PE1651/XXXXXXX
Dr Terry Lynch submission of 19 January 2018

I wish to formally express to you and your committee my serious concerns in relation to the proceedings at the petition hearing on 18th January 2018 in relation to Prescribed Drug Dependence and Withdrawal – PE01651.

I commend the convenor and the committee for their efforts in this matter. I have previously made a submission in relation to this matter.

I watched the YouTube video of the above meeting, and as a physician with 35 years' experience, a mental health specialist and public advocate in relation to mental health, I wish to convey to you my concerns.

- **In relation to antidepressants, Dr John Mitchell,** Principal Medical Officer and Psychiatric Adviser to the Mental Health and Protection of Rights Division of Scottish Government, may have **misinformed the petition committee** on a very important matter in relation to antidepressants and drug dependence. During this hearing, Dr. John Mitchell unequivocally informed the petition committee that people do not develop "tolerance" to antidepressants, that "You don't have to keep pushing the dose up to get the same effect".

  The issue of tolerance is very important and relevant, because the development of tolerance is seen as an important indicator of drug dependence. Such is the importance of tolerance as a marker for drug dependence, by asserting that tolerance does not occur with the newer antidepressants, Dr. John Mitchell is in effect stating that drug dependence does not occur with these substances.
  The facts confirm otherwise.

  Tolerance to SSRI antidepressants has been a recognised phenomenon for more than twenty years. A 2014 publication refers to "ADT [antidepressant] tachyphylaxis - also known as antidepressant tolerance, antidepressant 'poop-out, or 'breakthrough' depression." [1]

  The authors of this study referred to another study, published in 1995, 23 years ago: "Fava et al found that 26 of 77 depressed patients (33.7%) who had achieved full remission of symptoms on fluoxetine [Prozac] 20mg daily experienced a recurrence of symptoms (i.e. antidepressant tachyphylaxis, a medical term for tolerance) between 14 and 54 weeks despite maintenance treatment". [2] The conclusion arrived at by the authors of this 1995 study point to clear cases of tolerance, i.e. increasing the dose in an attempt to get the same effect: "An increase in dose of fluoxetine [Prozac] to 40 mg/day appears to be an effective strategy in the treatment of relapse among depressed patients who had initially responded to fluoxetine [Prozac] 20 mg/day." [3]

  A 2011 study found that "the results of the survey indicated the high possibility of developing tolerance to SSRI antidepressants during treatment of dysthymia . . . During the treatment of dysthymia [a form of depression] with antidepressants in the SSRI group, tachyphylaxis/ tolerance might be observed in a relatively high proportion of cases" – 41.9% of cases involved in this particular study. [4]

An article on the health website "Verywell" refers to this well-established phenomenon in relation to antidepressants: "When a medication no longer works as well for someone as it did when they first started taking it, that person is said to have developed a tolerance for the drug. The medical term for decreased effectiveness of a medication is tachyphylaxis. Note that this refers only to a drug that once worked well but is no longer as effective—not a drug that never worked at all. Experts don't know how often someone taking an SSRI will develop a tolerance for it, but some studies suggest that 25 to 30 percent of people will notice a decrease in effectiveness over time." [5]

In many cases, people experience the effects of antidepressants wearing off, go back to their GPs, and the dose is increased. This phenomenon has been flagged for over twenty years by mental health service users in relation to Prozac and other antidepressants, often referred to as "poop-out".

In my best-selling book *Beyond Prozac*, first published in 2001, I referred to this phenomenon, as it was already a reality at that time. Here is an extract from the 2004 UK edition of that book, 14 years ago now:

"In recent years, in my opinion because the initial buzz people feel from Prozac, Seroxat and related antidepressants wears off within a few months, doctors have been increasing the dosage of these drugs. Many people are now being prescribed three-to-four times the dosage of SSRI antidepressants recommended just a few years ago. I believe that there are parallels here with addiction to prescribed drugs such as the benzodiazepine tranquillisers, and in earlier times, to amphetamines and barbiturates. On the Antidepressant Web discussion forum, many patients describe their experience of steadily having their dose of Prozac or other antidepressant increased. With each increase, the buzz returns for a short period, then fades. This phenomenon has become known as 'poop-out' among those taking the drugs, and as 'tolerance' within the medical profession. As Charles Medawar, the creator of the Antidepressant Web points out, this need to increase the dose to get that buzz raises to possibility that these people have actually become addicted to the drug". [6]

- **In relation to the long-recognised phenomenon of benzodiazepine-induced drug dependence, neither Dr. John Mitchell nor the minister addressed this issue satisfactorily.**
  Yet, the dependency-forming potential of these substances has been widely accepted within the medical world for over twenty years. As you have heard in many submissions, there are little or no services available for people who find themselves dependent on these substances.
  According to the British Medical Association, more than a quarter of a million UK residents received long-term benzodiazepine prescriptions in 2015.[7] Given that the current guidelines are that people should not be prescribed these substances for more than 4 weeks because of high risk of dependence, it is likely that the majority of these quarter of a million people have become dependent on these prescribed substances. The repeated prescriptions serve to keep withdrawal symptoms at bay, to some degree at least, without addressing the issue of drug dependence at all. Yet there is no meaningful official policy in relation to how these people can be helped and supported.

The position in relation to prescribed drug dependence problems associated with benzodiazepines is well established. Neither the minister nor Dr. John Mitchel gave this reality anything resembling an appropriate consideration. In Scotland alone, thousands of patients are receiving repeat prescriptions from their GPs in order to avoid withdrawal problems that commonly occur when people stop taking benzodiazepines. Neither the minister nor Dr. John Mitchell conveyed the impression that they grasped the degree and severity of this very real problem.

- In her relatively lengthy first response to the convenor, **the minister** did not refer to the content of the petition at all. Rather, she presented a series of sound bites and many feel-good generalities such as "decisions should involve the patient". Well, here was a situation where patients, through the petition and many related submissions, were seeking to be heard, to be involved.
  Even when pressed by the convenor, the minister did not acknowledge that prescribed drug dependence as starkly described in many submissions actually happens.

- Similarly, although requested to do so by the convenor, in his initial response Dr. John Mitchell made no reference to the content of the petition in relation to benzodiazepines and antidepressants, and only did so when repeatedly asked to do so by the convenor.

- Repeatedly – I counted 4-5 occasions – the convenor had to repeat the central premise of the petition to the minister and Dr. John Mitchell and ask them to respond to it. This is concerning as it reveals, in my opinion, a reluctance – that I flagged in my submission – to engage fully with the serious nature of the concerns and public need raised within the petition and associated submissions.

- Although asked on several occasions to clarify her position in relation to the premise of the petition, at no stage did the minister state that she accepted the premise of the petition, i.e. that there is a prescribed drug dependence problem, including in relation to benzodiazepines and antidepressants. The minister's initial reply was "I don't accept that it routinely happens . . . we wouldn't accept the premise that it routinely happens". The convenor then correctly stated that a problem does not need to occur routinely for it to be a problem. It would be absurd to argue that, for example, because train crashes/accidents do not happen "routinely", train crashes/accidents do not happen at all, or merit little or no consideration simply because they do not happen "routinely".

- Although given ample opportunity by the Committee to do so, and requested to do so by the Committee on several occasions, neither the minister nor Dr. John Mitchell addressed the key issue of the level of GP awareness and expertise in relation to prescribed drug dependence and withdrawal to any significant degree.

- Dr. John Mitchell was prepared to assert unequivocally that significant problems with antidepressants occur very rarely – "Life limiting consequences are very rare" – a remarkable position to adopt given his admission that he had no statistics in relation to the extent of such problems.

- When asked regarding services for people in this situation, the minister emphatically replied that people should attend their GP for this. She conveyed the clear impression that no further services were either needed or being contemplated. This attitude completely dismisses the experiences of many people, who have found support from their GP to be completely inadequate, as you have seen in many of the submissions.

- I recommend that, in light of the response of the minister and Dr. John Mitchell, the Committee re-read my submission. I include a copy for your convenience.

The responses of both the minister and Dr. John Mitchell confirm the validity and the importance of this petition. It seemed clear from the words of both that (a) they grossly underestimate the degree and severity of the problem of prescribed drug dependence and have done little to ascertain the extent and seriousness of this problem (b) have no organised strategy in place to address this issue (c) have little intention of looking seriously as this very real and serious public health issue.

I would strongly recommend that the petitions committee progress this matter through the channels available to the committee.

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[1] Identification and Treatment of Antidepressant Tachyphylaxis. Steven D. Targum, MD *Innov Clin Neurosci*. 2014 Mar-Apr; 11(3-4): 24–28. Published online Mar-Apr 2014. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4008298/

[2] Fava M, Rappe SM, Pava JA, et al. Relapse in patients on long-term fluoxetine treatment respond to increased fluoxetine dose. *J. Clin Psychiatry*. 1995;56:52–55. https://www.ncbi.nlm.nih.gov/pubmed/7852252

[3] Fava M, Rappe SM, Pava JA, et al. Relapse in patients on long-term fluoxetine treatment respond to increased fluoxetine dose. *J. Clin Psychiatry*. 1995;56:52–55. https://www.ncbi.nlm.nih.gov/pubmed/7852252

[4] "Tachyphylaxis/tolerance to antidepressants in treatment of dysthymia: Results of a retrospective naturalistic chart review study"; *Psychiatry and Clinical Neurosciences* 2011; 65: 499–504; doi:10.1111/j.1440-1819.2011.02231.x http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1819.2011.02231.x/pdf

[5] "What To Do When Your Prozac Stops Working: Reasons This Can Happen and Simple Strategies To Deal With It". https://www.verywell.com/what-is-prozac-poop-out-1067022

[6] Dr. Terry Lynch, *Beyond Prozac: Healing Mental Distress*, PCCS Books, 2004.

[7] https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/prescribed-drugs-dependence-and-withdrawal