PE1651/SSSSSSS
Alyne Duthie submission of 11 February 2018

In the 1970s the benzodiazepines became one of the best selling drugs in the world. Hoffman La-Roche the makers of Librium (chlordiazepoxide) and Valium (diazepam) had estimated sales of $2 billion in 1971. The UK saw 300 million benzo prescriptions between 1960 and 1977 yet curiously the drug regulator in 1980 ventured only 28 people had been made dependent on the drugs, the reality being closer to the hundreds of thousands. Within a few years patients would be seeking redress in a large scale action lawsuit[1].

At the present time there is an estimated 1,092,000 long-term users of benzodiazepines in the UK and within that figure approximately 127,000 of Scots, out of a total of approximately 365,000 are prescribed benzos long-term. Anyone taking a benzo in these circumstances are going beyond the British National Formulary recommendation of 2-4 weeks and are at grave risk of dependence. The American Psychiatric Association's Benzodiazepine Task Force have reported that 40 to 80% of patients stopping benzos experience withdrawal. Esther Rantzen's That's Life programme was a shocking exposé of Britain's prescribed tranquilliser problem in 1985. Drug companies claimed benzos did not cause dependence when they were first launched but research in 1961[2] showed evidence of benzodiazepine withdrawal. As with the SSRIs, withdrawal symptoms were usually attributed to relapse. The iatrogenic victims of the benzodiazepine medical disaster are still waiting for a public inquiry as to why this was allowed to happen.

We have seen a phenomenal rise in prescriptions for antidepressants – in the UK they have more than doubled in the last decade – and the victims of this public health disaster are only starting to emerge from the shadows. Because of insufficient investigation the burden of proof has fallen to the patient and this is unacceptable, some have even been driven to write to the BMJ[3] to report their problems with withdrawal. To suggest that our experiences are neither the "normal or average" reveals the ignorance of many in the medical profession and devalues the testimonies of so many patients. I have already provided in a previous submission evidence for prolonged antidepressant withdrawal lasting several months[4], which underlines how "persistent postwithdrawal disorders may appear as new psychiatric disorders". Reports began to emerge in the 1990s of withdrawal problems from antidepressants whilst under pressure from the drug companies the terminology changed from withdrawal syndrome to discontinuation syndrome minimising for many patients the risks of these drugs. Charles Medawar, a specialist on medical policy and drug safety for the independent organisation Social Audit, wrote in 1997[5] of his concerns about SSRI dependence to the then president of the Royal College of Psychiatrists, Dr Robert Kendall. At the same time the social Audit confirmed that the numbers of reported Yellow Card withdrawal reactions to fluoxetine and sertraline were at least double those for diazepam. Consultant psychiatrist Dr Ben

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[1] http://w-bad.org/classactionlawsuit/
[2] https://www.benzo.org.uk/hollister.htm
[3] http://www.bmj.com/rapid-response/2011/10/30/venlafaxine-withdrawal-syndrome-personal-experience
[4] http://www.karger.com/Article/FullText/371865
[5] https://www.socialaudit.org.uk/4400rcp.htm

Green, was already documenting cases of "Persistent Adverse Neurological Effects"[6] following SSRI discontinuation in 2000. In 2002 WHO published a report that 3 SSRIs (fluoxetine, paroxetine, and sertraline) were among the 30 highest-ranking drugs for which dependence had ever been reported. The molecular biologist Professor Richard Lathe wrote in the same year[7] of his concern that the adverse effects of discontinuation of Venlafaxine exceeded the "maximum period of clinical trials" for a patient whose duration on the drug was 8 months. A 2012 study[8] found that discontinuation syndrome for benzodiazepines and SSRIs were "similar for 37 of 42" identified withdrawal symptoms belying the idea that SSRI withdrawal is either "mild" or "self limiting". Protracted benzodiazepine withdrawal[9] is a real syndrome and it is only a matter of time before there is due recognition for the SSRIs.

Sadly the limited life span of those diagnosed with mental health conditions will likely tally with the reduced longevity of those prescribed psychotropic drugs. Long-term use of benzodiazepines is associated with "excess hazard of death"[10] similar to smoking 1-2 packs of cigarettes a day and are linked with an increased risk of brain, colorectal, and lung cancers. For the elderly with a diagnosis of Alzheimer's who face a greater preponderance of benzo prescribing in care homes the chances of dying early are 41% greater than for those not taking the drug Antidepressants are associated with a higher risk of type 2 diabetes, abnormal bleeding, gastrointestinal problems including upper GI bleeding, weight gain, sexual dysfunction, bone fractures, stroke and death in older people. Both drugs are linked to cognitive impairment and both are linked with increased risk of suicide[11][12] especially in withdrawal. In addition, the clinical trials underreport the harms, Irving Kirsch discovered 40% of antidepressant clinical trial data had been supressed because of negative results and the favourability of antidepressants exaggerated. I point you to a review of 4 meta-analyses and of the largest trial ever conducted into antidepressant effectiveness[13] whereby it was noted that "successive pharmacological manipulations 'may propel depressive illness into a refractory phase'".

I think it isn't entirely unreasonable to believe that the negative aspects of antidepressants and all the subsequent drugs I was prescribed in withdrawal – and I'm thinking mostly of the disastrous effects of Diazepam and Pregabalin – will continue to dog me for the rest of my life. If there is one thing I would do differently I would follow the 10% taper reduction of every 4 weeks advised by Dr Peter Breggin which is seen as a harm reduction approach and avoids the overly fast advice given by the Royal College of Psychiatrists. As it is even with a slow taper my decades on antidepressants stood against my likelihood of getting of these medications successfully. The hardest, cruellest days of acute withdrawal are past for me but the trauma of akathisia, jerking limbs and hypersensitivity, of hot and cold sweats,

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[6] http://www.priory.com/psych/panes.htm

[7] http://www.priory.com/psych/venlafax.htm
[8] http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03686.x/full
[9] https://www.benzo.org.uk/ecpn.htm
[10] http://www.smrv-journal.com/article/S1087-0792(99)90076-X/pdf
[11] https://databankws.lareb.nl/Downloads/KWB_2014_2_benzo.pdf
[12] http://journals.sagepub.com/doi/full/10.1177/0141076816666805
[13] https://content.karger.com/Article/FullText/318293

insomnia, unbearable terror and an ultimate brush with suicide will haunt me and my family for a long time to come. I plead we do not leave others to a similar fate of unwitting prescribed drug dependence and withdrawal.