Dancing Round the Awful Truth
A Commentary On

Addiction to Medicines

Parliamentary Debate Hansard 16 Jun 2009

http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090616/halltext/90616h0004.htm#09061627000002

‘Always follow your doctor's instructions and those which are on the pharmacy label...You should continue to take these tablets for as long as your doctor tells you to.’
Diazepam Patient Leaflet

“What do Marilyn Monroe, Judy Garland, Jimi Hendrix, Elvis Presley, Paula Yates, Heath Ledger and Michael Jackson have in common? All seven were taking prescribed mind-altering drugs (often tranquillisers) at the time of their deaths.

And yet, we must so love and respect the medical practitioners responsible for prescribing these drugs that we are prepared to forgive and exonerate them. Not once, as far as I can recall, has a prescribing doctor been brought to justice. It seems a licence to practise medicine is also a licence to kill with impunity.

And spare a thought for the not so rich and famous. Countless numbers worldwide have been wiped out, incapacitated and crippled by doctors in the fifty years since benzodiazepines were first introduced. Their plight rarely even gets a mention.”
Ray Nimmo

The question is when is drug misuser the appropriate pigeon hole and label for a doctor’s patient? Over the Counter addictions and prescription addictions make uneasy bed-fellows, since a common-sense understanding of the two things says that OTC drugs are something you personally decide to take, often based on advertising claims, while the other is something you take on a doctor’s advice (ironically based on advertising claims and assertions made to him).

It seems the world has moved on and the innocent tranquilliser victims of past establishment irresponsibilities and failures, and the successes of pharmaceutical marketing strategies, have been all but forgotten in current concerns about drug seeking behaviour. They are so far forgotten that in establishment eyes they have been morphed into drug abusers to simplify the picture. In the recent parliamentary debate on addiction to medicines, Dr Brian Iddon quoted the press kit for the United Nations 2006 International Narcotics Control Board annual report:

“The Board added that medication containing narcotic drugs and/or psychotropic substances is even a drug of first choice in many cases, and not abused as a substitute. Such prescription drugs have effects similar to illicit drugs when taken in inappropriate quantities and without medical supervision. The ‘high’ they provide is comparable to practically every illicitly manufactured drug.”

The last sentence is of course true and is something benzodiazepine and ‘Z’ drug victims have been trying to tell the Department of Health for years, in an attempt to protect the innocent and have prescriptions controlled in a more effective manner than has been the case. Tranquillisers are controlled drugs used in an uncontrolled way as medicine. Benzodiazepines are not safe, even in low doses for extended periods and have a great capacity for addiction. If you find yourself addicted to tranquillisers or the newer ‘z’ drugs without warnings then in all conscience you are not a drug misuser – you are in fact misused by the drugs. It is horribly fascinating for historical victims to watch the whole point being missed. How can so many thousands be classified as drug misusers when

1. They had no idea that the drugs were addictive and Patient leaflets and doctors didn't tell them.
2. There was no internet from which to buy the drugs illegally.
3. They thought the drugs were medicine and necessary, though over time for many, they were producing the symptoms that made them (and more drugs) necessary

Surely drug misuse/abuse must necessarily mean going against advice and having prior awareness that a drug produces desirable sensations with deliberate seeking of such sensations. The DoH minister is reported as saying that the whole debate revolved around drug misuse but it doesn't. The guiltless patients who never knew until far too late are yesterday's men and women - a historical footnote now subsumed under the alien drug abuse banner. It must always be remembered too that Benzodiazepines never targeted any disease entity and do not even have the scientific cover of ‘something’s short in the serotonin department’ that the drug companies have used with SSRIs. Benzos stop worrying for a while, relax muscles for a while and promote sleep for a while and that’s about it. For these temporary benefits, an officially uncounted number of lives were wrecked – some of the victims are dead and some are still living with the indifference and non-understanding today.

Abuser or Abused?

These extracts are from one of the hundreds of media stories about what can happen to those who have taken prescriptions for benzodiazepines. It is clear to anyone with an open mind that that this woman was not a previous drug abuser, nor did she abuse the prescriptions she was given. It is clear too that she received no warnings and little help. In 2006, she had still not succeeded in halting the drugs but they had already exacted a heavy toll. Who is responsible for this widespread destruction of health – doctors, drug companies, government? It certainly was not the patient, though there may be some misguided souls today who could be seen as holding a degree of responsibility. Today and the past should not be confused however.

Valium became my illness

“In 1969 I was 19 and at teacher training college when I went to see my GP about a bad back. He gave me some tablets and told me they’d relax my back muscles and help with stress. I didn’t know what they were – I’d never heard of Valium (diazepam) and I didn’t think to question the doctor.

The tablets eased my back and made me feel calm. From then on, I kept taking them, getting them regularly on repeat prescription. They became a part of my life. Even when I changed doctors, nobody ever said I should stop taking them or questioned why they continued to be prescribed. In those days, doctors didn’t worry that they were addictive or that they might cause long-term health problems.

About a year after I started taking them, I remember having odd symptoms – dizziness and feeling out of sorts. From then on, there was always something wrong with me and I know people suspected I was a hypochondriac. In fact, the drug was starting to poison my central nervous system. Emotionally, I felt numb. Only huge events or traumas had any impact. Those pills cheated me of my adult life – I lived like a robot.

It wasn't until the late Nineties that I began to realise that Valium was at the root of many of my problems and that I should come off it.

I was never offered a programme or any real support. I wasn't even told what the physical effects might be or how long it would take to recover. The doctors just kept prescribing the tablets and expecting me to wean myself off them.

When my original doctor gave me Valium, all those years ago, he actually prescribed me an illness.

My balance is now damaged and I have to walk with a disabled person's walking aid. I am constantly tired, so even getting up is a huge effort. Sometimes my speech is slurred. Travelling exhausts me, so I tend not to go far. I can't concentrate on reading a book and I can't even measure out ingredients to cook, so I live on microwave meals.

I am hypersensitive to light and have also suffered headaches, stomach problems and altered sensations throughout my body. It often feels like I'm walking on cotton wool. I am constantly agitated and unable to sit still, and I have restless legs.

The symptoms are actually very similar to those of multiple sclerosis. I have been investigated for many conditions, including Parkinson's. I have also seen many specialists, including a psychiatrist who wrote that I do not have an underlying mental health issue – it is purely benzodiazepine addiction and withdrawal

I want my life back but I don't know if I'll ever kick Valium. I wish I'd never started taking it. There are thousands of people like me and there must be more in place to help us – not just voluntary groups. I think the prescribing of Valium and other benzos was the biggest medical blunder of the 20th century."
11 April 2006

Avoidable Deaths

"Concerns have been rising in recent years about the number of people who have become physically dependent on or addicted to legal substances, even overdosing on them, which has sometimes resulted in tragic deaths..."
Dr Brian Iddon

In a letter to Phil Woolas MP in 2005, Professor C.H. Ashton said:

"I have been sent copies of the correspondence with Sir Alasdair Breckenridge [chairman of the MHRA] concerning (1) benzodiazepine related deaths (his letter of January 11th 2005) and (2) comparisons between the Canadian and UK data sheets for Ativan (his letter of December 7th 2004).

(1) Benzodiazepine-related deaths

- Sir Alasdair cites a total of 170 cases of fatal outcomes due to suspected adverse reactions to benzodiazepines that were reported on the Yellow Card Scheme up to 2004. He admits that this figure is likely to be an underestimate due to underreporting and lack of clinical certainty. It is interesting that he does not mention other data.

- Home Office data [...] shows 1800 benzodiazepine-related deaths during a six year between 1990 and 1996, i.e. 300 deaths/year.

- Extrapolation of [Home Office] this data to the period 1964-2004 would suggest a figure of 12,000 such deaths.

- This figure is likely to be of the right order, considering that prescription numbers for Benzodiazepines were extremely high in the period 1970-1985 (reaching over 31 million/yr In the UK in 1978 compared with about 17 million at present), and considering that Benzodiazepines are taken in over 40% of all self-poisonings and by over 50% of all polydrug abusers.

- Adding the observation that benzodiazepines cause 110 road accident deaths per year (McDonald, Lancet 1998) the estimated figure for total benzodiazepine-related deaths rises to around 17,000. According to Home Office 1990-1996 figures, benzodiazepine-related deaths exceed the number of deaths attributed to all Class A drugs put together. The Yellow Card reports cited by Breckenridge represent only 1% of this total, a gross under-representation.

I understand that the Home Office is unable to provide figures for benzodiazepine-related deaths after 1996 because of a revised method of recording."

The Danse Macabre in Action

When push comes to shove, how many politicians can claim sufficient specialist knowledge which is in any way relevant to the departments they run? Do they, therefore, make genuinely informed decisions or do they just play politics?
Richard Preston, Daily Telegraph, June 18, 2009

'The Minister will acknowledge that the dangers of dependency on benzodiazepines are well known. The request for the inquiry is based on the understanding that the drug has been licensed for a long time and has caused immense agony and problems in the lives of many people, especially women. Will the Minister consider taking a number of steps further to control the prescribing of this drug...?'
Dawn Primarolo, Opposition Health spokesperson.

'Information about the incidence of addiction to prescribed tranquilisers is not collected centrally. Decisions about which tranquiliser addiction treatments have been provided between 1999 and 2006 have been made locally by each primary care trust, not by the Department, which does not hold this information. Prevention, effective treatment and legal controls are all important in reducing the number of people who become addicted to prescribed tranquillisers like benzodiazepines. The main focus of the Department's action has been to warn general practitioners, other prescribers and users of the potential side-effects and dangers of benzodiazepines and to try and prevent addiction/dependence occurring in the first place.'
Dawn Primarolo as Health Minister in 2008

From Government In-house Survey 2007
10 per cent — the number who think poor performance in our health service is dealt with effectively
16 per cent — the number who believe the DH is well-managed generally
37 per cent — the number who have confidence in their ministers

Yellow cards

Paul Flynn: “Is the Minister satisfied with the yellow card scheme? Only half a dozen adverse reactions to Vioxx were reported here, but the United States, which has a more rigorous way of measuring adverse reactions, decided that there had been 144,000 heart attacks and strokes as a result of using Vioxx, and it was therefore banned in this country and in America. Had we depended on the yellow card scheme, we would never have discovered the danger of that simple painkiller. Do we not need to improve the current system?”

Phil Hope: My hon. Friend raises an excellent point about comparisons between strategies that work in different countries. These matters are never quite comparable, but I shall certainly draw his concerns about the efficacy of the yellow card scheme to the attention of the Minister of State, Department of Health, my hon. Friend the Member for Lincoln (Gillian Merron), who has responsibilities for public health and this area of policy.

Note

Phil Hope became a Minister of State in the Department of Health following a reshuffle in October 2008. He was criticised in May 2009 for claiming £37,000 in expenses from the taxpayer over 4 years for a London flat. Less than a week later he agreed to return £41,709 to the taxpayer, admitting it looked dreadful. In a statement, Hope said that he was returning the money because of the "massive blow" caused to his reputation though he had been within parliamentary rules.

How Phil Hope voted on key issues since 2001 (They Work For You):

- Voted a mixture of for and against a transparent Parliament.
- Voted strongly for introducing ID cards.
- Voted very strongly for Labour's anti-terrorism laws.
- Voted very strongly for the Iraq war.
- Voted very strongly against an investigation into the Iraq war.

But a previous Minister of State already knew about the failings of the Yellow Card adverse reaction reporting scheme in patient protection.

"The number of reports received via the Yellow Card Scheme does not directly equate to the number of people who suffer adverse reactions to drugs for a number of reasons including an unknown level of under-reporting.”
Rosie Winterton, Minister of State at the Department of Health (Jun 2003 - Jun 2007)
Official Report, 19 April 2004; Vol. 420 c.222W

Note

How Rosie Winterton voted on key issues since 2001 (They Work For You):

- Voted against a transparent Parliament
- Voted strongly for introducing ID cards.
- Voted strongly for introducing student top-up fees.
- Voted strongly for Labour's anti-terrorism laws.
- Voted very strongly for the Iraq war.
- Voted very strongly against an investigation into the Iraq war.

Now Business Minister, Rosie Winterton was promoted in June and attends Cabinet. As part of the parliamentary expenses scandal she handed back £8,000 after admitting she had been claiming for mortgage capital instead of interest for several years.

The British Medical Association already knew about the yellow card failings.

“It has long been known that doctors do not report all the suspected side-effects their patients tell them about. Ten years ago, the BMA issued similar guidance to doctors, but it had little effect...The

number of reports received each year by the MHRA [UK drugs' regulator] has remained fairly constant, at around 20,000 since the mid-1980s. Various reasons, from having too much to do, to not having a supply of yellow cards to fill in, to lethargy, have been put forward.
The Guardian Friday May 12, 2006

The House of Commons Health Select Committee highlighted the failure of the Yellow Card system in 2005:

From the Parliamentary Select Committee on Health Fourth Report 2004-2005

103. The Post-Licensing Division of the MHRA is in charge of continuing surveillance of safety, whereby reports of adverse drug reactions (ADRs) are monitored and recorded after a licence has been issued and the medicine is on the market...doctors and other health professionals are encouraged to do so, by sending in Yellow Card reports.

104. The Yellow Card ADR reporting system provides the mainstay of the pharmacovigilance system... Adverse reactions are reported voluntarily by doctors, nurses, dentists, coroners, radiographers, optometrists, health visitors, midwives and pharmacists to the CSM using a yellow card. The MHRA/CSM acknowledge considerable under-reporting of suspected ADRs...

349. Such problems are compounded by an excessive reliance on results from pre-marketing clinical trials, together with a failing system of pharmacovigilance. The lack of pro-active and systematic monitoring of drug effects and health outcomes in normal clinical use is worrying. Improvements in post-marketing surveillance are clearly needed and would, no doubt, have led to the earlier detection of problems with SSRI antidepressants, COX-2 inhibitors and other drugs.

370. The recent review of the Yellow Card Scheme has led to a welcome increase in public access to information gleaned from the system and to the introduction of pilot schemes of patient reporting of suspected adverse reactions. However, we are concerned that these measures will not address the main failings of the Yellow Card Scheme. The rate of adverse drug effects reported by healthcare professionals is inadequate, and when they are reported they are not always investigated or pursued with sufficient robustness.

The UK Drugs' regulator knew about Yellow Card limitations

'It is recognised that spontaneous reporting schemes do have limitations in that the data they provide cannot be used to determine the frequency of an ADR as not all reactions are reported. Under reporting is an inherent feature of these schemes and it is estimated that only 10-15% serious reactions are reported *via* the Yellow Card system. The MHRA/CSM are continually working to increase the quality and quantity of reports received *via* the Yellow Card system in order to increase the potential for identification of new drugs safety issues.'
In letter to me from Dr Julie Williams Pharmacovigilance Risk Assessment Unit MHRA
3 February 2004

The Yellow card scheme does not work and has not worked, based as it is on the idea that a doctor faced with a patient has full knowledge of the possible effects of mind-altering drugs. Since unfortunately a doctor's information is largely supplied by pharmaceutical companies, and they have for obvious reasons been extremely reticent in the past about disclosing negative effects, prescribing doctors have not been in the ideal position to use clinical judgement. Dr Bill Inman who devised the scheme after the Thalidomide scandal, has acknowledged since that the great majority of adverse reactions are never reported at all, and outlined the 'seven deadly sins' which lead to non-reporting. Even if the scheme were compulsory rather than voluntary, it is debatable whether the situation

regarding psychotropic medicine would improve much in the absence of a scheme dedicated to finding out, collating and efficiently acting on, direct patient evidence. There is a kind of closed circle operating with mind-altering drugs:

- The drug is licensed on the basis of data supplied, which has been regularly shown by independent analysis to be unscientific, partial and produced by relatively small-scale, short-term observation only. Drug companies may be legally obliged to report serious side-effects, but they have not done it in regard to benzodiazepines, drugs such as zopiclone and SSRIs.

- The drug is then prescribed by doctors who believe the drug has been closely analysed before licensing and that it is a safe enough drug. Therefore they do not, most of them, recognize the relevance of the negative experiences related by patients and they are not reported on Yellow Cards.

When independent research evidence begins to filter in later suggesting that there are unknown consequences belonging to a particular drug, if the system was working, doctors would then be warned, to focus their observation, but they are not, or very belatedly and not in great detail, so they continue prescribing. When Guidelines were issued to doctors in 1988 regarding the prescribing of benzodiazepines, it had taken 15 years to reflect the research on which they were based. In the meantime doctors were listening to experts such as John Marks whose message was that there were no real problems with benzodiazepines and reported experiences were sensationalist. They were also listening to the pharmaceutical industry, reading the promotional material and being influenced by the lobbying efforts of individual drug companies such as Roche and Wyeth. Small wonder there have been very few yellow cards about drugs such as Valium and Ativan.

A Need to Know More?

'Will my hon. Friend say more about benzodiazepines? Is there a further case for getting more statistical information about addiction levels, across PCTs? Is that a possible role for Government?'
John Grogan MP

There is an obvious need and it should be seen as vital that the Department of Health (which has been saying for many years that it takes the problem seriously) investigates all aspects of the nature and scale of tranquilliser injury. But there are it seems – statistics, damned statistics, patient statistics and Department of Health Statistics which are not collected. These recent questions asked in parliament are symptomatic of the cavalier attitude with which the DoH tackles the 'serious problem'

February 2008
Jim Dobbin: To ask the Secretary of State for Health how many involuntary tranquilliser addicts have been successfully withdrawn by NHS treatment in each year since 1998.

Mr. Ivan Lewis *[holding answer 31 January 2008]:* The information requested is not available.

February 2008
Jim Dobbin: To ask the Secretary of State for Work and Pensions how many tranquilliser addicts are in receipt of disability benefits.

Mrs. McGuire: The information is not available

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.

Dawn Primarolo is the best example to date of an MP in power who knows about benzodiazepine prescription injury and yet when she became a minister in the health department – surely a great opportunity to effect change, she continued the dance in the old formulaic way. These are examples of questions she asked when in opposition:

Primarolo, Dawn
Written Parliamentary Question
Date of Answer:
02.03.1993
Question:
What estimate she has of the number of people addicted to benzodiazepines as a proportion of all addicts in (a) 1988 and (b) 1992. - This information not currently available centrally.
Member Answering Question:
Mawhinney, Brian

Primarolo, Dawn
Written Parliamentary Question
Date of Answer:
18.07.1989
Question:
To discuss with the leaders of the pharmaceutical industry the setting up of a compensation scheme for those people whose lives have been ruined or damaged by benzodiazepine addition. - No plans to do so.
Member Answering Question:
Mellor, David

Primarolo, Dawn
Written Parliamentary Question
Date of Answer**:**
12.04.1989
Question:
To estimate no of people put on benzodiazepines during 1988 who have taken them for longer than period advised by Committee on Safety of Medicines. - Not available centrally. (Holding answer 30 Jan 1989)
Member Answering Question:
Mellor, David

Primarolo, Dawn
Written Parliamentary Question
Date of Answer:
11.04.1989
Question:
If there are any plans to introduce a compensation system for people whose lives have been damaged by benzodiazepine addiction. - No plans to do so.
Member Answering Question:
Freeman, Roger

Primarolo, Dawn
Written Parliamentary Question
Date of Answer:
30.01.1989
Question:
How many working days were lost in 1987 as result of people withdrawing from benzodiazepines - Do not hold this information
Member Answering Question:
Mellor, David

Primarolo, Dawn
Written Parliamentary Question
Date of Answer:

30.01.1989
Question:
How many people are at present withdrawing from benzodiazepines in psychiatric hospitals within NHS - Do not have this information centrally
Member Answering Question:
Mellor, David

Primarolo, Dawn
Written Parliamentary Question
Date of Answer:
30.01.1989
Question:
How many people are at present receiving sick or invalidity benefit as a result of withdrawing from benzodiazepines. - This info is not held.
Answering Department:
Dept of Social Security
Member Answering Question:
Lloyd, Peter

Primarolo, Dawn
Written Parliamentary Question
Date of Answer:
30.01.1989
Question:
How many psychiatric hospitals within NHS have special units to enable people to withdraw from benzodiazepines - Do not hold this information centrally
Member Answering Question:
Mellor, David

The formula was plain to see then and has remained unchanged. I maintain the music for the dance is very clear to the ear. The nature of the replies to Primarolo in the 80s had not altered in the replies she later made as a minister.

A comment made to me by Ray Nimmo the creator of benzo.org.uk on this subject was as follows:

“The captains of the Health Lugger may change as often as the wind blows but the Lugger itself is sturdy and unsinkable. You can make an appeal to any of the captains while they strut the decks but any response you may receive will emerge from a faceless but well drilled crew below the decks. The Lugger has been designed to preserve and protect itself from all attack, keep a steady course, weather all storms and repel all boarders.”

Charles Dickens too summed it up admirably:

‘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.’ Little Dorrit, pp 736, 737

Users and Abusers

‘The evidence that we received suggests that there are two main groups of legal substances that are causing significant problems: the benzodiazepine tranquillisers and their successor drugs, the so-called zed drugs, and products containing codeine. Nevertheless, we recognise that millions of people have benefited worldwide from the use of those drugs.’
Dr Brian Iddon

We live in a society which has been largely indoctrinated by the pharmaceutical industry, and by the medical profession which it educates— into the belief that psychiatric drugs are by and large safe and effective and properly prescribed. None of these things is ultimately true. Any examination of the downside of a particular drug is, (as a reassurance), almost always accompanied by an unsubstantiated statement that millions have been helped. This message comes straight from the pharmaceutical industry but because of the widespread belief in society in drug safety and effectiveness, and the power of science, it is duly reported as fact, without questioning or analysis.

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 structure built by the indoctrinators? But the desire to believe in the positive aspects of medicine and its providers 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.

Benzodiazepines, of course, are class C drugs under the Misuse of Drugs Act 1971. They are popularly known as "benzos" and are used as downers by those who use stimulant street drugs or uppers such as cocaine and crack cocaine. Evidence available from the NHS suggests that there about 200,000 illicit users of benzodiazepines in the UK. The drugs are being smuggled into the UK now in considerable quantities. The ready availability of drugs on the largely unregulated internet has exacerbated drug abuse problems, in my opinion. The Royal Pharmaceutical Society of Great Britain has estimated that about 2 million Britons now get access to medicines through online pharmacies. The Society has devised a logo scheme for online pharmacies that follow its code of conduct for use. However, there are lots of websites on the internet that allow the purchase of prescription medicines without a prescription.
Dr Brian Iddon

Tranquillisers are known as "benzos" by the victims of prescriptions too. Dr Iddon is perfectly at liberty to concentrate on the modern phenomenon of internet purchases and growing illegal use since his interest has been in the misuse of drugs but it should not be forgotten that I am writing on behalf of people who have never taken part in either activity. There may be 200,000 illicit users of benzodiazepines in the UK but consider these figures:

There were 328 million benzodiazepine prescriptions between 1978 and 1989 and an unknown number before that, though considering the 1970s are considered to be their heyday and Librium was introduced in 1961, the numbers between then and 1978 must have been greater.

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.

2002 12.7
2003 12.5

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:

2004 ?
2005 11.252
2006 10.769
2007 11.7
2008 8.024 for 9 months (excluding clobazam and clonazepam) plus 4 million Z drug prescriptions
Full year 11.439 plus nearly 6 million Z drug prescriptions

The Department of Health does not collect figures on how many individuals are involved in these prescriptions but over fifty years it must certainly have been millions. Many will have recovered from the experience, others have put the experience into the back of their minds but there is a large but unquantified percentage of people who have been receiving prescriptions for decades and still others who no longer take the drugs but are disabled – sometimes economically, sometimes through created ill health and not infrequently impacted by both. There has never been recognition of this truth by government and to receive any kind of basic benefit help, patients thus affected have had to rely on the degree of belief held by individual doctors.

In the Journal of Substance Abuse Treatment, Vol 8, pp. 53-59, 1991 Professor Malcolm Lader said this:

'...Part of the problem was the widespread perception of the safety of the benzodiazepines. During the 1960s, the medical profession realized that the benzodiazepines were surprisingly safe in overdosage, compared with their predecessors, the barbiturates...'

'The extensive usage of the benzodiazepines was beginning to raise doubts in a few clinicians' minds by the early 1970s. Astute observers noted an increasing cohort of long-term users. The oft-repeated assertion that this just reflected the chronic nature of anxiety disorders failed to reassure some. But the alternative explanation-that patients could become physically dependent on therapeutic doses-was so dissonant with accepted teachings on dependence that it was dismissed by almost all authorities.'

'Another publication comprised a review of the literature on diazepam dependence and then a survey of 50 diazepam users (Maletzky & Klotter, 1976). The review of literature is admirably critical and points out that none of the studies reviewed used controls sufficient to disprove the possibility that diazepam induced dependence. Their own study comprised an interview of 50 patients taking diazepam. The data show clearly that patients tended to increase their dosage and had difficulty discontinuing, experiencing anxiety, tremor, and insomnia. The authors argue cogently that this constitutes a withdrawal syndrome because sometimes the patient had been free of anxiety when the drug was initially prescribed or the initial anxiety had resolved. Also, many of the patients (17 of 24 who had attempted discontinuation) complained of new symptoms. There were no predictors of drug

use or dependence. This study should have had a major influence, setting the alarm bells ringing among the medical profession. It did not.'

'More recent studies such as that by Busto, Sellers, Naranjo, Cappell, Sanchez, & Simpkins (1986) have established that about 15%-25% of long-term (over 12 months) users undergo a definite withdrawal syndrome.'

'A further development has been the realization that withdrawal may be prolonged (Ashton, 1984) or associated with major depressive disorder (Olajide, Lader, 1984).'

In the Comprehensive Handbook of Drug & Alcohol Addiction 2004 Professor C.H Ashton described Protracted Withdrawal Symptoms from Benzodiazepines:

'For some chronic benzodiazepine users, withdrawal can be a long, drawn-out process. A sizeable minority, perhaps 10 to 15% develop a "post-withdrawal syndrome", which may linger for months or even years. This syndrome is clearly not a disease entity; it probably represents an amalgam of pharmacological and psychological factors directly and indirectly related to benzodiazepine use. The syndrome includes pharmacological withdrawal symptoms involving the slow reversal of receptor changes directly induced in the brain by benzodiazepines, and psychological symptoms resulting indirectly from long-term benzodiazepine use, including exposure of poor stress coping abilities and other personal difficulties.'

In 2003 she said:

'Withdrawal symptoms can last months or years in 15% of long term users. In some people chronic use has resulted in long-term possibly permanent disability.'

What kind of picture is painted by these findings? I suggest it is not one where patient protection from licensed drugs is in the foreground – more disappearing out of the frame.

First, it would be wise to define toxicity when comparing benzodiazepines and the predecessor barbiturates. Barbiturates would certainly kill you more readily, especially if taken in overdose or with alcohol BUT there is an insidious and progressive element of toxicity associated with benzodiazepines in long-term use. The percentage of long-term prescribed patients (whatever that is), who live with daily physical impairment hold this to be a self-evident truth. What a pity it is that modern medicine requires near absolute proof before general acceptance (something hard to provide when proof is either too difficult to produce or the research is simply not carried out).

"... the Institute Of Medicine report concludes that, although barbiturates are indeed as hazardous as everyone thinks, the chief alternatives, benzodiazepines, may be just as risky, and in some ways may be even more risky than barbiturates. " [p. 287]
Smith RJ. Study Finds Sleeping Pills Overprescribed. Science 1979; 204: 287-288.

Second, Lader is not describing drug misusers. Indeed he says:

'Patients who have become dependent and have either been unable to withdraw or have only done so with great symptomatic distress justifiably feel aggrieved against their doctors and the benzodiazepine manufacturers for not warning them about the risk.'

Third as Heather Ashton describes, the experience of benzodiazepines for many was and is not some temporary glitch in their lives, the effect has been severe, long-term and for an unquantified number it has been permanent.

All three conclusions are amply justified in the research and comment at the end of this paper, even though the real extent of the injuries has never been explored.

'Patients are commonly incapacitated through their dependence on or addiction to benzodiazepines, or through their self-withdrawal from these medicines. Some are left with long-term health problems, even after withdrawal. Many would say that their lives have been wrecked as a result of being introduced to these drugs.'
Dr Brian Iddon

Faced with this reality why has this saga of prescription drug injury rolled on for fifty years? Why has the approach of governments been so low-key and non-urgent? Why has the saga rolled on for so long that today, in a new age, it is possible for government and others to assert and maintain that the internet and drug-seeking behaviour is the cause of what has happened to affected patients?

By the 1970s, benzodiazepines were the most widely prescribed of all prescription medicines. They are still widely prescribed: 11.7 million prescriptions were issued for them in 2007. However, many who have tried to stop taking them have experienced severe withdrawal symptoms as a result of their involuntary addiction. I remember Esther Rantzen and her "That's Life" team highlighting these problems in the early 1980s, and a book was published in 1984 as a result of her campaign.
Dr Brian Iddon

Many of the people taking benzodiazepines in the 70s and 80s are either still taking them today or living with the unacknowledged consequences of over-prescription. Medicine has shown no real concern and neither has government.

The all-party group came across patients who have been prescribed benzodiazepines for more than 30 years. Evidence suggests that repeat prescriptions being handed out without the doctors monitoring their patients is a common cause of such involuntary addiction.
Dr Brian Iddon

"The committee [...] further suggested that patients receiving benzodiazepine therapy be carefully selected and monitored and that prescriptions be limited to short-term use."
Committee on the Review on Medicines quoted in The British Medical Journal, **29 March, 1980:**

The CRM highlighted the need to monitor patients almost 30 years ago. The number of prescriptions after that and the estimated 1 million plus patients dependent on them now shows how well the profession monitored their patients. Do prescribers listen to drug agency warnings and official advice? It would appear many did not. That attitude may well continue in spite of stated government efforts to improve medical education and may well be an unwelcome predictor of the future. After all, many have noted that medicine learned nothing from its past involvement with mind-altering drugs and prescribed in huge quantities everything new that came along from opium and alcohol to barbiturates. This history which is ongoing, serves to underline the demonstrably rank amateurism of medical research on psychotropic drugs; it purports to be definitive but often hides and leaves un-investigated, more than it reveals. Benzodiazepines are reputed to be the most investigated drugs in the history of science but take a look at what has been investigated and what has not.

Karl Marx once wrote that history repeats itself, first as tragedy and then as farce. He was not talking about psychotropic medicine but he could have been.

A Chink of Light

'Our report contains 24 recommendations. They include the adequate training of medical professionals; raising awareness of the problem; proper prescribing and the monitoring of patients; more research to establish the scale of the problem;

and, most important, recognition of those patients with problems and the ability to refer them to an appropriate treatment centre.'
Dr Brian Iddon

'With both tranquilliser and codeine addiction, we found that most GPs either do not recognise the problem that their patients have or are at a loss to know how to deal with them. The plain fact is that it is probably easier today for an illegal drug user to get a referral to a drug and alcohol action team—a DAAT—than it is for those having problems with legal drugs, other than alcohol, to get treatment for their condition.'
Dr Brian Iddon

'The National Treatment Agency was set up in 2000 and has been very successful in treating those referred to it who are addicted to controlled—or street—drugs. However, we believe that it is not geared up to treating those with the problems that I have been describing. The stigma associated with controlled drug addiction, and the shame associated with those who have become involuntarily addicted to prescription and over-the-counter medicines, means that such patients are hardly likely to volunteer for referral to the facilities provided by DAATs. In our report, therefore, we have recommended that the Department of Health provide centres for treatment within the NHS, but separate from those provided by DAATs.'
Dr Brian Iddon

'Finally, it is important that the Department of Health commissions research to measure the extent of these problems and monitor future prescribing and sales of the problem medicines.'
Dr Brian Iddon

'Rightly, successive Governments have spent a lot of time, energy and money dealing with the problems associated with illegal drugs. I am sure that we all support that effort. There have been different ways of approaching the problem, but the thrust has always been to deal with the social and personal impact of illegal drugs. None the less, we must start by saying that such an approach has led to the more difficult problems associated with perfectly legal drugs—prescription-only drugs and over-the-counter medicines—not receiving the attention that has so rightly been brought into focus.'
Greg Mulholland MP

'We do not know exactly how many people are addicted to prescription-only medicines let alone those who are addicted to over-the-counter medicines. Could more work be done to establish that figure? Difficult though that would be, it is important to understand the scale of the problem.[I can see that happening]
There are guidelines on prescription-only tranquillisers, including of benzodiazepines, which have already been mentioned, but are they working?'
Greg Mulholland

'As the hon. Member for Bolton, South-East said, an estimated 1.5 million people are addicted to benzodiazepine drugs and 2 million people were addicted to a broader group of drugs. He also said that some drug users are using prescription tranquillisers as part of a regular drug routine. However, other people are stuck in a cycle, having been properly prescribed drugs—at least they believe that they have been properly prescribed them. Again, people access the drugs for different reasons, which is another factor that makes the situation difficult to deal with.'
Greg Mulholland

The Candle Gutters

Remember the title of this debate is Addiction to Medicines. Even though called by Dr Brian Iddon, retiring chairman of the All Party Parliamentary Group on Drug Misuse, it should have addressed issues which were not in any shape or form related to drug misuse. I make no apology for repeating this quote from Brian Iddon:

'With both tranquilliser and codeine addiction, we found that most GPs either do not recognise the problem that their patients have or are at a loss to know how to deal with them. The plain fact is that it is probably easier today for an illegal drug user to get a referral to a drug and alcohol action team—a DAAT—than it is for those having problems with legal drugs, other than alcohol, to get treatment for their condition.'
Dr Brian Iddon

Dr Iddon made several perfectly correct points in the debate regarding benzodiazepines but perhaps if he had made it clear that the historic prescribing of tranquillisers is a separate problem with a different nature to OTC codeine addiction, the contributions from those who appear to see only drug misuse by non-doctors might have been headed off.

‘The Royal Pharmaceutical Society of Great Britain has expressed concerns that there is currently no referral system specifically for misusers of prescription-only and over-the-counter medicines...’
Greg Mulholland

‘There has been a great deal of debate, research and Government policy thinking on the misuse of illegal substances, but the report rightly highlights that to date, there has been no significant focus on the misuse of legal substances.’
Mark Simmonds MP Shadow Junior Health minister (2007 - present)

Were he talking about the misuse of patients through unsafe prescribing, he would be right but it appears he was not. He sees only two positions, the misuse of illegal drugs and the misuse of legal drugs. Benzodiazepines of course are both legal and illegal. While he holds the same view on both, there seems little hope in the future for the justice mentioned by David Blunkett and Paul Boeteng in the past.

‘In many cases of addiction to prescription medicines, the GP is aware of the situation. As the hon. Member for Bolton, South-East said in response to my intervention, GPs know their patients best, but GPs often do not feel suitably qualified to assist patients in reducing their dependence. More must be done to make GPs aware of the possibility of addiction and help them to deal with patient dependence. Part of that could involve ensuring that GPs are aware of the British national guidelines on the optimum length of prescriptions for medicines...’
Mark Simmonds MP

Not only has he failed to distinguish between drug misuse by patients and drug misuse by doctors, but he also fails to understand that GPs have been regularly reminded through various channels (including their own professional bodies) to prescribe circumspectly over nearly 30 years. He obviously does not understand that GPs have little idea on dealing with addictions they themselves create and have little time to do it in any case. The aims sound worthy but these aims have been aims for at least three decades. Who has paid the price for doctors remaining unaware for so long of the details of best practice?

‘We know that all parties act against illegal drugs, because no one who has a vested interest in defending them can do so publicly, but if a future Government were to campaign to reduce the use and abuse of legal medicines, they would meet ferocious opposition from the pharmaceutical industry, which would denounce the Government for keeping medicines away from the public.’
Paul Flynn MP

‘I do not see that as the issue. The issue is ensuring that over-the-counter and prescription medicines are used responsibly. Most patients in this country use access to medicines responsibly to better their lives, but we are discussing misuse. Any responsible Government should focus on misuse, which is not necessarily the same thing as attacking the pharmaceutical industry, as the hon. Gentleman suggests. The pharmaceutical industry plays a significant role in alleviating the pain and suffering of many people in this country. It is misuse that we need to focus on, not the market as a whole.’
Mark Simmonds MP

Mr Simmonds is wrong, the issue to focus on in the context of tranquillisers is the connection between the pharmaceutical industry, government and drugs’ regulators and the infliction of harm rather than benefit on patients. Perhaps he is unaware for example of the pharmaceutical industry reaction to an attempt by government to reduce the number of benzodiazepines available through the NHS – they fought it tooth and nail, suggested to doctors they should oppose it and managed to dilute the proposals.

Kenneth Clarke, Minister of Health, 11.12.84
‘The reaction from the vested interests [ABPI, BMA, Roche et al] to our proposals to contain expensive and unnecessary prescribing under the health service has been close to hysterical.’

Kellett JM.
The Benzodiazepine Bonzanza.
Lancet 1974; ii: 964.
"Dr Tyrer is certainly right to draw attention to the multiplicity of benzodiazepines (---). Not only

are there too many, but one suspects that they are too often prescribed in ways which cause harm to the patient."

Not in the view of the pharmaceutical industry and apparently for some reason, not in the view of drugs' regulators or government.

'For the Government, it is important to address all drug addiction, including addiction to prescription and over-the-counter medicines. We want to make it clear that tackling drug misuse of any kind is a Government priority, and we have made massive strides in reducing the harm that drug misuse can do to individuals and to society as a whole.'
The Minister of State, Department of Health (Phil Hope)

The present Minister of State, Phil Hope was delighted to follow on the line of drug misuse leading to addiction [although to be accurate, addiction to prescription drugs is [rightly in my opinion] called dependence since addiction lends itself too readily to being associated with personal abuse. He made the usual references to priority and was careful to state that these priorities related to drug misuse of any kind. Unfortunately the government feels unable to deal with tranquilliser misuse by doctors and the consequent damage to society.

Some Points Not to Ignore

- Government refuses or perhaps is not capable of recognising the difference between prescribed drug harm and drug misuse harm (I favour the first).
- There is little or no help for the victims of tranquilliser prescriptions.
- Government information may have been counter-productive and has certainly not solved the problem.
- Government some how finds itself unable to go beyond superficiality and use specific controls.

Professor C.H Ashton to Rosie Winterton, Minister of State DoH, 9th January 2007
You do not seem to understand or acknowledge the distinction between long-term prescribed benzodiazepine users and those who misuse or abuse the drugs recreationally, along with opiates, cocaine and other "hard drugs". The problems and needs of prescribed benzodiazepine users were described in detail to you in our meeting in 2004. The only one of our suggested recommendations that you supported was to persuade the Chief Medical Officer to send a letter to doctors asking them to reduce their prescribing of benzodiazepines. At the meeting I personally offered to assist the CMO in drafting such a letter. This offer was ignored and his badly worded letter was a predictable disaster which resulted in many general practitioners abruptly reducing benzodiazepine prescriptions to long-term patients and some PCTs reducing their budgeting for such drugs - with similar unfortunate effects on patients...

Prescribed benzodiazepine users do **not** have proper access to primary health care services because general practitioners lack the expertise and time to withdraw long-term prescribed patients from benzodiazepines, and the waiting list for psychological therapists, who are in any case not properly trained, is up to two years in most PCTs. These prescribed patients also do not have access to secondary health care services: they are regularly refused treatment because they are not abusing opiates or other hard drugs...

Your attitude and your repeated statements lead one to despair of politicians. Like journalists they seem only interested in the subject for one moment. They may pay lip service but then turn to other matters. I understand that politics and academic medicine are worlds apart but feel that your interest

in prescribed benzodiazepine users is facile and so far futile. As Health Minister the public expects more of you.

Rosie Winterton, Minister of State DoH to John Grogan MP, 13 January 2004
I acknowledge the point made that advice and guidance on prevention is not always enough, but we have to work with the levers that are available to us.

Patient talks to Doctor

Not only do an unquantified number of patients and former patients have to live with the experience of benzodiazepines but after withdrawal they also have to live with the disbelief of doctors. Ray Nimmo recently gave a far from amusing summary description of a process which is all too common:

GP: I do not believe that you are suffering from benzodiazepine withdrawal symptoms eleven years after you stopped taking the drugs.

RN: Well no, neither do I. I do however believe that the symptoms I have described to you are the result of long-term benzodiazepine therapy and that I have sustained permanent injury to my central nervous system. The symptoms I have described to you (tinnitus, paraesthesiae, formications, muscular spasms, head/jaw and facial pain) are evidence of this damage.

GP: I'm not convinced. You are the only person I have ever seen who has complained of damage caused by benzos. Whatever you have must be something else.

RN: I am not surprised by your reply at all. Firstly, the majority of people exposed long-term to benzos are either still on the drugs or dead. And secondly, you are unlikely to have encountered any of the very few who have managed to come off the drugs. In fact, the few who do are very often persuaded by their doctors that they are suffering from something else and, more often than not, are subject to misdiagnosis and may receive inappropriate treatment.

What kind of system is it that refuses to see the need for research into patient claims? As a consequence of the absence of that research, any random front line doctor is free to deny a connection between benzodiazepines and the symptoms reported. Long term benzodiazepine-related symptoms have been pointed to in numerous research papers but neither drug companies nor governments have seen fit to design studies which seek to substantiate and explore the nature of the un-researched symptoms. Has any academic ever researched the effects post withdrawal that patients complain about? I have never come across anything relevant. This is a central question since it means the denial takes place in the absence of negative evidence. An absence of scientific evidence is not evidence of absence.

Considering Reality

‘And this week, renowned clinical psychologist Richard Bentall publishes *Doctoring The Mind: Why Psychiatric Treatments Fail:* In meticulously referenced detail, Bentall documents the shocking failures of biological psychiatry and the drug-based mental health system it perpetuates, and calls for an evidence-based alternative that offers patients support, care and respect.’
Observer /Guardian 29 June 2009

‘GPs ignore official advice that patients should take powerful benzodiazepine tranquillisers for no more than four weeks by handing out repeat prescriptions without even seeing them in their surgery,

says an all-party parliamentary group on drug misuse [APPG on Drug Misuse]. The Home Office blames the mis-use benzodiazepines for causing 17,000 deaths since their introduction in the Sixties.' The Observer, Sunday 10 February 2008

Whatever else the 50 year benzodiazepine scandal illustrates, it shows in bald terms that NHS doctors I'm afraid have a licence to kill and maim and then move on from it. They do not set out to inflict injury of course, but a failed and inadequate system of regulation, shortcomings in medical education and the government-pharmaceutical cartel of mutual interest guarantees that the injury happens.

The licence is kept in the fiercely defended wallet of clinical judgement. Clinical judgement has its place, but using it to judge the impact of psychotropic drugs on patients while remaining largely ignorant of independent evidence and abrogating common sense and caution is certain to inflict harm. Inflict the harm for long enough and the priority is not to do something about it but to find justification for it.

It seems that medicine has a golden sugar-coating round it, where all good things are - good practices, rights, professionalism etc (polished daily by providers and politicians). But inside that coating is reality where lies - brusque rudeness, indifference, blind self-belief and a superiority complex.

Doctors are given the drugs by the existing structures, are educated to believe in their efficacy and safety and the result is that patient reports are ignored. The medical research and comment at the end of this paper demonstrates the out of balance faith placed in licensed medicine, the inordinate time span involved in discovering the downside and widespread ignorance of the downside. I urge everyone to read it and deny these truths. Stuart Jones who has had considerable personal experience of this reality describes the situation well:

'The almost obscured elephant in the room of the iatrogenic induced benzodiazapine plague, and the ineffective system of medicines regulation and pharmacovigilance in the UK, which predicated it would happen,...is that had the legal action against Hoffman La Roche and Wyeth, been allowed to proceed, the whole scandal of Pharma's corporate dominance of health politics would have been exposed for what it mostly is - a money making scam [...] An alleged quote from a Roche executive illustrates the why of the matter: "We are not in the business of curing people, we are in the business of making money" I have no reason to doubt that was said, and what difference? After all it is the truth. So are the illicit drug cartels, but of course they don't have their bought medical journals, medical articles, key opinion leaders and political lobbyists, nor do they fund govt. regulators [...] in truth the pharmaceutical industry manufacture many good and effective treatments, but in the matter of the so-called psychotropic drugs and the way they have been marketed by the industry, there is often little difference twixt the illegal (recreational) psychoactive drug(s) and the licensed drug(s) or their adverse effects, certainly with regard to their addictive properties, although with the licensed versions we have come to be dependant on the drug, not addicted to the drug. What difference?' Stuart Jones, Drug Safety Advocate 24 June 2009

The Mainline Diversion

'Dr Steve Field, chairman of the Royal College of General Practitioners, said it would take on board the MPs' findings, which raised some important concerns about how family doctors treat patients who may be abusing either prescription or shop-bought drugs, or both. Some GPs needed to improve their repeat prescription systems so that the amount of drugs that patients were taking could be monitored and that fresh supplies would only be approved if they were medically necessary, he admitted.' Dr Steve Field, chairman of the Royal College of General Practitioners, February 2006

”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

"It is reasonable to say there was overuse of benzodiazepines but no-one can say it was because the GPs were not thinking and weren't aware of the drawbacks.

"It is very difficult to apply the over-prescription view in retrospect as there was very little choice in the 70s and 80s.
Dr Jim Kennedy, chair of the Royal College of GPs 24.7.2006

The Correct Destination

“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

"Doctors over-prescribing benzos were not treating heroin addicts. It started with over-prescription by doctors in exactly the same way that amphetamines were over-prescribed just after the end of the Second World War."

"They are available in most pubs and clubs in the country's cities. Almost 90% of illicit drug users and alcoholics in clinics use benzos. It is stupid and ironic that the same story is repeating itself from morphine to opium going back more than 100 years. The number of illicit users is much smaller than the over-prescribed. It is just the tip of the iceberg."
Professor C.H. Ashton 24.7.2006

"If any drug over time is going to just rob you of your identity and be an ironic reaction to early effectiveness, [leading] to long, long term disaster, it has to be benzodiazepines."
Dr John Marsden, Government Adviser on Drug Addiction, and senior lecturer in addictive behaviour at the Institute of Psychiatry, November 2007

Colin Downes-Grainger, 2 July 2009

Benzodiazepine Medical Research and Comment

Ingram IM, Timbury GC.
Side-Effects of Librium.
Lancet 1960; ii: 766.
"Side-effects were seen in over half the patients. 2 felt drowsy on the smaller dose, 5 on the larger. 2 felt fatigued and apathetic, and dizziness and constipation were reported. 1 patient felt more energetic and 2 complained of severe irritability. After taking the drug for a week a schoolteacher struck his wife for the first time of the twenty years of their marriage. (---). Although the number treated is small and the findings uncontrolled, the results are disappointing enough and the side-effects sufficiently troublesome to deserve attention. Other side-effects reported in trials in the United States have included dissociative reactions, hyperactivity, and ataxia. We feel justified in suggesting that the drug should be used with circumspection and scepticism until the results of controlled trials are available. "

Feldman PE.
An Analysis of the Efficacy of Diazepam.
Journal of Neuropsychiatry 1962; 3 (suppl 1): 62-67.
"Instead of prompting the appearance of delusions and/or hallucinations, many of the patients receiving Valium displayed a progressive development of dislikes and hates. The patients themselves deliberately used the term "hate".

Dimascio A, Shader RI, Harmatz J.
Psychotropic Drugs and Induced Hostility.
Psychosomatics 1969; 10: 46-47.
"We generally call it a "paradoxical reaction" of the drug when a patient responds in a manner inconsistent with - or opposite to - our conception of how he or she should respond to a psychotropic agent. But it is only our lack of knowledge - or our limited conception of what these drugs do and in whom the do what that necessitates the label "paradoxical". With knowledge, these actions should not remain "paradoxical" but become "predictable drug effects. " [p. 46]

"These drugs are also supposed to calm and quiet agitated and irritable individuals. Indeed, if you remember, when chlordiazepoxide was first introduced, it was publicised as being able to tame even the wildest and most ferocious of animals, without reducing their ability to move about. The initial expectation, therefore, was that it would do the same in man. However, even from the beginning of the use of the drug, it was noted that in some patients a state of increased anger, irritability and overt aggression was induced or unmasked. Because it was not expected, the phenomenon was labelled as "paradoxical". [p. 46]

"When prescribing for patients with anxiety states the potential action of these drugs on hostility and aggression has to also be considered. " [p. 47]

Clare AW.
Diazepam, Alcohol, and Barbiturate Abuse.
BMJ 1971; 4: 340.
"It is suggested that the sanguine view held by many members of the medical profession towards the minor tranquillisers has been transmitted to the lay public and militates against attempts to remove patients from unnecessary and potentially harmful treatment with these drugs. "

Katz RL.
Sedatives and Tranquilizers.
New England Journal of Medicine 1972; 286: 757-760.
" What can be recommended is that every time a physician reaches for his prescription pad, he ask himself if he is prescribing a sedative or tranquilizer because he has a roomful of patients waiting and is in a hurry to get on to the next patient... or whether he has carefully considered all the evidence, has found that sympathy, understanding, suggestion and reassurance are not sufficient, and has decided to prescribe a sedative or tranquilizer for positive reasons rather than as an easy way out." [p. 670]

Cochran PW.
Drugs for Anxiety.
JAMA 1974; 229: 521.
"Your editorial, "Drugs for Anxiety" (228: 875, 1974) prompts an uneasy feeling that has been growing on me for some time. Diazepam is cited as a safe drug not particularly subject to abuse when prescribed on an as-needed basis with a cover statement that some psychic distress should not be alarming. This is floridly at variance with my uncollated experience; in fact, so

much so that I regard it as virtually a "once on, never off" preparation.

Kellett JM.
The Benzodiazepine Bonzanza.
Lancet 1974; ii: 964.
"Dr Tyrer is certainly right to draw attention to the multiplicity of benzodiazepines (---). Not only are there too many, but one suspects that they are too often prescribed in ways which cause harm to the patient."

Haskell D.
Withdrawal of Diazepam.
JAMA 1975; 233: 135.
"The manufacturer's literature warns of physical addiction to diazepam or other benzodiazepines, mainly with excessive doses. However, I have seen several patients experiencing barbiturate-type withdrawal symptoms after four to six months of diazepam therapy in doses as low as 15 mg/day."

"Symptoms such as tremors, agitation, fearfulness, stomach cramps, and sweating made patients extremely uncomfortable, but dangerous reactions, such as convulsions, did not occur. All of these patients had been admitted to a psychiatric hospital for depression. They were generally reluctant to stop using diazepam, but when the symptoms subsided after two to four weeks, they were usually happy to be free of medication."

"Also, the possibility of depression after prolonged diazepam treatment, as reported in another letter (226; 1572:1973), underscores the need for further study and caution with this drug. "

Maletzky BM, Klotter J.
Addiction to Diazepam.
International Journal of the Addictions 1976; 11: 95-115.
" ... several subjects complained of extreme anxiety upon abstinence, yet had been free of anxiety when the drug was initially prescribed. in addition, symptoms such as tremor, diaphoresis, and even insomnia, which had been rare prior to taking diazepam, emerged when the drug was stopped. " [p. 110]

"In addition, many subjects not thought to be "addiction-prone" developed what appeared to be both tolerance and withdrawal. These subjects, given the drug for medical reasons and without a psychiatric history, were just as likely as psychiatric patients to develop tolerance and withdrawal." [p. 111]

"... age, sex, and the presence or absence of a history of psychiatric, alcoholic, or drug-related problems had no bearing on development of tolerance or withdrawal, thus raising the question about the validity of the "addiction-prone" concept. " [p. 112]

Grant I, Adams KM, Carlin AS, Rennick PM, Judd LL, Schooff K, Reed R. Organic Impairment in Polydrug Users: Risk Factors.
American Journal of Psychiatry 1978; 135: 178-184.
"If our findings are confirmed by others, several implications might be considered. First, sedatives and opiates might produce more long-term toxicity than has previously been suspected. If this is so, we need to rethink practices that have led to exceedingly widespread use of sedatives and minor tranquillisers." [p. 183]

Smith RJ.
Study Finds Sleeping Pills Overprescribed.

Science 1979; 204: 287-288.
"Sleeping pills, the most prescribed medication in the world, are more dangerous and less useful than either physicians or patients realize, according to a recent report by the Institute of Medicine (IOM) - National Academy of Sciences. " [p. 287] “

"... the IOM report concludes that, although barbiturates are indeed as hazardous as everyone thinks, the chief alternatives, benzodiazepines, may be just as risky, and in some ways may be even more risky than barbiturates. "[p. 287]

Sen. Edward Kennedy (D-Mass.) Senate Subcommittee on Health and Scientific Research 1979
"If you require a daily dose of Valium to get through each day, you are hooked and you should seek help."

Hendler N, Cimini C, Ma T, Long D.
Comparison of Cognitive Impairment Due to Benzodiazepines and to Narcotics.
American Journal of Psychiatry 1980; 137: 828-830.
"However, the most significant problem that benzodiazepines create seems to be cognitive impairment with associated EEG changes (---). Acute, single dose administration of diazepam does seem to produce impairment in learning, memory, and psychomotor functioning. " [p. 828]

"...one could conclusively state that benzodiazepines were far more likely to produce cognitive impairment, with concomitant EEG changes, than were narcotics. " [p. 830]

Edwards JG.
Adverse Effects of Antianxiety Drugs.
Drugs 1981; 22: 495-514.
It is perhaps humiliating for us to realise that we have learnt little from history. Is it possible that having previously contributed to barbiturate and other addiction we are now reluctant to accept that we may have also contributed to benzodiazepine addiction?”

Ban TA, Da Silva T, Gagnon MA, Lamont CT, Lehmann HE, Lowy FH, Ruedy J,Sellers EM.
Therapeutic Monograph on Anxiolytic-Sedative Drugs.
Canadian Medical Association Journal 1981; 124: 1439-1446.
"Various unusual responses have been documented, including nightmares, paradoxical delirium and confusion, depression, aggression and hostile behaviour. Some patients experience a dry mouth, a metallic taste or headaches. Awareness of the sometimes bizarre effects of these drugs is important. " [p. 1443]

Crawford RJM.
Benzodiazepine Dependency and Abuse.
New Zealand Medical Journal 1981; 94: 195.
"The earlier drugs with longer half lives of several days have now been adequately researched, and two facts emerge:
(1) The longer a person takes them, the harder it is to stop, i.e. withdrawal symptoms (headaches; muscle cramps; light-headedness; vertigo; muscular in-co-ordination; paranoid reactions; epileptic fits, and malaise) occur which the patient learns can be stopped by another pill.
(2) These effects can occur in people who have had doses in the normal recommended clinical range. “

Herxheimer A.
Driving under the Influence of Oxazepam: Guilt without Responsibility ?

Lancet 1982; ii: 223.
"Benzodiazepines can blunt perception, confuse thought, and cause amnesia. The defendant described feeling "fuddled and muddled" and driving less sharply than usual. This state of mind, if it was induced by the drug, would aggravate the difficulty of understanding that something was wrong, and of taking appropriate action, let alone suspecting a connection between the state of mind and taking the drug. "

Prescott LF.
Safety of the Benzodiazepines . In: Costa E, ed. The Benzodiazepines. From Molecular Biology to Clinical Practice. New York: Raven Press, 1983; 253-265.
"The most common and most important adverse effects of the benzodiazepines are those affecting the central nervous system. These effects usually represent exaggerated pharmacological actions and include drowsiness, lethargy, retardation, depression, dysarthria, ataxia, confusion, disorientation, and, in the elderly, dementia. These drugs also have subtle effects on mood, mentation, and behaviour, reducing activity, drive, and initiative to the extent that patients may fail to react appropriately to adverse or dangerous situations and be unable to face and cope with their problems. In addition they may blunt discretion and precipitate the taking of an overdose. The elderly are particularly susceptible to the central effects of benzodiazepines, and they are also least able to compensate for cerebral functional impairment. " [p. 254]

"It is the prescribing doctor's clear responsibility to warn patients accordingly. Unfortunately many patients who had been prescribed these drugs do not seem to have been warned of the possible risks by their doctors. I have encountered drivers of double-decker buses, heavy goods vehicles, and even the operator of a very large dockside crane who stated they had been prescribed benzodiazepines without any warnings or restrictions. " [p. 256]

Trickett S.
Withdrawal from Benzodiazepines.
Journal of the Royal College of General Practitioners 1983; 33: 608.
"I have started a support through withdrawal scheme for people coming off benzodiazepines. The enormous amount of suffering I see makes me wonder how much information on the toxic effects of these drugs, and illness caused by their withdrawal, reaches the doctors. The pharmacological manuals grossly understate the dangers of tolerance, dependence and withdrawal that have been demonstrated so clearly after the use of these drugs. This is not only after long-term use at high dosage, but also after very short-term use (two weeks), on a normal therapeutic dose.

We must look urgently for the most effective treatment, since a quarter of benzodiazepine users will become severely physically dependent. Widespread dependence, as much as over-prescribing, must be the reason for the enormous use of these drugs.

The withdrawal syndrome has many unique features and needs to be treated as a new disease. In acute withdrawal, psychosis, convulsions and suicides are a great deal more common than the literature would suggest. The physical symptoms, many of which are not typical of anxiety, are the worst aspect of the illness.

Some of the symptoms are belated and are not associated with the drugs by patient or doctor. Rebound insomnia is a persistent symptom. Unfortunately, and so often, doctors prescribe another benzodiazepine for night sedation when the patient complains of this.

Psychological dependence is less of a problem. Many users report craving for the drugs, but at the same time feel revolted by them, and angry that they have to take them to avoid withdrawal

symptoms.

Thousands of people could not possibly invent the bizarre symptoms caused by the 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, and even less about treatment. The drugs newsletter on benzodiazepines issued in this region will help them. Is anything being done elsewhere?

Release and self-help groups all over the country have done wonderful work, but why should people need to form groups for an urgent medical problem? This is drug-induced disease, not drug abuse. "

Murray D, O'Leary D.
Recommendations for Data Sheets on Benzodiazepines Ignored.
BMJ 1984; 288: 717.
"The Committee on Review of Medicines, in its guidelines for data sheets on 10 named benzodiazepines, "considered that an appropriate warning regarding long-term efficacy be included... particularly in view of the high proportion of patients receiving prescriptions for extended periods of time." In conjunction with a survey on prescribing patterns we examined the Association of the British Pharmaceutical Industry's Data Sheet Compendium 1983-1984. We found the 10 named compounds represented by 17 proprietary preparations. Although 16 warn that "prolonged" or "excessive" use may lead to dependence, only one carries a caution regarding long term efficacy. If the pharmaceutical industry is allowed such latitude in the data sheets we can hardly expect higher standards in their advertising literature."

Romney DM, Angus WR.
A Brief Review of the Effects of Diazepam on Memory.
Psychopharmacology Bulletin 1984; 20: 313-316.
"Moreover, it [i.e. diazepam] appears to produce side effects, previously unnoticed, both on mood, causing depression and rage, and on cognitive and psychomotor functioning. " [p. 313]

Higgitt AC, Lader MH, Fonagy P.
Clinical Management of Benzodiazepine Dependence.
BMJ 1985; 291: 688-690.
"Withdrawal symptoms have been reported after treatment for as little as four to six weeks. The withdrawal symptoms observed are wide ranging, and, while they include some related to anxiety, they are clearly distinguishable from a simple re-emergence of pre-existing anxiety. Particularly frequently reported are instances of increased sensory perception such as hyperacusis, photofobia, paraesthesia, hyperosmia, and hypersensitivity to touch and pain, but gastrointestinal disturbances, headaches, muscle spasms, vertigo, and sleep disturbances are also frequent.

The proportion of long term users of benzodiazepines in whom withdrawal symptoms may be expected to emerge has been variably estimated to be between 15% and 44%. The symptoms typically emerge in the first week after stopping the drug but may develop after a reduction in dosage. Until recently the withdrawal syndrome was reported as lasting for up to three months, but we are now seeing more patients whose symptoms have persisted for more than six months - in some cases for a year or more." [p.688]

Ashton H.

Adverse Effects of Prolonged Benzodiazepine Use.
Adverse Drug Reaction Bulletin 1986; 118: 440-443.
"Chronic benzodiazepine usage can cause both depression and "emotional anaesthesia", an apathetic state with dulling of all emotions. In patients with depressive illness, benzodiazepines can aggravate the depression and provoke suicide. On the other hand, some individuals experience euphoria, and benzodiazepines have abuse liability when used intravenously. Occasionally, benzodiazepines produce apparently paradoxical stimulant effects. (---) Patients on low chronic doses of benzodiazepines sometimes commit uncharacteristic antisocial acts such as shoplifting or sexual offences, while higher doses may produce outbursts of rage and violent behaviour, especially in anxious patients. “

Poser W, Poser S.
[Abuse of and Dependence on Benzodiazepines.]
Internist 1986; 27: 738-745.
"The withdrawal syndrome does not abate rapidly in all patients, occasionally it may be protracted for months after ingestion of the last dose. The authors know of certain patients, who are complaining of perceptual disturbances for years afterwards, although no anxiety disorder was known prior to the benzodiazepine dependence. "[p. 744]

Rickels K, Case WG, Schweizer EE, Swenson C, Fridman RB.
Low-Dose Dependence in Chronic Benzodiazepine Users: A Preliminary Report on 119 Patients.
Psychopharmacology Bulletin 1986; 22: 407-415.
"In fact, one hard-earned lesson is that long-term BZ users are in need of much more intensive psychiatric and social support than other anxious or depressed patients. " [p. 414]

Roberts K, Vass N.
Schneiderian First-Rank Symptoms Caused by Benzodiazepine Withdrawal.
British Journal of Psychiatry 1986; 148: 593-594.
“Benzodiazepine withdrawal has been found to give rise to numerous physical and psychological symptoms.”

Ross M.
Lorazepam-Associated Drug Dependence.
Journal of the Royal College of General Practioners 1986; February: 86.
"I should like to draw attention to what, in my opinion, are the unequivocal risks of lorazepam-associated drug dependence and exaggerated withdrawal symptoms. In my experience, this can occur often with low dosage, short courses and for many months after cessation of therapy.
It is common to find other general practitioners and psychiatrists who share this view and there is also widespread lay awareness of the problem. For the last year and a half I have been communicating with the Committee on Safety of Medicines about the problem. They answer that they have received few yellow card reports on this problem.
My personal view is that this is because doctors do not realise that reporting an expected side-effect of a drug is as useful for epidemiological purposes as is reporting an unexpected side-effect for general scientific purposes. I should like, therefore, to appeal to all the general practitioners who must be seeing this problem, to report any cases to the Committee on Safety of Medicines. "[p. 86]

Ashton H, Dangers and medico-legal aspects of benzodiazepines, J. Med Defence Union, Summer 1987, 6-8.
"There is now little doubt that regular use of benzodiazepines can lead to drug dependence in patients who are not drug abusers. Such patients come to rely on the drugs for psychological comfort

and suffer withdrawal symptoms if the drug is stopped or the dosage reduced. It is estimated that one-third of patients taking benzodiazepines for six months become dependent... Present estimates suggest that perhaps 500,000 people in the UK... are now dependent on benzodiazepines"

Ashton H.
Benzodiazepine Withdrawal: Outcome in 50 Patients.
British Journal of Addiction 1987; 82: 665-671.
"None of these symptoms or behaviours were the original indication for starting on benzodiazepines but developed during chronic use. It is arguable whether the patient would have developed the symptoms over time in the absence of benzodiazepines, but the fact that they were not present before benzodiazepine use, were not amenable to treatment during benzodiazepine use, yet largely disappeared when the drugs were stopped, suggests that benzodiazepines may actually cause or aggravate a variety of psychological and psychosomatic symptoms. " [p. 670]

Borg S.
Dependence on Hypnotic/Sedative Drugs.
In: Pharmacological Treatment of Anxiety. National Board of Health and Welfare, Drug Information Committee, Sweden 1988; 1: 135-143.
"In spite of good socio-economic conditions the long-term prognosis for patients with hypnotic/sedative dependence seems to be similar to that encountered in e.g. alcohol abuse. " [p.137]

Gene-Badia J, Blay-Pueyo C, Soler-Vila M.
Risk-Factors in the Use of Benzodiazepines.
Family Practice 1988; 5: 283-288.
"... general practitioners, who are the principal prescribers of drugs, are causing overmedication in the population. " [p. 283]

Golombok S, Moodley P, Lader M.
Cognitive Impairment in Long-Term Benzodiazepine Users.
Psychological Medicine 1988; 18: 365-374.
"The finding that patients taking high doses of benzodiazepines for long periods of time perform poorly on tasks involving visual-spatial ability and sustained attention, implies that these patients are not functioning well in everyday life. Furthermore, the lack of relationship between benzodiazepine intake and the cognitive Failures Questionnaire, a subjective measure of impairment, suggests that they are not aware of their reduced ability. This is in line with clinical evidence that patients who withdraw from their medication often report improved concentration and increased sensory appreciation, and that only after withdrawal do they realise that they have been functioning below par. " [p. 373]

“It appears... that not only are long-term benzodiazepine users at risk of dependence, but that cognitive impairment also represents a very real hazard. " [p. 373]

Kellman AM.
Benzodiazepine Withdrawal.
American Journal of Medicine 1988; 85: 755.
"Unfortunately the widespread use of these medications in the general medical community has not been accompanied by concomitant knowledge of their potential adverse effects. All too often, biased information from pharmaceutical representatives is used to guide therapy with benzodiazepines. In my own experience, I have encountered far more problems with patients who have become inadvertently dependent on benzodiazepines than with patients who refuse to take these medications due to concerns about possible addiction. In particular, I have seen a

number of very severe withdrawal reactions from alprazolam, including on death as a result of subdural hematomas incurred during a withdrawal seizure."

Levander S.
Psychophysiology and Anxiety - Current Issue and Trends.
In: Pharmacological Treatment of Anxiety. National Board of Health and Welfare, Drug Information Committee, Sweden 1988; 1: 43-51.
"However, it cannot be excluded that treatment with benzodiazepines may have negative therapeutic long-time effects, and may induce neuropsychological impairment, which in the worst case can be permanent. " [p. 49]

Lobo BL, Miwa LJ.
Midazolam Disinhibition Reaction.
DICP 1988; 22: 725.
"Some studies suggest that benzodiazepines have an inherent potential to cause aggression. In a double-blind, placebo-controlled, cross-over study, Gardner and Cowdry showed that alprazolam produced a significant increase in behavioural loss of control in patients with a borderline personality disorder. Wilkinson demonstrated an aggression-enhancing effect with diazepam, especially in the low-anxiety group. Other studies have demonstrated that chlordiazepoxide and diazepam may decrease anxiety but increase affective hostility. " [p. 725]

Priest RG, Montgomery SA.
Benzodiazepines and Dependence: A College Statement.
Bulletin of the Royal College of Psychiatrists 1988; 12: 107-109.
Amnesia is frequently a real side effect of the use of benzodiazepines and not just a figment of the individual's imagination or a coincident symptom of emotional disorder.
It is often inadvisable to prescribe benzodiazepines to a patient in an acute crisis as the amnestic property of these compounds may not allow patients to make an optimum response to the situation which they are facing. In cases of loss or bereavement, the psychological adjustment to this trauma may be severely inhibited by benzodiazepines and any tendency to denial could be reinforced. " [p. 107]

Schneider-Helmert D.
Why Low-Dose Benzodiazepine-Dependent Insomniacs Can't Escape Their Sleeping Pills.
Acta Psychiatrica Scandinavica 1988; 78: 706-711.
"It has recently been recognised that the widespread use of benzodiazepines bears a considerable risk for patients to develop dependence on therapeutic dosage. One of the major reasons to use these substances on a long-term basis is chronic insomnia. Half of the patients reporting to the Medical Center Mariastein are dependent on benzodiazepines according to clinical criteria. They typically defend their persistent use of sleeping pills with the claim that they experience such poor sleep when stopping medication for only one or two nights and they therefore feel forced to continue drug intake despite fading hypnotic efficacy. In fact, insomnia has been reported to be among the most frequent withdrawal symptoms after somatic dependence has developed with the use of benzodiazepines in therapeutic dosage for months or years. "[p. 706]

Short TG, Maling T, Galletly DC.
Ventricular Arrhythmia Precipitated by Flumazenil.
BMJ 1988; 296: 1070-1071.
"The patient was extubated 20 hours after admission by which time her electrocardiogram was normal. Further questioning disclosed that she had a nine year history of physical dependency on benzodiazepines and had developed insomnia, anxiety, and phobias on attempted

withdrawal. "[p. 1071]

The Effect of Minimal Interventions by General Practitioners on Long-Term Benzodiazepine Use.
Journal of the Royal College of General Practitioners 1989; 39: 408-411.
"Given the evidence of cross-tolerance of some benzodiazepines with alcohol it might have been expected that subjects would have sought alcoholic alternatives when deprived of their usual drug. However, this was not the case according to the interview data and only one patient reported an increase in cigarette consumption. This parallels Ashton's finding that none of her subjects replaced benzodiazepines with other drugs or alcohol. "

"The evidence of the detrimental effects of benzodiazepines on cognitive and psychomotor performance following long-term use suggest that people may perform better in a number of ways without the drugs... Attempts to tackle the causes of the symptoms may not be initiated or may fail through decreased problem solving skills... Anecdotal evidence from patients seen by one of the authors... and other workers in the field supports the view that people feel that their capacities have been dulled by the drugs and that a new, or forgotten, self emerges when the drugs are discontinued. " [p. 410]

Schweizer E, Case WG, Rickels K.
Dr. Schweizer and Associates Reply.
American Journal of Psychiatry 1989; 146: 1242.
"It is our position that most of these patients did not require long-term benzodiazepine therapy - certainly not continuously for many years. In fact, we have unpublished data which demonstrate that many patients, once they have been withdrawn from their maintenance benzodiazepines, show more improvement on clinical measures of anxiety and depression than they did during their chronically medicated state. " [p. 1242]

Higgitt A, Fonagy P, Toone B, Shine P.
The Prolonged Benzodiazepine Withdrawal Syndrome: Anxiety or Hysteria ?
Acta Psychiatrica Scandinavica 1990; 82: 165-168.
“It is fortunate that patients who continue to manifest symptoms long-term following withdrawal are relatively small in number (although they may amount to 30% of a benzodiazepine dependent sample..." [p. 167]

Oster G, Huse DM, Adams SF, Imbimbo J, Russell MW.
Benzodiazepine Tranquilizers and the Risk of Accidental Injury.
American Journal of Public Health 1990; 80: 1467-1470.
"We found accident-related care was more likely among persons who had been prescribed benzodiazepines; among these persons, the probability of an accident-related medical encounter was higher during the months in which a prescription for a benzodiazepine had recently been filled compared to other months. " [p. 1467]

Ashton H.
Protracted Withdrawal Syndromes from Benzodiazepines.
Journal of Substance Abuse Treatment 1991; 8: 19-28.
"Even with long-acting benzodiazepines such as diazepam, there is usually a history in long-term users of steadily increasing anxiety, with the development over the years of new symptoms such as agoraphobia, often with perceptual distortions and depersonalisation, despite continued usage of these supposedly anxiolytic drugs. " [p. 22]

Tyrer P.
The Benzodiazepine Post-Withdrawal Syndrome.

Stress Medicine 1991; 7: 1-2.
"Much more needs to be done to establish the post-withdrawal syndrome as a clinical and pharmacological entity, but it is unlikely to be an artefact or entirely "mediogenic" (created by the media). The subject certainly deserves more attention from research workers in the stress disciplines. " [p. 2]

Blennow G, Romelsö A, Leifman H, Leifman A, Karlsson G.
Sedatives and Hypnotics in Stockholm: Social Factors and Kinds of Use.
American Journal of Public Health 1994; 84: 242-246.
"It is reasonable to believe that being unemployed or on a disability pension may be associated with number of psychological problems caused by, for instance, social isolation. However, drug use in itself may be the reason for unemployment or a disability pension. [p. 245]

Byrne A.
Benzodiazepines: The End of a Dream.
Australian Family Physician 1994; 23: 1584-1585.
"Benzodiazepine tranquillisers were introduced in 1960 after brief clinical tests at the University of Texas in 1959. Controlled trials were not required for evaluation and "efficacy" was demonstrated by anectdotes and testimonials. If introduced today they would probably only be approved for limited indications." [p. 1584]

"Some critical authors have suggested that the medical profession and drug companies have been guilty of knowingly ignoring the dangers of tranquillisers. " [p. 1584)

“Side-effects, including instability and falls in the elderly, memory disturbance, abnormal sleep patterns, sexual disturbance, depression, fatigue and habituation are all well documented. " [p. 1584]

"Some patients can withdraw from these drugs rapidly without great trouble. For others, it is a long, harrowing experience. " [p. 1585]

Tata PR, Rollings J, Collins M, Pickering A, Jacobson RR.
Lack of Cognitive Recovery Following Withdrawal from Long-Term Benzodiazepine Use.
Psychological Medicine 1994; 24: 203-213.
“Twenty-one patients with significant long-term therapeutic benzodiazepine (BZ) use, who remained abstinent at 6 months follow-up after successfully completing a standardized inpatient BZ withdrawal regime and 21 normal controls matched for age and IQ but not for anxiety, were repeatedly tested on a simple battery of routine psychometric tests of cognitive function, pre and post- withdrawal and at 6 months follow-up. The results demonstrated significant impairment in patients in verbal learning and memory, psychomotor, visuo-motor and visuoconceptual abilities,compared with controls, at all three time points. Despite practice effects, no evidence of immediate recovery of cognitive function following BZ withdrawal was found. Modest recovery of certain deficits emerged at 6 months follow-up in the BZ group, but this remained significantly below the equivalent control performance. The implications of persisting cognitive deficits after withdrawal from long-term BZ use are discussed.” [SUMMARY p. 203]

Cohen SI.
Alcohol and Benzodiazepines Generate Anxiety, Panic and Phobias.
Journal of the Royal Society of Medicine 1995; 88: 73-77.
“In almost half the patients seeking advice for anxiety, panic and phobias the cause was alcohol or benzodiazepines.” [SUMMARY p. 73]

Javed MA.
Misuse of Benzodiazepine.
Journal of Pakistan Medical Association 1995; 45: 289-290.
"The persistence of the withdrawal syndrome furthermore complicates the matter. Surveys have shown that about 15-30% of the patients continue to report significant symptoms from 10 months to 3.5 years following the withdrawal of these drugs. This certainly requires increasingly energetic attempts to help patients to give up benzodiazepines."

Fava GA.
Anxiety Sensitivity.
American Journal of Psychiatry 1996; 153: 1109.
"We should not be blind to the possibility that benzodiazepines may increase chronicity in panic disorder and that they simply should be avoided whenever possible. " [p. 1109]

Michelini S, Cassano GB, Frare F, Perugi G.
Long-Term Use of Benzodiazepines: Tolerance, Dependence and Clinical Problems in Anxiety and Mood Disorders.
Pharmacopsychiatry 1996; 29: 127-134.
"Long-term use of BZ seems to induce chronic dysphoric mood, with persistence of anxiety, irritability, difficulty in concentration and memory impairment." [p. 130]

O'Brian CP, McLellan AT.
Myths about the Treatment of Addiction.
Lancet 1996; 347: 237-240.
"... addictions are similar to other chronic disorders such as arthritis, hypertension, asthma and diabetes. Addicting drugs produce changes in brain pathways that endure long after the person stops taking them. Further, the associated medical, social, and occupational difficulties that usually develop during the course of addiction do not disappear when the patient is detoxified. These protracted brain changes and the associated personal and social difficulties put the former addict at great risk of relapse. Treatment for addiction, therefore, should be regarded as being long term... " [p. 237]

Biswarup Saha, Ananda Mukherjee, Chitta Ranjan Santra, Atiskumar Chattopadhyay, Amar Nath Ghosh,, Utpal Choudhuri, Parimal Karmakar
Alprazolam Intercalates into DNA
Journal of Biomolecular Structure & Dynamics, ISSN 0739-1102, Volume 26, Issue Number 4, (2009) July 30, 2008

'...Thus our observations suggest the strong interaction of Alp with DNA, which may raise serious questions about the random uses of Alprazolam.'

'...Consequently, after entering into cells BDZs can interact with different molecules and modulate their functions of which PBR mediated apoptosis and cell cycle arrest have been already reported (15,16).'

'...By measuring cytochrome c oxidase, it was shown that Alprazolam induces selective changes in brain oxidative metabolism (18).'

Dr Harris Stratyner vice chairman of the National Council on Alcoholism and Drug Dependence, August 2008
'Not only do benzos create a physical addiction, the drugs can alter how the brain processes neurotransmitters that calm a person down.'

Professor Carlton Erickson, University of Texas, September 17, 2008

Drug dependence must also be ‘handled’ differently from drug abuse in terms of responsibility and culpability in law enforcement.’

Professor C.H. Ashton June 2009
“It is possible that a deficiency in GABA/benzodiazepine receptors can result from long-term can result from long-term benzodiazepine use.”

The Washington Post
Tuesday, June 30, 2009
Medical guidebooks say the drugs bind to receptors in the brain and spinal cord, intensifying the effects of the neurotransmitter gamma-aminobutyric acid, or GABA. "So pretty much it kind of tells your brain to slow down," creating a calming effect, said Stephanie Licata, a Harvard Medical School behavioural pharmacologist who studies the medications. In some people, that can lead to memory loss and impaired motor skills.

The Washington Post
Tuesday, June 30, 2009
John Steinberg, a physician and former medical director of the chemical dependency program at the Greater Baltimore Medical Center, estimates that 10 to 20 percent of those taking the drugs for extended periods will have problems with dose escalation and physical dependence. "For a serious side effect, that's a fairly large, significant number," he said. "It is, after all, a devastating and debilitating adverse effect for those who experience it."

The Washington Post
Tuesday, June 30, 2009
Heather Ashton, a professor of clinical psychopharmacology at Newcastle University in England, who has studied the drugs since the early 1980s, said long-term use also affects one's mental state. "For one thing, which is what people regret most, there is a break-up of family life, because you're in a sort of daze; you don't realize that you're neglecting your children, or not listening to them or forget what they're saying," she said.