post-exertional and long recovery) pain, sensitivity to smell	Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis
Headache, vomiting, dizziness	Post Concussion Syndrome
Pelvic pain, painful sex, painful periods	Chronic Pelvic Pain
Pain and tender points, fatigue	Fibromyalgia/Chronic Widespread Pain
Chest pain, palpitations, shortness of breath	Non-cardiac chest pain
Shortness of breath	Hyperventilation
Jaw pain, teeth grinding	Temporo-mandibular Joint Dysfunction
Reaction to smells, light	Multiple Chemical Sensitivity