August '95 Discovery Issue 1

VOT Newsletter

Victims of Tranquillizers

SECTION 1

Editor's Letter

At last VOT has managed to produce its first and long awaited newsletter. As you can see, it is a bumper edition.

The main objectives of our newsletter are to establish contact between members and to keep members informed. We shall also submit issues to certain doctors, lawyers, politicians, the press and other interested parties to keep them up to date as to VOT intentions and activities.

Whilst constructing this newsletter, I thoroughly enjoyed receiving articles, letters and poems from VOT members and friends. I think a variety of ideas will make the newsletter more interesting and a constant turnover of information from all sources will keep IVOT alive and more importantly kicking. So send in your articles and information to any of the VOT co-ordinators listed at the back of this issue. I will not alter any contributions to the newsletter and therefore the opinions of one article may not necessarily be the opinions of VOT as a whole.

I would like to take the opportunity to invite the professionals and the pharmaceutical companies to comment on certain issues of interest to them in order to keep the debate lively and well balanced.

I hope you find this newsletter informative and you feel you can participate in some area of VOT activities.

Remember that in order to keep VOT afloat we require financial assistance. So if you can stretch yourself to a contribution to the VOT Appeal fund, however small the amount, we would be most grateful.

Regards

Liz Wood

Editor 26/7/95

SECTION 2

Aims of VOT

MISSION STATEMENT

I. To PROMOTE the awareness of side effects and adverse reactions caused by tranquillizers and other psychoactive drugs

II. To PROVIDE help, support and information to those who have suffered medical and legal problems resulting from these drugs

VOT was founded in the spring of 1993. The primary aim of VOT was to act as a lobby pressure group to fight the injustice surrounding withdrawal of funding of the benzodiazepine litigation and subsequent dismissal of Legal Aid Certificates by the Legal Aid Board. However, VOT now sees itself as a medico-legal support group as well as a pressure lobby group due to the demands of claimants who were originally suing the benzodiazepine manufacturers with the support of legal aid and who are now continuing claims as Litigants In Person.

VOT also acts in a secondary role as a support group for people struggling with withdrawal as a result of reduction of drug dosage and those suffering protracted withdrawal after successful discontinuation of drugs.

VOT aims are:-

1) To educate about addiction
2) To lobby parliament for recognition of the potential of medically prescribed drugs to cause irreparable harm to the mental, physical and social well beings of the individual
3) To seek justice for those individuals whose lives have been ruined by benzodiazepines
4) To support individuals trying to reduce dosage or to take legal action
5) To contact groups overseas
6) To keep abreast of research
7) To up-date and inform an already over-worked medical profession of potential and actual drug problems
8) To provide contacts for isolated members
9) To contact other action groups for prescribed drugs and other medical problem e.g. Thalidomide, Septrin and ECT

Section	Contents	Page

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SECTION 3

Diary of Events, Bristol and Redditch Conference Overview

Date	Brief Overview
June/July 1992	Battle Against Tranquillizers Meeting about the litigation: Case Experts reports were not up to standard.
Jan 1993	Beginning of the discharge of Legal Aid Certificates
Spring 1993	Formation of Victims of Tranquillizers
Jan 1994	BBC North programme Close Up 'The Bitter Pill' about the litigation. VOT members contribute
Feb 1994	VOT Bristol Conference
March 1994	Summons to Litigants-In-Person (Valium)
April 1994	26th April Hearing
June 1994	Deadline for Litigants-In-Person. Notice of Intention to Proceed
July 1994	Two day meeting in Manchester. VOT and Graham Ross Solicitor
Oct-Sept 1994	Radio Programmes: Radio 4 Radio Oxford Radio Cleveland Radio West Midlands
Oct 1994	Summons to December Hearing received by Litigant-In-Person (Valium)
Oct 17th 1994	World In Action Programme. Dr Peart appears together with other VOT members concerning tranquillizers and road traffic accidents
Nov 1994	Deadline for affidavits for Dec 14th Hearing
Dec 1994	14th Dec Hearing case adjourned
Feb 20th 1995	20th Feb Hearing: Valium writs are struck out by Master Prebble on financial viability. VOT win on two thirds of the hearing but fail on a third.
Feb 27th 1995	Application for an appeal of the decision of the 20th Feb Hearing. VOT representatives meet with Master Prebble
March 1995	GMTV - Four morning slots on prescription drugs. Dr Peart talks about tranquillizer addiction.
March 1995	Hearing with Master Prebble
April 6th	Ativan Hearing Liverpool
April 17th	Meridian TV programme on tranquillizer addiction
April 25th 1995	Hearing before Justice Kennedy. Dr Peart successfully achieves an adjournment of the 12th-14th June Hearings until October 17th (Valium and Ativan)
8th-9th July 1995	Co-ordinators meeting in Redditch

Bristol Conference

In February 1994 VOT held its first conference in Bristol. It was a successful meeting of VOT co-ordinators and others involved with the benzodiazepine problem. The items on the agenda were as follows:

First Session

Legal

Denial - Keith Pirelli

The Wider Issue - Graham Ross

Litigation In Person Society - A. Kirby

Medical

Addiction / Case Experts ? - Reg Peart

Australian Experience - William Day

Underlying Illness or Benzodiazepine Dependence? - Dr. Cosmo Hallstrom

Second Session

Support/Action Groups

Health Authority Support Groups/The Sharp End - Joyce Simnett/Una Corbett

Back to Life - Pam Armstrong

Activities in the Manchester Area - Phil McDougall

Activities in South Devon - Lynn Piper

Alternative Therapies in Benzodiazepine Withdrawal - Chi Maher

Political/Sociological

Northern Activities / MP's lobby meeting

Political Issues - Paul Cummings

Perspectives from MIND - Yvonne Richards

Redditch Conference

The most recent meeting of co-ordinators was held on the 8th and 9th July at the Southcrest Hotel in Redditch. Unfortunately, Graham Ross VOT's lead solicitor, was unable attend as there was a huge fire at Birmingham New Street Station.

In the absence of Graham, VOT concentrated on purely VOT matters and it was felt that many interesting and important points were raised and decisions finalised.

Conclusions and Recommendations

Item	Description	Action
1	Revision of Master Statement of Claim	
2	Clarification of Contingency Fee System	GR
3	Enquiry to the Law Society	JR
4	Overview of cost benefit situation	GR
5	Further info on addiction and patients prescribed for physical problems	BM
6	Overview of statute of limitations	GR
7	Advice on claimants who have not contributed financially	GR
8	Strategy re outstanding Valium and Ativan appeals to Legal Aid Board	
9	Document Ross/CITA/VOT funding	
10	Overseas/Euro MEP/European Court info	JH
11	Representation to Lord Chief Justice Taylor re Judge	
12	VOT Mission Statement & approved constitution	
13	John Atkins and Sue Bibby withdrawal from VOT, letter to claimants	
14	J Atkins and S Bibby to pass claimants files to J Rudge	
15	Three tier system of assessment of records to be implemented	
16	Treasurer must receive receipts for all expenditure	
17	Liz Wood to produce newsletter draft for end July, Mark Peart to print by August	
18	Ativan claimants advised that McKenna's will pass on their records upon request	
19	Communication with other prescribed drug victims for formation of national association	
20	Request copies of generic research reports from Graham Ross	
21	Efforts to get members to participate in areas of interest e.g. funding, overseas, links with other organisations	
22	Further meeting to be arranges with Graham Ross	

Participants:

Reg Peart	VOT
Una Corbett	BAT
Liz Wood	VOT
Barry Merchant	VOT
Jessica Hart	VOT
Jean Rudge	VOT
Frank Carey	VOT
Dorothy Carey	VOT
Mike Edge	VOT

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SECTION 4 - MEDICAL

Benzodiazepine Addiction - An Introduction

By Dr Reg Peart

Although the word dependence is more generally accepted scientifically, I, like some medical institutions and journals, prefer the word addiction because it more accurately reflects the nature of benzodiazepine problems, and because the word dependence (neutral or nebulous) can and is used to minimise the problems and sweep them under the carpet. In essence I use both words in a synonymous sense.

There are four overwhelming facts to bear in mind when discussing addiction:

1) That ALL mind altering drugs, prescribed or otherwise, have the potential for addiction: it is only a question of degree

2) That the individual sensitivity to these drugs is extremely wide. This is not stressed enough or insufficient account is taken of this by the medical profession or the drug companies. This aspect has been known and accepted by support groups for over 50 years, i.e. the primary consideration is the effect of the drug on the individual. Other aspects like how much, how often, where, why and when are secondary.

3) That the cause of drug addiction is the interaction between the body and a drug is obvious, but needs stating. Hence the probability of becoming addicted is largely independent of such factors as race, colour, creed, intelligence, physical stature, social stature, profession, gender or sexual orientation etc. Hence factors relating to pre-morbidity, underlying illness etc., personality defects or disorders are largely irrelevant. I'll come back to the latter point.

4) Conversely, the pattern in the decline of the addict in physical, mental, emotional, sociological and spiritual terms is overwhelmingly similar in a general sense. Of course there are specific differences due to different drugs and especially their accessibility or availability.

Professor Krivanek, the Director of the Clinical Drug Dept at Macquarie University, Sydney, Australia, put things in perspective: the only difference between a drug addict and the rest of society is the drug.

There are many myths about addiction and I would like to quote Dr. Phelps, who is the Clinical Professor at the Medical School of the University of Washington and is a self declared recovering addict. These myths are:

1) Addicts are criminals.
2) Only illegal drugs are addictive.
3) Problems, pressure or stress can turn somebody into an addict.
4) Addiction is immoral and addicts have weak characters.
5) Addiction is a psychological problem - belief in this leads to treatment of peripheral symptoms which doesn't work and both patients and doctors come to believe the trouble must be in the patients mind.
6) There are different kinds of addiction - this leads to doctors differentiating between physical and psychological addiction and insisting that there are addictive personalities which lead to addiction. In fact, addiction causes an addictive personality (if there is such a thing). As is frequently the case for benzo problems the medical profession puts the cart before the horse. I wonder why they do not suggest that the diabetic personality causes diabetes, or the hypoglycaemic personality causes low blood sugar problems.

I do not believe the medical profession has more than its fair share of members with personality disorders, defects or problems. There are other reasons why it is high in the league of addiction with 5%-6% of its members addicted to either prescribed drugs, alcohol or hard drugs. Indeed some sections of the medical profession have higher rates e.g. 10% - 12% for anaesthetists in the USA (Aust. Journal of Addiction).

In recent years the World Health Organisation (WHO) have declared:

1) 33 benzodiazepines as drugs of addiction
2) That benzo addiction is the second largest addiction after alcohol in the western world
3) That the definition of addiction is independent of the drug used
4) That this addiction (or dependence) syndrome includes seven key elements:

a) A subjective awareness of compulsion to use a drug(s) usually during attempts to stop or moderate drug use
b) A desire to stop use in the face of continued use
c) A relatively stereotype drug taking habit i.e. a narrowing in the repertoire of drug taking behaviour
d) Evidence of neuroadaption (tolerance and withdrawals)
e) Use of the drug to relieve or avoid withdrawal symptoms
f) The reliance of drug-seeking behaviour relative to other important priorities
g) Rapid reinstatement of the symptoms after a period of abstinence

5) It is not tenable to consider physical and psychological dependence as independent aspects (dualism of the brain and mind is an out dated 19th century concept). Psychological addiction must be considered in the context of the psychological changes produced by the drug.
6) That the result of addiction is a complex web of physical, mental and social problems: all must be considered in any assessment or diagnosis of addiction and that in general there is a chain of causation (from the physical to the mental to the sociological).

This article is an extract from the talk given by Dr. Peart at the Bristol Conference.

Psychology versus Physiology

By Liz Wood

It is often very difficult to tell how much of addiction is psychological and how much is physiological primarily because these drugs act on the brain and therefore affect the mind. The rule to follow, however, is that the psychological and physiological are interactive processes; they are interconnected.

Many GPs and psychiatrists unconsciously revert to the hypothesis that the mind affects the brain but not vice versa and that these two areas are in some way separate (therefore addiction is all in the mind). It is a school of thought called Cartesian Dualism by the philosopher Rene Descartes.

Of course, the mind, the way you think, affects the brain and affects your physiological activities. If it did not we wouldn't have freedom of choice and the ability to move about in our own environments successfully. However,

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there are constraints, physiological constraints. We can all daydream about stepping off the doorstop onto a tropical beach even when we are living in a big city but we know that our mind will not physically transport us there.

The same is true in addiction, no doubt the way that we think and what we are thinking has an effect upon our withdrawal experience positively or negatively to some extent, but it is a nonsense to suggest that some so-called neurotic individual is creating a whole range of physiological withdrawal affects simply by imagining that they are happening. One only has to look at the withdrawal in new born babies to see that this is a nonsense. A new-born baby has a very limited ability to affect itself psychologically but once it is separated from the placenta, the source of the drug, after the birth, it will suffer withdrawal symptoms. Some people will try to argue that it is picking up its mother's experience in the womb, but the fact of the matter is the baby will withdraw once it is separated from the source of the drug regardless of whether the mother was comfortable on a steady dosage and not experiencing withdrawal symptoms or was experiencing withdrawal symptoms during pregnancy and birth.

In the physiological section below I shall explain how benzodiazepines works biologically and why tapering the dosage is a logical method to use. In the psychological section I shall explain the effects of classical conditioning on addiction and withdrawal and its possible limitations

Physiological

By Liz Wood

Biological mechanisms of action of benzodiazepines and withdrawal.

A receptor is a sensory nerve ending that changes specific stimuli into nerve impulses. It is an excitable cell that receives information.

All benzodiazepines bind to specific receptors and these receptors mediate an anti-anxiety effect. These receptors are found in the body and the brain with the highest concentration existing in the cerebral cortex.

Benzodiazepines have no direct effects after binding to their receptor sites, but they seem to increase the effect of the neurotransmitter GABA (a chemical by which a nerve cell communicates with another nerve cell) which diminishes the excitability of the cells reducing the excitability of the central nervous system. It is this inhibiting effect of benzodiazepines which is responsible for the reduction of anxiety, sedation and anti-convulsant actions.

Benzodiazepines exhibit the phenomenon of tolerance which depends upon adaptive changes in the receptor complex. The therapeutic effect of the drug or its biological action will decrease with time when the drug is taken on a regular basis and that is why patients will feel the need to either increase the dosage or put up with feeling unwell. These adaptive changes may also explain why in order to achieve a desired therapeutic effect dosage may vary from person to person.

As well as binding to receptors, benzodiazepines also bind to plasma proteins (plasma is a fluid portion of the blood or lymph in which the corpuscles and cells are suspended) and possibly of tissue proteins as well. For a given dose of benzodiazepines the blood plasma levels for different individuals can vary enormously.

The duration of action of benzodiazepines will be determined by its rate of elimination from the body. The rate tends to determine both the rapidity of onset of action and the duration of action. However when certain benzodiazepines are metabolised (broken down) within the system they are broken down into active metabolites like oxazepam or temazepam which are also available as prescription drugs. (A doctor prescribing diazepam is in effect prescribing a cocktail of drugs and this underlines how unscientific it is for some doctors to prescribe both oxazepam and temazepam together or certain other combinations simultaneously.) As far as the elimination rate is concerned, it is the most slowly cleared active metabolite that determines the rate and not the drug itself.

Some researchers claim that there is a significant inverse relationship between plasma benzodiazepine levels and severity of withdrawal symptoms. There are two reasons for this decrease: the amount that you cut down and the elimination half life. If the half life is long as it is in diazepam then the drug will remain within the system longer and withdrawal symptoms will be spread over a longer period of time easing the severity. If the drug is also cut down slowly the withdrawal symptoms may be less painful. However, a clear inverse relationship is not always seen in patients because neuroadaption (where changes occur at the benzodiazepine receptor) seem to play a very significant role. In this case the receptor and neurotransmitters etcetera, do not recover at the rate that the drug is eliminated from the system and withdrawal may go on for much longer than would be otherwise expected. This would explain why someone who has been withdrawing continually over a long period of time has symptoms that become more and more severe as time progresses and may have to pause for a rest period before cutting down any further amounts of the drug. After a period of rest from reduction and on restarting reducing again it may be possible to see a clear pattern of withdrawal emerge for a while. I found when reducing lorazepam an increase of symptoms would occur on the third day and taper away to nothing on the tenth day. However, if I continued to try to reduce a small amount every ten days after a period of time the withdrawals would become more and more prolonged until they were continual and severe and I would have to take a rest from reduction for a while.

Neuroadaption in tranquillizer addiction is primarily a physical occurrence with a physiological input - the tranquilliser in question. However there is also a psychological component in recovery and neuroadaption must be considered within both contexts psychological and physiological.

It will take the body time to recover from a continual input of a particular chemical as it will need to start producing its own natural tranquillizers once again amongst other things. However, regardless of the reasons why a person is given a tranquilliser either for psychological or physiological reasons, the psychological impact of addiction due to physical changes in the brain is enormous. As the physiological changes and symptoms of withdrawal occur, the addictive brain will colour the perception of that person's environment and his everyday experiences producing habits or behaviour patterns that may be difficult to change even once this person is drug free. It is also possible that these experiences cause neuronal changes which are physical as will be dealt with in biological mechanisms of memory. This is why recovery from addiction should be viewed as a five-fold one: physical, mental (intellectual), sociological, emotional and spiritual.

There are four phases of addiction and withdrawal:-

1) Tolerance withdrawals

   As neuroadaption increases and the drug loses its therapeutic effect those withdrawals begin to occur. This can happen within one week of a normal dosage depending on the individual.

2) Detoxification

   Withdrawal occurs as the drug is eliminated from the system until body levels reach a minimum of a few per cent.

3) Full blown withdrawals

   These occur once the drug is at a minimum and the length of withdrawal varies widely from drug to drug and from person to person.

4) Recovery

   No hard and fast rules to the length of withdrawal as neuroadaption has a psychological and physiological component. Again the emphasis is on

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the interactive process. The reason for prescribing may be physical or psychological. Once the drug is taken physical changes occur in the brain which affects the mind and therefore the psychology of the patient.

The World Health Organisation states that psychological craving must not be considered in isolation and only in the context of physiological changes caused by the drug.

Sometimes when people have withdrawn from benzodiazepines they find that the original problem re-emerges. This is not always the case, however. Often after many years of addiction the original problem for prescribing the drug in the first place has been resolved years before and is no longer of any relevance. This does not mean however that a person will not suffer long term physical and psychological withdrawal after stopping the tablets. These may occur because:

i) It takes the benzodiazepines receptor complex a long time to recover.

ii) The psychological trauma of addiction has created learned behavioural responses that need to be changed.

Psychological

By Liz Wood

An important psychological area that affects addicts in withdrawal is called classical conditioning or associative learning. A Russian scientist [PAVLOV] was the first to document this phenomenon. He studied salivation which is a reflex response given in the mouth to the presence of food and he decided to see if a dog could make an association between the ringing of a bell and the possibility of food. In order to do this he paired the sound of a bell with receiving food. Eventually the dog associated the sound of the bell with food to such an extent that it would salivate at the sound of a bell alone.

The implication of classical conditioning in addiction is straightforward: once you have associated the little blue or yellow tablet with a bad physical experience due to its chemically addictive properties you will set up an expectation of withdrawal anxiety every time you try to reduce, adding to the misery of the physiological withdrawals. Also, there will have been, initially, an association with the drugs therapeutic effects, regardless of the reasons why you were prescribed them, so that you may begin to associate taking the drug with being able to relax rather than using your own innate ability to relax.

A possible biological mechanism for this could be due to a form of neuroadaption or biological mechanism of memory.

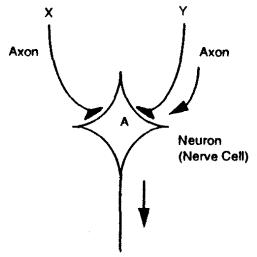
A synapse is the point at which a nerve impulse is relayed from the terminal portion of an axon (a long extension of a nerve cell that conducts impulses from the cell body) to the dendrites (short extensions of a nerve cell which conducts nerve impulses towards the cell body) of an adjacent neuron (nerve cell).

It may be that the formation of new synaptic connections or improved connections of existing synapses between neurons may be involved in the process of learning and memory.

A psychologist Donald Hebb proposed that existing synapses within a neural circuit will change the efficiency of the activated synapses in the circuit so forming a 'memory trace' of information.

This point could be illustrated through classical conditioning:

Neuron A is involved in salivation. There are two neural pathways (axons) X and Y converging on the neuron A. X is a strong pathway from the olfactory system that responds to the smell of food and always activates the neuron A. Y is a weaker pathway from the auditory system that responds to the sound of a bell but rarely activates neuron A. If X and Y are activated together the activation of A by X sends a retrograde signal to Y which strengthens the synaptic connection between A and Y. The neuron A will have learned to become responsive to Y as well as X and Y will have learned how to activate A more efficiently. So that an association between X and Y and been 'learned' by neuron A and the sound of a bell would produce salivation.



X is the strong pathway that responds to the olfactory system. Y is a weak pathway from the auditory system. A is a neuron involved in salivation.

This is a very simplified model of learning. However, there is some evidence that learning creates structural changes in the nervous system: the synapse contains little vesicles that contain neurotransmitters and massive changes in the number of synaptic vesicles in synapses have been recorded in animal learning experiments.

This may all seem very complicated and involved but the point of it is to give some idea of how experience can affect a person physically and how habits can be formed by neural pathways in the brain. We do have some conscious control over these pathways. It may not always seem easy but habits can be broken by using our minds to consciously control the habit and that by doing this we are no longer activating that particular neural pathway or pathways and therefore no longer activating these synapses. We may not be able to erase these pathways completely once they are formed, we may be merely 'holding down' the old pathways with new ones which would explain why old habits can be easily reformed again if we are not vigilant. However by consciously controlling our actions we are able to change our ways to some extent.

Stopping benzodiazepines effectively relieves the physical withdrawals and the conditioning associated with taking the tablets. However, memory often plays an irritating role in reminding us that benzodiazepines once tranquillized us and stopped horrible withdrawal symptoms. Sometimes when we are off tablets memory can trigger off certain problems as we are reminded of what it used to be like when we were on the drugs and we need to have a tremendous amount of conscious control over our feelings. Sometimes recovery from benzodiazepine addiction can take a long time because of learned behavioural responses during physical withdrawals. There are a number of people who develop agoraphobia whilst they are on benzodiazepines and continue to have this very disabling problem for years after coming off them. This may be because of neural damage. On the other hand, it may be that the original phobia that was triggered by withdrawals has become a learned response and a frustrating habit that needs to be broken and would respond to behaviour therapy.

The psychological fear associated with drug withdrawal can be helped by the placebo method. In order to overcome this, the doctor withdraws the patient in hospital from the real drug over a period of a few weeks and then substitutes it for a substance that looks like the real drug but has no pharmacological effect as it does not contain any molecules of the original substance. If this method is used correctly with a sensible reduction of the real drug initially and then a substitution of the real drug with placebo without the patients knowledge it can help with the psychological strain of a physical withdrawal.

However there are limitations to all of this and doctors should not believe that the placebo effect is all that occurs in benzodiazepine withdrawal and that withdrawal is all in the mind and therefore that the placebo method is all that is required.

To illustrate this point I shall take the results of a placebo-controlled withdrawal

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study (Pecknold et al) (1991). There were three groups of people involved in this trial. The first group A were given short term treatment with diazepam. The second group B were given a short term treatment with a non-addictive tranquilliser Buspirone and the third group C were given placebo. The results of this trial showed that after group A discontinued diazepam their symptoms increased whereas both groups B and C had no increase of symptoms.

The moral of the tale is that benzodiazepine withdrawal symptoms are not all in the mind.

My own experience in hospital also illustrates that associative learning can have a limited effect in drug withdrawal. When I was taking lorazepam on a daily basis I was in a strict regime of taking it by the clock as I believe it gave me control of my reduction programme. If I took the tablet about 20 minutes out of the appointed time I would suffer from withdrawals unless I cleverly adjusted the time to compensate. When I went into hospital I was told that this clock watching was purely a conditioned response: a learned habit of associating the time with the need for a tablet. I was told that if I could break these habits by substituting lorazepam with diazepam by taking the diazepam at differing times to which I was taking lorazepam I would be over the worst part of the withdrawal. As it happened this substitution and so-called breaking of clock watching was by far the easiest part of the withdrawal. In fact I quite enjoyed disappearing into a nebulous cloud of long-acting drug induced relaxation after years of struggling with the short-acting lorazepam. This experience would suggest that the effects of the metabolic half life of the tablets is over and above the possible conditioning effects of clock watching to take tablets. Almost from day one of the withdrawal programme the irritating habit of taking the tablet by an alarm became like a long forgotten dream.

In conclusion, Doctors like all of us to tend to compartmentalise, as it is very difficult to work within a framework of many possible variables rather than just one. When a withdrawal programme is introduced it is best to take an interactive approach rather than trying to quantify which bits of withdrawal are psychological and which bits are physiological.

The possibility of withdrawal falling into the expected pharmacokinetic patterns is small if a short acting drug is substituted with a long acting one, or the withdrawal programme is started when the patient hasn't cut down tablets for many months and whose tolerance is high, or a further therapy like five point ear acupuncture is introduced. If all these variables occur together the possibility of a clear pattern emerging is even smaller.

Therefore, if the pattern does not emerge as expected, it does not mean that the patient is not experiencing physical or pharmacological withdrawals. It does not mean that the anxiety or the original problem is returning.

If you are a researcher, of course, you are aware of these variables and ensure that the trials are properly controlled. If you are a doctor, merely treating a patient, it is best not to jump to conclusions unless you are involved in a proper double blind placebo-controlled trial situation.

Benzodiazepine Withdrawal Symptoms

By Liz Wood

As time has gone by, it has become more and more obvious that the benzodiazepines have intrinsic addictive properties; they would not be exchanging hands on the black market if they did not.

Over the years, however, doctors and patients have had tremendous problems separating the withdrawal syndrome from an anxiety syndrome, because the benzodiazepine withdrawal syndrome does mimic an anxiety syndrome to a large extent. This is only to be expected due to tolerance of the drug at the benzodiazepine receptor complex: a decrease in receptor sites results in the inhibitory effects of the neurotransmitter GABA becoming less and less effective and excess excitatory effects result in anxiety symptoms.

There are some symptoms that some researchers believe are seen mainly in benzodiazepine withdrawal and rarely seen in anxiety. Examples are perceptual symptoms like undulating floors. As a general rule however, these symptoms that develop during benzodiazepine ingestion and withdrawal that are different from the original problem are symptoms of a withdrawal syndrome. Usually there are a cluster of symptoms that appear together.

Some of the symptoms that occur can be attributed directly to benzodiazepines whilst others like weight gain are secondary symptoms related to the overall withdrawal; effect i.e. inability to exercise due to muscular rigidity could result in weight gain. Also the symptoms that may have occurred due to an original anxiety problem may well be enhanced by the addiction. The very people the drug is supposed to help the most are those that it helps the least.

It is also worth mentioning that regardless of whether the drug is addictive or not, the therapeutic effects are not conducive to solving the original problems. In the very short term the sedative effects may be beneficial in situations of shock due to accident or death for example. However counselling, behaviour therapy and psychotherapy are less effective whilst the drug is being ingested.

List of Symptoms

This list was compiled by Stanley Coombes. It is interesting to note that during ingestion and withdrawal he experienced all of these symptoms. In the next issue of this newsletter a list of side effects and withdrawal symptoms listed in the medical literature will be given.

Double vision
Sore and tired eyes
Blurred vision
Screwing up of the eyes
Panic attacks
Fear of being alone
Tiredness
Tension between the eyes
Dizziness
Agitated sight - loss of control of the movement of the eyes
Brain moving within the skull
Buildings appear to be leaning
Speech appears to be two feet in front of you when speaking
Thoughts and feeling that you are dying
Legs arms and head very heavy
Difficulty in writing slowly
Rapid blinking of the eyes
Tight band around the head
Sharp throbbing pain in the wrists
Fear of water
Loss of concentration
Hair loss
Tinnitus
Speech difficulties
Inability to write
Inability to read
Seizures
Loss of interest in people and things
Pupils of eyes become minute
Iris in eyes change colour
Feeling of vulnerability
Feeling of extreme cold
Extremely nervous and jumpy
Muscle wastage
Impotency
Unable to walk
Nightmares
A fear of insanity
Loss of memory
Pains in the temple
Depersonalisation
Repetitive thoughts
Heartburn
A feeling of impending doom
Loss of self respect
Earache
Sinus problems
Agrophobia
Feelings of worms under the scalp
Feelings of the spirit being out of synchronisation with the body

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Depression
Problems of decaying teeth and gums
Insomnia
Vertigo
Anxiety
Allergies to food
Extremely disturbed
Twitching of the head
Numbness, pain, pins and needles
Saliva running from the mouth while sleeping
Neuralgia
Cracked and sore lips
Pains in the neck to the shoulder blades
Tickling and itching feeling over the whole body
Heavy pounding heart when climbing stairs
Breathlessness
Intense fuzzy feeling in the head
Cuts and abrasions take weeks to heal
Severe muscular rigidity all over
Demented and murderous thoughts
Irrational rage
Extreme thirst
Toe and finger nails change colour from pink to grey
Feeling bloated
Diahorrea
Constipation
Rashes and blotches on the skin
Pains in the lungs
Pains in the chest
Severe cramping in the stomach
Electric shock and muscular spasms
Swallowing difficulties
Dry mouth
Hallucinations
Hypersensitivity to light and sound
Inability to cope with a lot of information
Feelings of shaking inside and out
Hyperactivity
Aching joints and muscles
Restlessness
Restless legs in bed at night
Paranoia
Over breathing
Arms and legs feel detached from the body
Grinding teeth
Intense jaw pain
Jaws clamped together
Total loss of confidence
Hysterical and inappropriate laughter
Waves, sparks and flashes of light
Body feels like jelly
Sweating
Inability to comprehend the simplest of things
Obsessive behaviour
Suicidal feelings
Nausea
Flu like symptoms
Disorientation
Feelings of unreality
Lack of co-ordination
Metallic taste in mouth
Phobias
Fear of losing control
Clumsiness
Flashbacks

Polypharmacy, Alcohol and Other Drugs

Many people who have recovered from benzodiazepine withdrawal symptoms find that they suffer withdrawals when trying to discontinue a further drug; often an anti-depressant. This does not mean that anti-depressants and other drugs are necessarily addictive, but they can slow down the recovery process.

Benzodiazepines and alcohol must not be mixed as one increases the potency of the other. After stopping benzodiazepines alcohol must not be used to aid recovery as both substances use the same receptor sites. The three articles below discuss problems associated with other prescription drugs.

THE USE OF ANTIPSYCHOTIC DRUGS IN ATTEMPTING TO RELIEVE SYMTOMS OF BENZODIAZEPINE WITHDRAWAL

By Colin Hope

HEALTH WARNING! This note is intended as a warning about the dangers involved in taking antipsychotic drugs. These drugs used to be called 'major tranquillisers'; they are also sometimes referred to as 'neuroleptics'. They have been used by psychiatrists since the 1950's to control the symptoms of serious mental disturbance, amounting to insanity. This is termed 'psychosis', the most common manifestation of which is called 'schizophrenia'.

There are a number of antipsychotic drugs; they are very similar in their actions and their effects. The oldest and most common is called 'chlorpromazine'; its trade name in this country is 'Largactyl' and in America it is called 'Thorazine'. These are the drugs that were given to Jack Nicholson's character in the film 'One Flew over the Cuckoo's Nest'; they are the drugs that were used in Russia to 're-educate' soviet dissidents; this is the 'medication' that a large number of psychiatric patients seem so unwilling to take. The terms 'chemical cosh' and 'chemical straight jacket' refer specifically to these drugs.

People who are dependent upon a benzodiazepine drug (diazepam, lorazepam, temazepam etc.), and who are attempting to withdraw, and who are experiencing difficulties in so doing, are sometimes persuaded to take an antipsychotic drug by a well intentioned member of the medical profession in order to ease the pain of withdrawal. This is a very bad plan.

The idea is that these are old drugs - tried and tested; that they have anxiolytic properties; are 'non addictive', with few problems on withdrawal, and are safe - with few side effects and no serious ones. The only truth in this is that they are old drugs. Many people regard their use over the last 40 years as scandalous and indicative of the low esteem in which psychiatric patients are held. They are not 'addictive' in the sense that people do not exhibit appetetive behaviour towards them: unlike diazepam and temazepam they are not sold illicitly on the streets; street drug users don't want them because they make them feel bad rather than good. There is, however, a significant withdrawal syndrome associated with these drugs.

They have multitudinous side effects, many of them serious and some of which can be fatal. This is not contentious: the pharmaceutical companies themselves admit this. In the short term they commonly cause a movement disorder closely resembling Parkinson's disease (this is usually regarded as reversible). In the medium to long-term they commonly cause tardive dyskinesia ('T.D.'). This is a profoundly disfiguring and disabling condition which is regarded as permanent. The British National Formulary suggests that this occurs 'rarely'; my reading of independent research (that not sponsored by the pharmaceutical companies) suggests that more than minimal T.D. occurs in between 20% to 60% of long-term users of this drug. The definition of 'short term' varies between 2 weeks and 6 months depending on whom you read.

These drugs do not induce tranquillity, except possibly in the nursing staff. They often have quite the opposite effect - sometimes inducing profound agitation; once again this is not contentious: the manufacturers admit this. They are very effective in controlling disturbed, violent or 'odd' behaviour. They do this by attacking vitality and, effectively crippling a person. They are very very unpleasant drugs.

The idea that they can help ease the pain in withdrawing from a benzodiazepine drug is very misguided. They are a completely different class of drug; in principle they cannot do this. The notion of introducing such a toxic chemical into a nervous system already compromised by a benzodiazepine is very strange. A very simple contra-indication in this context is that they lower the convulsive threshold - sometimes actually causing fits. Once again this is not contentious. It is well known that there is a possibility of epileptic seizures when withdrawing from benzodiazepines, especially if the withdrawal is rapid. For this reason alone the prescription of an antipsychotic drug to someone withdrawing from a benzodiazepine drug is a dangerous practice. I believe that the only defence for this very dubious practice is one of ignorance. Some doctors appear not to understand even the basic facts concerning the drugs they are licensed to prescribe.

There seems to be a broad consensus now amongst people who have been addicted to benzodiazepines and recovered. Also amongst many professionals who are specialists in the field of drug addiction and recovery. Firstly

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it is that the withdrawal syndrome associated with benzodiazepines is arguably the worst of any mood altering drug - including the so called 'hard drugs' such as heroin. This is largely because of its duration. Secondly that withdrawal must be gradual. Unlike withdrawal from opiates or alcohol benzodiazepines should not be discontinued abruptly. They should be tapered off slowly at a pace that is comfortable for the person concerned; this may take months. Thirdly that there are measures that can be taken to help ease the pain: in the overwhelming majority of cases these measures do not involve using other drugs. Antipsychotic drugs are particularly unhelpful.

Heminevrin Clomipramine manufactured by Astra Pharmaceuticals

By an anonymous contributor

I must firstly, gratefully state, that on the evidence that I have seen, the Manufacturer Astra have always behaved responsibly by way of warning the prescriber doctors of it's addiction potential and it's side effects (which all drugs have). Though I am not qualified to state this, I am sure it is a very valuable drug, if it is used as the manufacturer intended.

Heminevrin has been in use for a very long time, since the 1960's.

Astra have always recommended limiting it's use to **NINE DAYS** -- because it is obviously very addictive.

Some Doctors quoted in early Martindale's say even this is too long and to avoid dependency (addiction) it is safer to limit its use to just SIX DAYS.

There is one VOT member who was prescribed it continuously by various doctors (obviously just to feed the addiction) for over 15 YEARS. Naturally it took her well over a year to remove herself from it.

It is indicated (recommended to be used for) aiding Alcoholic withdrawal, because it stops or drastically reduces withdrawal symptoms (DT's - delirium, tremors etc.).

Heminevrin is so famous for its use in alcoholic withdrawal that it is wrongly known as a 'cure' for alcoholism. The Committee for the Safety of Medicines (CSM) point out that this is not so.

It was however originally also recommended (as a substitute aid) in relieving drug dependency, and has also been recommended for severe insomnia / confusion in the elderly (short term use).

It is apparently widely prescribed as a general tranquillizer in contravention of these known facts.

All drugs have their dangers, Heminevrin is no different. It can and has killed many people when alcohol is taken with it.

This became such a problem that the CSM did remind all doctors of these facts in their safety circular called 'Current Problems' sent to all doctors in August 1986. (All of these Safety Circulars are all kept in Medical Schools Libraries - find what you need first, photocopy it or order it free from the Medicines Control Agency, London.)

The deaths are cause by respiratory depression which is increased when Heminevrin is taken with Alcohol.

A mixture of Heminevrin and say diazepam is potentially just as dangerous, hence Astra's responsible warning in their current data sheet.

Most doctors do not read the data sheets. I know of a case where one doctor even ignored the CSM's safety circular for 6 months and left a asthmatic patient on a mixture of Heminevrin and diazepam.

If you have been prescribed Heminevrin over NINE DAYS, especially since the CSM's categoric warning circular in 1986, you obviously have a strong case against the prescriber doctor. One member of VOT has a Legal Aid Certificate for this. There is another claimant known, who is actually in the process of setting down an action after getting a positive experts report in support of the claim.

There would seem to be absolutely no excuse for prescribing Heminevrin for over 9 days.

Editors comment: It is pleasing to note that some pharmaceutical companies are responsible about warnings.

Antidepressants, Mixtures of Mono Amine Oxidise Inhibitors (MAOIs) and Tricyclics

By an anonymous contributor

Broadly speaking there are the two types of anti-depressant in everyday use. Many of you will think that none of this applies to you, sadly you will probably be wrong.

Anti-depressants are routinely given to people who do not suffer at all from depression. The chances of a benzodiazepine addict being given antidepressants, particularly MAOI's are high because they are recommended for people with 'phobic' states. It is well known in VOT that benzodiazepines cause or drastically aggravate agrophobia - hence you are quite likely to have been prescribed an MAOI if you have been made phobic by benzodiazepines.

The CSM, while not yet saying that benzodiazepines cause agrophobia, have said in another edition of 'Current Problems' (1980 I think) that benzodiazepines should NOT be prescribed for phobic states (obviously because they can drastically exaggerate previous conditions that were not a problem until benzodiazepines were taken).

Tryptizol (Amitriptyline) is the most common tricyclic antidepressant amongst very many others. There are only three straight MAOIs, Parnate which is Tranylcypromine, Nardil which is Phenelzine, and Marplan which is Isocarboxazid.

The MAOIs alone are very dangerous IF you accidentally eat or drink anything which reacts with them. The list of things that cause this is endless and includes cheese, oxo, Bovril, Marmite, pickled herring, broad beans etc. or anything that is going 'off'. Even alcohol free beer can cause a reaction as can ordinary beer spirits or wine.

If you do eat or drink any of these things while taking MAOIs you may suffer a potentially fatal hypertensive crisis, which causes a sudden and unpredictable rise in blood pressure which can occasionally lead to a stroke. It is important that your doctor therefore warns you of these facts, nowadays you will also be given a warning card about this by the chemist when collecting a prescription.

Most people will only have the terrible disabling throbbing headaches, flushing, photophobia (aversion to light) perhaps akin to a very bad migraine attack. As far as I know migraine's cannot kill you. An MAOI induced hypertensive crisis can kill you even if this is rare, or alternatively some people will suffer permanent damage if the stroke occurs.

Meyers survey of unwanted drug reactions in the late 1960's and Martindale of the day show that nearly all these facts have always been known, they also point out categorically that the same dangers are present if you are prescribed two MAOIs together or a Tricyclic with a MAOI.

BNF, the doctors' handbook, summarises the facts that have been known for 25 years by saying:-

"Other antidepressants should NOT be given to patients for 14 days after treatment with a MAOI." Some psychiatrists use selected Tricyclics in conjunction with MAOIs but this is hazardous, indeed potentially lethal except in experienced hands when there is no evidence that the combination is more effective that when either is used alone. Parnate with clomipramine is particularly DANGEROUS".

In summary, the risks are potentially fatal and there is no known benefit, so any doctor prescribing them in this way fails 'the duty of care test'. The only defence would be a very very extreme reason for their use in the first place and then their use would have to be under strict medical supervision (in hospital), where there is quick access to blood pressure reducing drugs, because the unpredictable reaction typically occurs in under an hour.

Failure to comply with these precautions and criteria would give good grounds for gaining a Legal Aid Certificate. There is one VOT member who has one.

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Alternative Therapy

Many people have found some relief from tranquillizer withdrawal and addiction by applying various alternative therapies. I shall comment on various therapies and alternative methods of relaxation and control of anxiety in each issue of the newsletter.

It must be said that these therapies only ease the problems of addiction, they do not cure.

HOMOEOPATHY

By Liz Wood and Lynn Piper

Mrs Lynn Piper is the director of the Tranquilliser Addiction Self Help Association (TASHA) in Devon. Her address and contact number is listed under support groups. She has kindly provided me with some information on her experiences of the use of homoeopathy in tranquillizer addiction.

However, before we come to that, I feel I must add a word of warning: homoeopathy is a very effective medicine that relies on what HAHNEMANN (the discoverer) called 'the Laws of Similars' - like affects like. This happens when symptoms that a substance would normally cause in a healthy person match the symptoms of the illness that the patient is suffering from, and that substance is used in the homoeopathic remedy but diluted to minuscule amounts. In fact it is an extraordinary phenomenon because the original substance that is often toxic in normal quantities is diluted until not even one molecule of the substance remains. Yet double blind placebo controlled trials in animals suggest that it is an extremely effective treatment.

At the present time science is unable to explain why homoeopathy works. There are several theories; some say it is the placebo effect, others say that the molecular vibrations of the original substance match the electromagnetic vibrations of the patients during illness and this somehow triggers the body's defence mechanism. However, it does seem to be effective when the correct remedy matches the patient. In order to make this match an homoeopathic therapist undergoes years of training and although it is well known that bad homoeopathic prescribing cannot do toxic harm, it has been said that it may disrupt the 'vital force' or the electromagnetic energy of the patient rendering further good treatment ineffective. You should therefore never be tempted to work your way through every different remedy listed until you find the correct treatment or to take as many remedies as will cover all of your symptoms. The differing remedies which are considered to have their own electromagnetic field are all dissimilar in vibrational frequency and therefore create dissonance with one another. In a nutshell they are out of tune with each other.

It is best to be treated by a fully trained homoeopathic doctor. In principle one remedy ought to cover all of the patients symptoms to be effective and years of training are required to match all of these symptoms and patient characteristics to the remedy.

Although as yet there is no scientific explanation of homoeopathic treatment it is best when using any medicine to ERR ON THE SIDE OF CAUTION.

The following section is from Lynn Piper of the Tranquilliser Addiction Self Help Association (TASHA)

I would like to inform you and other members of the use of Homeopathy, as we have had a great deal of success when using this treatment during the withdrawal from benzodiazepines. Not many people realise that you can help reverse the ill effects and side effects of any drug including benzodiazepine by using a homoeopathic potency drug of that drug. Say you are taking a benzodiazepine drug, for example lorazepam, you would still continue to withdraw it daily, but at the same time you could take homoeopathic lorazepam in a 30c potency, what ever side effect a drug can cause, in homoeopathic potency it can help to cure. We have found this method has helped hundreds of our clients, many of whom had failed to withdraw before.

The homoeopathic remedy is taken as follows: 1 tablet dissolved on the tongue 3 times daily whilst withdrawing the drug, if you have already withdrawn the drug, you would take, 1 tablet dissolved on the tongue 3 times daily for 10 days only.

For panic attacks. Homeopathic ACONITE in a 30c potency helps a lot, this can be taken as and when you need it, but generally 3 time daily.
Agrophobia. Can be eased by homoeopathic ARGENT NIT in a 30c potency, 3 doses per day for 10 days.
Headaches. Can be helped by homoeopathic NAT MUR, 30c potency, 3 doses per day for 10 days.
Nausea and digestive problems. Can be helped by homoeopathic NUX VOM in a 30c potency, 3 doses per day for 10 days.
Bloated stomach and bowels. Can be eased by homoeopathic CARBO VEG in a 6c or a 30c potency, several doses daily or as needed.

Sleeplessness. Can be more difficult to treat, but homoeopathic COFFEA can sometime help in a 30c potency, 3 doses daily as needed.

I would advise any one interested in Homeopathy to invest in, **THE BAREFOOT HOMOEOPATH, (written by Madeleine Harland & Glen Finn) published by, Hyden House Ltd, Price: £8.99 from all good book shops.** This book is a really good self help guide that is easy to understand.

GALEN HOMOEOPATHICS, LEWELL MILL, WEST STAFFORD, DORCHESTER, DORSET, DT2 8AN, Tel: 01305 263996, are a very good reliable and friendly firm to deal with, if you order today, you receive the remedy the following day, (very fast!).

VERY IMPORTANT. If you are going to take homoeopathic remedies, please follow these instructions: **You must not EAT or DRINK or SMOKE for 20 minutes either side of taking the remedy, as your mouth has to be clean, having said that you must wait for the same amount of time after cleaning your teeth as well.**

AVOID THE FOLLOWING. You must avoid, COFFEE, PEPPERMINT, CAMPHOR, GARLIC, STRONG PERFUMES, as these will all **antidote** the remedy. **Sometimes** people can get a slight reaction to the remedy, an increase in symptoms for a couple of days, **DON'T PANIC,** this is a **good sign** and shows the remedy is doing its job. As homoeopathy works from deep within the body, to bring things to the surface to be cured, don't expect to feel better straight away, it can take weeks and even months sometime before things start to improve, after all if you have been ill for many years, you wouldn't expect to be well in two weeks would you! Although you only take most remedies for 10 days, the remedy goes on working in the body for up to 6 weeks after you stop. If things were not improving by 6 weeks, you should either repeat the remedy or try another. I would like to stress that it is always better to go and see a **qualified homoeopathic practitioner,** if you can afford to do so.

BREATHING AND PANIC ATTACKS

By Liz Wood.

Recently on television there was an excellent series about anxiety, depression and other problems. The psychiatrist Anthony Clare was the programme host and a well known person was his guest speaker.

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One of the programmes featured the actress Imogen Stubbs documenting her experiences with panic attacks. I found this programme not only informative but extremely helpful to me personally as I was originally prescribed tranquillizers for panic attacks. Tranquillizer addiction has curtailed my ambitions to be an actress but it was only after watching this programme that it finally brought it home to me just how different my life might have been if, like Imogen Stubbs, I had thrown the tablets away after two weeks and discovered other methods of panic control.

Imogen Stubbs recalled how she had first suffered a literally paralysing panic attack sometime after seeing somebody killed by a huge wave on the beach. She was given tranquillizers but threw them away after a fortnight as she felt they made her like a zombie. Her panic attacks remained particularly disabling until she eventually went to a therapist who taught her how to breathe properly. This therapist showed her how poor breathing results in low carbon dioxide levels in the blood which can trigger panic attacks. It was demonstrated that correct breathing restores the carbon dioxide levels and panic attacks can be controlled and alleviated.

Imogen Stubbs pointed out to Anthony Clare that all she needed was good breathing. She avoided psychotherapy and counselling and she is today a living testimony of how a simple effective treatment without recourse to drugs can resolve a disabling problem.

Methods of Control

Sometimes, doctors suggest that you breathe into and out of a paper bag (it must be a paper bag and not plastic bag!). I have found this technique particularly helpful when a panic attack seems to be never ending.

By breathing into a paper bag you breathe out carbon dioxide which you then inhale back in to the system from the paper bag, restoring your carbon dioxide levels.

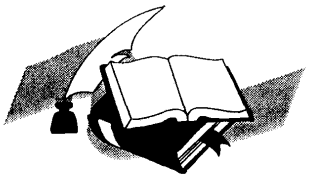
Alternate Nostril Breathing

There are many ways of developing good breathing. Prana Yama yoga teaches several. One of these techniques is alternate nostril breathing which is very effective.

Hold your nose between your thumb and the second finger of your left hand, pinching the nostrils between them. Lift your finger away from your right nostril and breathe in to the count of about six seconds. Pinch the two nostrils between your thumb and your finger as you hold your breathe for a further six seconds. Then release your thumb from the left nostril and release the air to the count of six. Then breathe in through that same nostril to the count of six, hold your breathe again to the count of six and release the air through your right nostril. Continue this rhythm until you are more relaxed.

Good breathing is stomach breathing. If your are breathing shallowly your will notice that only the upper part of the chest is rising and falling. If you take deeper breaths you will notice that the stomach will also rise and fall. This is a good habit to try and form.

Good breathing is essential because the tranquillizers are respiratory suppressants and poor breathing becomes a habit.



General Reading on Tranquillizers

Coming Off tranquillizers and Sleeping Pills - Shirley Trickett, 1991, Thorsans, ISBN 07225 2398

Women and Tranquillizers - Celia Haddon, 1984, Sheldon Press ISBN 0-85969-420-8

Escape from Tranquillizers and Sleeping Pills - Larry Nield, 1990, Ebury Press ISBN 0-85223-913-0

Alive and Kicking - Peter Ritson, 1989, Casa Publications ISBN 1-872331-00-9

Prisoner on Prescription - Heather Jones, 1990, Headway Books ISBN 09513945-26

Life without Tranquillizers - Vernon Coleman, 1985, A Corgi Book ISBN 0552 12718 3

Darkness Visible - Willian Styron, 1991, Jonathon Cape Ltd ISBN 0-224-03045-0

Nip Beyond the Barrier - Felicity Bielovich, 1993, Lynx Pub. (South Africa) ISBN 0-620-17712-8

Back to life - Pam Armstrong, 1992, Paint Origination (NW) Ltd ISBN 903348-349

Benzo Junkie (How Doctors and Drug Companies get us Hooked) - Beatrice Faust, 1993, Penguin Books Ltd (Australia) ISBN 0-670-85145-0

The Lost Years - Joan Jerome

The Tranquillizer Trap and How to Get Out of It - J Melville, 198?, Fontana Books, London

Bottling It Up - V Curran and S Golombok, 1995, Faber and Faber

Support Groups

1. City and Hackney MIND - Tranquillizer project.
   8 - 10 Tudor Road
   London
   E9 7SN
   Tel: 0181 533 6565

2. Tranquilliser Anxiety Stress Help Association (TASHA)
   60 High Street
   Brentford
   Middlesex
   TW8 OAH
   Tel: 0181-569-9933

3. Mental Health in the Elderly
   Directorate (team B)
   Lewisham and Guy's Mental Health NHS Trust
   Hither Green Hospital
   Hither Green Lane
   London
   SE13 6LU
   Tel: 0181 698 4611

4. Tranquilliser Dependency Service
   Charing Cross Hospital
   London
   W6 8RF
   Tel: 0181 846 1502

5. Benzodiazepine Dependence Clinic
   Clinical Psychopharmacology Unit
   Institute of Psychiatry / Maudsley Hospital
   Tel: 0171 703 5411

6. MIND in Camden Tranquilliser Service
   Barnes House, 9-15 Camden Road
   London
   NW1 9LN
   Tel: 0171 911 0816

7. Newham Drugs Advisory Project
   Abbey House
   361 Barking Road
   Plaistow
   London
   Tel; 0171 474 222

8. Tranquillizer Advisory Counselling Service (TACT)
   The Elms
   Redbourn Road
   Hemel Hempstead
   Herts
   HP2 7AZ
   Tel: 01442 211 478

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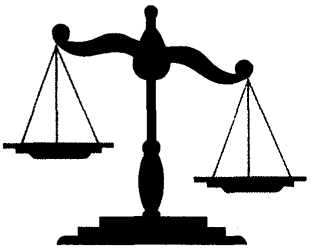
9. Tranquilliser Addiction Self Help Association (TASHA)
   4 Smithfields
   Totnes
   TQ9 5LR
   Tel: 01803 867 249

10. Council for Involuntary Tranquilliser Addiction (CITA)
    Cavendish House
    Brighton Road
    Waterloo
    Liverpool
    L22 5NG
    Tel; 0151 949 0102

11. Battle Against Tranquillisers
    PO Box 658
    Bristol
    BS99 1XP
    Tel: 0117 966 3629

SECTION 5 - LEGAL



Overview of the Current Legal Position

By Liz Wood

Benzodiazepine litigation was started in 1988 by Freeth Cartwright and other solicitors who formed a steering committee to oversee civil proceedings against the manufacturers of benzodiazepines, the prescribers of the drugs, the committee for the Safety of Medicines and the Health Authorities.

The case proceeded for several years before the Legal Aid Board decided to withdraw funding on the grounds that it was no longer financially viable. They came to this decision after about six years of hard work and approximately £35 Million of taxpayers money had been spent on solicitors, barristers and case experts fees amongst other costs. Not a penny was received by the plaintiffs.

It was decided that the cost of the litigation far exceeded the damages that the plaintiffs would recover and the case was halted on these grounds

However, in the first instance, individual cases had been assessed on surprisingly low general damages and special damages had not been considered at all. A woman told me that her case had been assessed at £850 which after 20 years of addiction had almost certainly been spent on prescriptions alone.

How cases were assessed for damages still seems to be something of a mystery except that psychiatrists were sent a form stipulating three amounts of damages: £3000 and below; £3000 - £5000; above £5000. They had to select a category for each plaintiff as the amount that they felt that person should receive for the injuries they believed were sustained. This, on the face of it, seems to be a very strange and unscientific way of categorising plaintiffs and one wonders if there were more detailed guidelines that VOT is as yet unaware of. This however begs the question as to why the damages were assessed at such piffling amounts? Perhaps a precedent from another pharmaceutical group case was used. This would once again highlight the appalling injustice surrounding the amounts of damages received in this type of litigation. It seems to be true in Britain at least that successive governments are happy to comply with the profiteering of multi-national pharmaceutical companies at the expense of the public at large. As it is a matter of trust and chance, we are all possible lambs to the slaughter and if you are unlucky enough to be damaged there is no real compensation for your injuries. At present, the reward for the drug companies is greater than the punishment for wrong doing and whilst it remains so the general public is at risk.

General damages cover the injuries sustained, either physical or psychological. The other area, special damages, covers such matters as lost income. Oddly enough, adding to the controversy surrounding this case, Justice Kennedy insisted early on in the litigation that only general damages should be assessed. One has to ask the question as to how, could financial viability be considered with the bulk of the assessment missing from the calculations? It seems to reduce the whole of the legal process to an expensive farce.

VOT is also aware of a QC's report that assessed general damages at a maximum of £100,000 per capita. This assessment appears to have been completely ignored by the legal aid board.

Case expert reports were another area of contention. Psychiatrists seemed to have been issued poor sets of guidelines on how to properly substantiate reports for the court. Psychiatrists were not properly vetted to ensure that they were capable of assessing and issuing reports correctly. Barristers were therefore forced to return to the case experts the psychiatric reports which did not match the information in the medical records or simply did not relate the injuries complained of to the drug in question. Some psychiatrists merely quoted the plaintiff rather than committing themselves to a decisive opinion, making a mockery of the report and destroying the point of having a psychiatric report in the first place.

Above all, is the question of conflicts of interest. Many of the case experts were psychiatrist who had prescribed benzodiazepines in the past and could in principle be the very person about to receive a writ from a plaintiff, even if in practice that didn't occur.

One assumes that the Steering Committee chose only those psychiatrists who had prescribed these drugs carefully. Even so, many psychiatrists seemed to be defensive about the whole issue and many plaintiffs reported the 'them and us' syndrome at their psychiatric interviews.

In assessing the case as a whole, a major criticism would have to be that lead cases were not pursued through the courts before so many thousands of cases were substantiated and psychiatrically assessed. An enormous amount of money could have been saved if the bulk of the cases had been put aside until a later stage and several first class cases had taken the litigation to discovery and beyond.

If our lawyers had proven the viability of a few and honed the procedures with those cases, a better blueprint would have been available for other cases in the future. Many mistakes would have been avoided and a lot of money would have been saved. Particularly as the whole procedure seems to have been a process of learning.

VOT now has the unenviable task of trying to redress the mistakes of the past litigation by co-ordinating those remaining plaintiffs as Litigants in Person. There are, at present, about 80 claimants continuing in this matter. So far VOT has successfully steered the ship through rough waters towards the new contingency fee rulings; a new land of hope and perhaps plenty! The No Win No Fee system seems to offer a much more realistic approach to pursuing this action than as Litigants in Person. I am not able to give full details at this time, however, as the new system has only just become law and the finer details have yet to be worked out.

April 25th 1995 Hearing

Reg Peart represented the plaintiffs at the Hearing and won an extraordinary victory by securing an adjournment of the 12 - 14 June Hearings until October 17th. The adjournment has given VOT the time to organise a number of important matters.

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This success has given us a much greater chance of succeeding at the October 17th Hearing which will allow us to proceed to "Discovery" of the defence's documents.

The Hearing will be an appeal of the decision made by Master Prebble to strike out the cases on financial grounds. Although we had successfully argued our case on two thirds of the issues we lost it on the thorny issue of cost benefit analysis. As far as costs versus damages are concerned, the situation is now being addressed. Also if we proceed under the Contingency Fee system then a possible insurance scheme will not only protect the plaintiffs against costs if they lose but will also ensure that the defence is able to recover their costs at the end of the day if they succeed.

ALeRT

Allied Lawyers Response Team

founded and run by The Ross Park Partnership Solicitors

SPEECH BY GRAHAM ROSS AT THE LAUNCH OF ALERT AT THE RACQUETS CLUB LIVERPOOL ON THE 2ND JUNE 1995:-

Ladies and gentlemen first a confession. ALeRT is in the business of expanding business ... the business of product liability and group litigation. We will be criticised for being commercial, most fervently by those of whom it was once said by one of their own kind in their own professional journal "towards the goal of making the most possible money they normally devote their energies day in and day out." I am talking about those who work in the pharmaceutical industry. (Schwarz H-Scrip 1620/21, 29 May 1991,pp22-23). I think the words that spring to mind are "pot" and "kettle".

Yes we will be financially successful for our members and ourselves. But there is another side to the issue. It is about benefit not to the pockets of our members, not to the benefit of our clients and our members' clients but to the health of the public. I know this may sound a bit high blown and altruistic. But I am asserting a fact.

Let me lay the scene by giving you a couple of quotations from a very interesting book. "Product Liability" by lawyer Christopher J Wright, a book of practical advice to manufacturers to help minimise their exposure to personal injury litigation. A sort of tactical warfare manual.

He admits candidly that for manufacturers generally "costs may well be one reason for not improving, or actually lowering, safety levels." This guy's too honest. But, in doing a memoed report on a product defect "Don't imply that cost or resource constraints always take priority over safety." lest they be discovered by Plaintiff lawyers. "Do not suggest unreasonable risks are being taken". He does not qualify that remark by saying unless such is true.

Here's one for the accountants amongst us? He advises that one management strategy for minimising financial risk of product liability is to form a separate £100 company with limited assets that can go into liquidation if claims are made.

This, ladies and gentlemen , is what we are up against and exactly why an initiative like ALeRT is so right.

Keith and I have been running group litigation for nine years now, from haemophiliacs infected with HIV, patients damaged by various drugs, tranquillisers, sleeping tablets, anti-depressants, steroids, vaccinations, etc. During that time we have gained valuable experience of how drug companies operate. Of how manufacturers of consumer products operate. Of how health authorities operate. Of how government departments operate.

What is the problem? Medical treatment causes illness. You would expect that by now some system was in place to control this problem. I can tell you after nine years of investigating drug companies and authorities and in particular the regulatory systems, that the system simply does not work.

But in those nine years some improvements have occurred. Thanks not to the manufacturers or regulators but to the media and to lawyers.

Here is a quote from a consultant psychiatrist who has written widely on the subject, Dr Cosmo Hallstrom "If the popular press and more recently the legal profession had not taken up arms against the over prescription of tranquillisers, the issue of benzodiazepine dependence would still remain a medical curio only for the pages of medical journals. The media and lawyers have undoubtedly altered prescribing practices mostly for the better." Cosmo Hallstrom Journal of Forensic Psychiatry 1991, 2 pp5-7.

It was, in fact, a matter of about 3 months after the tranquilliser litigation began, including my writs against the CSM, that the Committee on Safety of Medicines wrote to every doctor telling them to only prescribe them short term.

After legal investigations were commenced by us against manufacturers of infant fruit drinks on the grounds of failure to warn about tooth decay, warnings then appeared.

Legal action sometimes works, therefore, even before the trial. It is damage limitation by the manufacturers and it really works.

But perhaps most importantly look at the results of our litigation in the field of haemophilia treatment. For years in the 1970s, to save government digging deep into their pockets to make safe home produced blood products as promised, they imported commercially donated blood from America known to be infected with hepatitis viruses. Despite this disaster of widescale hepatitis infections, they continued to sail, by way of analogy to another disaster of the times, as it were, with the bow doors open, until AIDS came along. After our successful legal action, low and behold, ultra safe product only is now used.

Question. What would have been the outcome if ALeRT had been around in the mid-70s? I shall tell you. We would have become ALeRTed to the problem of hepatitic infections from imported commercial blood products. We would have investigated the legal issues and concluded, as we did in the late 1980s, that the Department of Health were liable in law. We would have then sued the Government in exactly the same way (our Statement of Claim in the HIV litigation was primarily based on the negligence in the pre-AIDS 1970s). Not only would we have recovered compensation for ruined lives, but the Government would have been thereby forced, if not embarrassed, into stopping the importing of US product BEFORE HIV came along. And 1,200 haemophiliacs would not have become infected with HIV.

And, ladies and gentlemen, that is what ALeRT is all about. We are no longer going to wait until injured patients come to us. We are going to research and develop litigation against drugs and manufacturers and government and authorities as soon as we learn of potential problems. In that way, not only will we help our members to generate business, We will help reduce the numbers of people avoidably damaged by products and drugs.

If anyone tells you that such initiatives will force drug manufacturers to reduce their work so that less new drugs will come onto the market, let me tell you that is an absolute nonsense. Firstly there are very few ground breaking drugs coming onto the market. The overwhelming numbers of drugs being produced are same again copies of other drugs. But more importantly look at the facts. America is the most litigious society in the world.

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More suing goes on there than anywhere. Yet more drugs are manufactured in America. So that argument cannot be right.

But there' another reason. Why? Manufacturers are wise enough to know that the money they make up until a drug that causes damage is withdrawn more than outweighs what they have to pay in damages or liability insurance premiums. One reason for that in the UK is that the courts do not award exemplary or punitive damages. That is to say damages over and above compensation for injury that attempt to provide a disincentive to companies to run the risk of compensation. They should but they don't and that is the protection to manufacturers.

So we are going to go in early. We will operate a research and development facility that will react as soon as problems with products are noted. How are we going to do it. With Internet. It is only thanks to the wonders of modern technology that we will do it. Why? because it gives us access not just to the millions of medical and scientific papers that are published but to much more in the way of communications not published in the important media.

Incidentally, one lawyer I was speaking to said he can do what we do because he was on the Internet. With all due respects that is a bit like saying that, because you have a spade and some plastic bags, you can do archaeology. You need to know where to look and, more importantly, recognise the little fragments of information and what they form when put together. We daily trawl through the systems around the world retaining all we see of interest building up files of data, so that, whenever we are asked about a product or company we will have often already a wealth of information.

So we go in early. Look at what happens when problems are seen with a drug. It starts usually with a letter form a doctor in one of the medical journals, asking if anyone else has noted a problem with a drug. Then someone may publish a retrospective study. Then the general media publish a story or Watchdog or someone cover the matter. Then patients begin to realise they may have a problem and eventually the lawyers are brought in.

Well ALeRT is pushing itself to the front of the queue. In so doing we will respond to that first letter and so it will mean that less people at the end of the day will be damaged.

I will finish with one example that may well lead to a new action. Here is a message left on the Internet by a New York doctor. She is seeking information about patients who may have suffered damage from a drug. I won't mention the name as the cameras and press are here. This message is for doctors to read. But with the Internet I can read it. I have e-mailed this doctor and am waiting for more information. ALeRT will now investigate. If we decide there is a potential claim, then the public will be ALeRTed and ALeRT members will act.

In an age when countries are breaking up into smaller and smaller units and manufacturing companies are becoming larger and larger, encompassing the globe, and making more of an influence on society, the time has never been more right for something like ALeRT to deliver real law to the public.

Thank you for your time and your attendance here today .

SECTION 6

Political Activities

By Liz Wood

Dennis Veale of VOT and his MP Anthony Streen arranged a meeting of a number of MP's at the House of Commons to examine the problems of the benzodiazepine litigation and to seek new lines of action for benzodiazepine litigants. This meeting took place on the 22nd March 1995.

The outcome of this meeting was to seek a further meeting with the Lord Chancellor to discuss the issues. This occurred at the end of June. The possibility was considered of investigating a handful of cases so that any funds available from the Legal Aid Board would be used to validate a few cases and be used to take a test case of sufficient merit to trial.

SECTION 7

Overseas Activities

By Liz Wood

VOT is making excellent contacts with other victims of tranquillizers overseas. From the beginning, we had strong contacts with Barry Hoffman and Will Day of Australia who attended our Bristol Conference in February 1994. Since then further contacts have been made. Notably Anna de Jong of Patients Adversary New Zealand and Felicity Bielovich in South Africa.

Quite recently a Belgian expert in pharmacology and toxicology contacted us to offer his services to us and establish a Belguim VOT group. He had personally experienced paradoxical effects of benzodiazepines.

Jean Rudge, our VOT co-ordinator for Liverpool, recently advertised for victims in Loot, an international free ads magazine. She has received, at this date 200 replies from many countries.

Through the Internet we have established several links. Notably, Johnny Sands and Dag Zetterberg in Sweden, who have provided us with pages and pages of scientific reports and data sheets. We are extremely grateful for this support.

Johnny would be grateful if victims could write to him about their experiences on tranquillizers so that he can establish a permanent record (archive). His address is:

Johnny FB Sand
c/o Persson/Lundberg
FALTSPATSVAGEN
S-703 74 OREBRO
SWEDEN

VOT co-ordinators Jean Rudge and Jessica Hart will be furthering Barry Merchants excellent work in contacting foreign embassies and establishing overseas contacts.

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SECTION 8

TV and Press Coverage

There has been over the last few years some excellent reporting on the benzodiazepine problem of addiction on television, radio and in the National and Local newspapers. Below is a list of the major events:

BBC North television programme Close Up 'The Bitter Pill' about the litigation.

BBC Radio organises programmes to coincide with launch of Mental Health Foundation booklet. VOT members appeared on:

Radio 4
Radio Oxford
Radio Cleveland
Radio West Midlands

World in Action: Dr Peart and other VOT members talk about tranquillizers and road traffic accidents

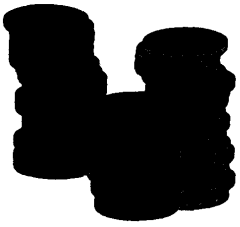
GMTV: There were four morning slots on prescription drugs. Reg Peart talked about tranquillizer addiction and the litigation.

Central Weekend: Lively debate about tranquillizer addiction and the litigation.

Panorama: Programme about temazepan exchanging hands on the black market in Scotland and the drugs war surrounding this. My only criticism is that the programme claimed that Temazepan is perfectly safe as a hypnotic on prescription. Temazepam is of course another benzodiazepine that can produce normal dose dependence over long term usage. If they do not address the root of the problem that the drug is intrinsically addictive, how do they propose to deal with the larger issue, its availability on the black market. Apart from this major error, the programme was excellent.

Occasionally, somebody writes a very special article. This is true of a recent article in the Sunday Times by Brian Deer on the antibiotic Septrin and the horrific damages caused by this drug and the problems of litigation.

SECTION 9



Financial Appeal

FUNDS, FUNDS, FUNDS. We always need money. If you have any ideas about raising money please get in touch.

At the present we are asking for small donations from claimants continuing their actions against the pharmaceutical companies and although some of these people have paid promptly, some haven't paid at all. It is understood that most claimants are on a very low income and feel they have no extra money to give but in order for VOT to continue and succeed we must receive money.

If members wish to help raise money they are allowed by law to go out on the streets with a collection box at specific times. If they wish to do this they must contact their local police for advice. VOT is considering having a National collection day when members and/or their relatives and friends across the country can go out collecting for the appeal. If you would like to participate, or help organise, please contact Barry Merchant.

Congratulations and many thanks to David Wheat (VOT co-ordinator for the Potteries) for raising £180.00 for the VOT appeal from his sponsored runs and walk. Also thanks to Margaret, Joanne, Claire, Liam, and Jill / the Lindrop family - Linda, Jeff, Debbie, Dave, Paul and Tommy / Members of Changes: 12 Step programme for Mental Health / The Kyujon Karate Club.

David says "If this fund-raising exercise has taught me one thing it is that there is overwhelming public support for our cause. I hope that we are soon in a position to take advantage of the fact".

Many thanks must also go to the members of VOT and others who have contributed generously to the VOT appeal and particularly these people who have no direct involvement with the court case and have not suffered from tranquillizer addiction.

Thanks also to CITA for our generous share of an anonymous donation to all tranquillizer support groups.

Also many thanks to several businessmen who have donated to our fund anonymously.

DONATION FORM

❑ I enclose £.....as a contribution toward the August 1995 VOT Newsletter

❑ I enclose £.....for the next Newsletter (Winter 95/96)

❑ I enclose £.....as a donation to help VOT continue its work

Name: _____

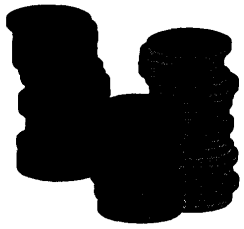
Address: _____

_____

_____

Tel No: _____

To be sent to the VOT Treasurer, Liz Wood, 12 Berkeswell Close, Church Hill North, Redditch, B98 8SF



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SECTION 10 MEMBERS

Thoughts Poems and Prayers

I am delighted to have shared your thoughts about benzodiazepine withdrawal, injustice and life in general, particularly through your poems. I hope you will continue to send in your contributions as they have given me much pleasure and I am sure they will give pleasure to all.

I will work on a first come, first served basis and I will try to publish every piece that we receive.

Daniel Kelly wrote his poem 'Deja-Vu' about his feelings on benzodiazepines. I think this feeling is something that you will all recognise. In his own words, "The feeling that I associate most with that time [on benzodiazepines] is the occasional feeling I used to get, that would suggest to me that life hadn't always been this way and maybe some day it would change back again. As I am sure you will remember after so many years, it was hard to believe that life had ever been any different. I believe that it was this feeling, that occasionally intruded into my conscious mind, that kept me alive".

Deja-Vu by Daniel Kelly

The rat-tat-tat of the long gone child,
Tapping on the mists of time,
The siren wail, of one so frail,
Hauntingly unkind.
Shadows of a fragrance
Rushing through my mind
The first Noels and jingle bells
Mean joy that's unconfined
Tippy toe, I feel as though
I should remember, long ago.
Its under my skin, and deep in my soul
Pervades my all, but I can't recall
What it was, or how I felt,
Its size, its shape or how it smelt
It sneaks and strikes and then takes flight
I'll catch it yet, I think I might
Stealing feelings, like a psyche mugger
Next time, I'll get the bugger

Friendship by Ann Dutshak

I've found a friend, who's rare and true,
For me such friends are all too few,
Ready to share in trouble and in strife,
For that is what we go through life,
Someone to talk with when in need of a break,
And in their problems you try to partake
A helping hand reaches out to you
The sign of a friend so dear and true
Having a special friend is rare
But you know in your heart that you can share.

Mundane Existence or Emptiness by Barry Merchant

How do I see myself?
Is it a construct of genes, conditioning and consciousness,
Who is this person with thoughts, feelings, dreams, values, ideals?
Where do I come from?
Who and why was I put together?
Together for a purpose I beg of you
What are we doing here?
I know say some, we are spiritual astronauts
'Not so', say the scientists.
Love is an illusion
Only for fools and beasts
We say, measure everything and get results
I'm nice to you
You are nice to me, we survive
That is the way things are.
'God forbid', say the romantics, love, love and
More love.
I see you, feel you, caress your sweet hair
You recognise me as an individual entity
My wet tears, the way I feel the source of you
We are alive!
Sweet smell of daffodils, so vibrant on my emotions
I'm dying, if this is the last time my creativity, my hopes and physical existence,
Will dare shadow this plane
Harken, wrathful deities above the senses
Who guard beauty and seek truth
Are above suspicion
For truth will indeed reign supreme

Blossoms of Love by Ann

Love blossoms in spring
When birds start to sing
It grows with the sun
When summers begun
It blossoms again
But lacking the rain
It withers and dies
Heartbreak and sighs

Perhaps try again
Face the storm and the rain
The draughts and the dews
The blossom renews
Natures sublime
But it takes its time

There is definitely a moral in Ann's poem for slow reduction of dosage in benzodiazepine withdrawal!

Awareness by Barry Merchant

Being here is not enough
To feel and grow are surely mine
but, who knows amongst the dark
a place of injustice grows

Guard your mindfulness,
the bird of prey is watching
he knows you seek divine peace
alas, take nothing for granted.

Seek, reflect, do not compromise
bear the pains of laughter true
and cherish the fruits of wholesome vision
that reside within our being just

Thought

One cannot cause pain and distress to another human being or being without causing pain to oneself.

In John Donne's words:

No man is an island, entire of itself. Everyman's a piece of the continent, a part of the main. Any man's death diminishes me, because I am involved in Mankind, and therefore never send to know for whom the bell tolls; it tolls for thee.

PRAYERS

A prayer to affirm that spiritually we are never separate from God.

Psalm 139

Lord, you have examined me and know all about me.
You know when I sit down and when I get up.
You know my thoughts before I think them.
You know where I go and where I lie down.
You know everything I do.
Lord, even before I say a word, you already know it.

You are all around me - in front and in the back - and have put your hand on me.
Your knowledge is amazing to me; it is more than I can understand.

Where can I go to get away from your Spirit?
Where can I run from you?
If I go up to the heavens, you are there.
If I lie down in the grave, you are there.
If I rise with the sun in the east and settle in the west beyond the sea, even there you would guide me.
With your right hand you would hold me.

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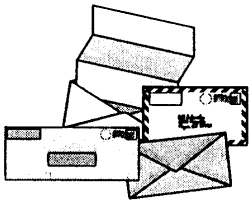
If I could say, "The darkness will hide me.
Let the light around me turn into night".
But even the darkness is not dark to you.
The night is as light as the day; darkness
and light are the same to you.

You made my whole being; you formed me
in my mother's body.
I praise you because you made me in an
amazing and wonderful way.
What you have done is wonderful.
I know this very well.
You saw my bones being formed as I took
shape in my mother's body.
When I was put together there, you saw
my body as it was formed.
All the days planned for me were written in
your book before I was one day old.

God, your thoughts are precious to me.
They are so many!
If I could count them, they would be more
than all the grains of sand.
When I wake up, I am still with you.

God, I wish you would kill the wicked!
Get away from me, you murderers!
They say evil things about you.
Your enemies use your name
thoughtlessly.
Lord, I hate those who hate you;
I hate those who rise up against you.
I feel only hate for them;
they are my enemies.

God, examine me and know my heart; test
me and know my nervous thoughts.
See if there is any bad thing in me.
Lead me on the road to everlasting life.



Letters

Keith Pirelli is a property developer living abroad. He was addicted to valium for 2 years

After 5 years of benzodiazepine cessation, many letters of protestation, meetings, accusations, disbelief and recriminations, I am uncertain how else to positively contribute to a VOT newsletter. Except, perhaps, to return to those lonely frightening times during the unrelenting withdrawal agonies. I needed hope, for people to help me comprehend the incomprehensible and for the medical profession to take responsibility for such widespread bungling ineptitude which caused so much unnecessary suffering. Yet primarily I wanted someone who had been through this to tell me unequivocally I would recover. So this is my contribution!

Five years on and I've built a new life in a new country. If I'm cautious with my alcohol intake, apart from some head and facial pain, I'm my pre-benzo self and it feels good. It has been a long time coming but all of you can make it, often, in spite of professional medical intervention. I'm afraid the attempts to compensate by seeking remedy at law have been so indecipherable to the layman and farcical for those who were able to observe the whole physical pitiful performance in painful detail.

The medical profession, including some of the more deluded icons involved in media evangelism have proved woefully inadequate in both support and in accepting responsibility for prescriber negligence. It is a sad fact that so many of them still neither comprehend or accept the damage their irresponsible prescribing habits have caused.

My contribution, despite all of this, is one of hope. Even when your doctor / psychologist / counsellor / lawyer / alternative therapist or local shopkeeper, try to convince you that you really always have been "a few slices short of a picnic" f*** them because they are wrong. You will get better and in the fullness of time those who contributed to our suffering will be forced to accept responsibility. Didn't you know the good guy always wins in the end?!

Don't ever give up

Best wishes

Keith Pirelli

PS Sorry no 'expletive deletive' the subject's too important

[Editor deleted it but I'm sure you get the message.]

Dear Liz,

Mary Baker has passed your letter to me as an ex-tranx victim and I hope that some of the following comments might be of use:

1) I feel it is of prime importance that GP's adopt a different approach in dealing with anxiety in the first place. Nutritional and life style assessments should be made, as I know to personal cost, anxiety can be caused by a hormonal imbalance (leading to three suicide attempts after being prescribed Librium, Valium and Temazepam and various anti-depressants). After three years of hell, I was eventually prescribed HRT and after just four days was able to contemplate withdrawal which took me 8 months. This was after being told by a leading psychiatrist that no-one could help me and that I would be on Valium until my dying day.

2) Victims should have a hand in withdrawal. It is vital to feel that you are not being withdrawn too quickly as the experience can be terrifying and totally off-putting. I eventually withdrew with the help of Mary Baker, whom I found to be more knowledgeable and of much more support than either a psychiatrist or a doctor. Support groups provide an invaluable service, telephone support being vital for victims who are house-bound. To realise that you are not alone in your bewildering experience and that you are not going mad can be a life saver. Also, in my case, to have confirmation that you are not just another middle-aged neurotic housewife who needs to get a life!

3) Counselling, hypnotherapy, relaxation and yoga are in my experience very helpful but only when not taking tranx.

4) Victims should be made aware of the possible value in taking alternative medicines, although I do think that a qualified practitioner in which ever brand of medicine is chosen should be consulted. As individuals vary, different medicines suit different people. Personally, I have found that large doses of Oil of Evening Primrose (in my case up to 1000mg per day) to begin with a maintenance dose of 500mg per day, plus a yeast free B-complex tablet, Vitamin C with bioflavonoids to be an invaluable support to the nervous system whilst withdrawing and to cope with the physical aftermath.

5) When able, exercise can really help to boost one physically and emotionally and muscles which have been so detrimentally affected by these drugs, which artificially relax them, start to recover. At one stage I did not have the power to dress myself and now I am swimming and cycling regularly.

6) Reading literature available at the local library can be informative and helpful. I found the following particularly helpful:-

   Shirley Trickets - Coming off Tranx and sleeping tablets
   Claire Weeks - Self help for your nerves
   Ann Dickson - A woman in your own right
   Gill Jacobs - Candida Albicans

In conclusion I think that the medical profession should recognise just how potentially life threatening these drugs are and be in a position to offer alternative therapies to alleviate stress, also taking more time to assess the root cause of the

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patient's problem. A self help group attached to the surgery? It would save an awful lot of misery, time, money and lives in the long run.

Tranx prescriptions should be a last resort and the patient should be made aware of the probable consequences. A mention here about the inability to drive safely when on medication. I was recently asked to appear in a 'World in Action' programme entitled 'A Fatal Prescription' concerned with the effects of these drugs on concentration. I really believe that as is operational in Holland, patients should be banned from driving whilst on these drugs. I know I was unsafe and gave my car up for 3 years.

To anyone who is withdrawing I would confirm that there is life after tranx and it can be actually better than before. You realise just how precious life and family are. Every day to me is a celebration of life. If my suicide attempts had been successful, I dread to think of the affect it would have had on my wonderful, long suffering family and friends. Now I want to enjoy every minute - not reflecting on the 'what ifs' and counting my triumphs instead of my bruises. Coming through withdrawal is a metamorphosis like Mary Baker explains and I certainly feel like I've gained the wings of freedom and I am flying free at last.

If I can be of help to anyone, in anyway, I shall be only too pleased.

Josie Hollis

Dear VOT

Congratulations on your proposed Tranx newsletter. Not the first, however. I wrote, produced and distributed one world-wide in the early and mid 1980s for several years. It was called 'Life without Tranquillisers' and came out quarterly. It was very widely distributed, read and quoted but in the end I couldn't afford to keep doing it (I paid for it myself and although there was a modest subscription it didn't cover the costs).

With best wishes for your newsletter.

Sincerely

Vernon Coleman

Dear Liz,

I was prescribed valium in 1983 as an aid in attempting to stop smoking cigarettes. I became addicted. I decided to try and get off it in 1990. I took a 3 month sabbatical from work to do this. I was advised (by a doctor) to just stop abruptly. I had several attempts at this, once staying off valium for 10 weeks, but failed. I have no family, and had no friends local to me at that time - i.e. no support. I took myself off to an Anthroposophical 'therapeutic community' in the West Midlands. This is a general purpose clinic following the teachings of an Austrian mystic Rudolph Steiner; it is not a psychiatric clinic, nor is it a drug treatment centre. The people there are well intentioned and mostly harmless. Unfortunately they have 2 medical doctors whose understanding of psychoactive allopathic drugs is limited.

I eventually persuaded them that I needed to withdraw from valium slowly. They persuaded me that it would be a good plan to take Largactyl (200mg./day) and Anafranil (a tricyclic antidepressant 150mg./day) to help "ease the pain" and "provide extra inner space" with which to engage in their artistic therapies (painting, sculpture and eurythmy). At no stage had I exhibited any symptoms of psychosis, nor did they think that I had. They appear to regard these drugs as innocuous and almost 'herbal'. They assured me that these drugs had few side effects and no serious ones; they mentioned only 'increased photosensitivity' and 'difficulty in micturation'. It is well known amongst experts that these 2 types of drug should not be mixed as their side effect profiles are very similar; in any case such polypharmacy is regarded by many as a very bad plan - the side effects are worsened and the actual 'therapeutic' effects become more unpredictable.

I ended up paying them a serious amount of money and staying for 18 months. I became too ill to leave. Although I did finally get off valium I regard the price as being way too high; I'm scared that I have been permanently damaged by Largactyl. I would not do this again. Basically I almost died. I started out not being particularly depressed, certainly not 'clinically'. I ended up profoundly despairing. I very seriously contemplated suicide. This was a direct result of the 2 drugs I was given. I was hardly eating, yet became 2 stones overweight and was growing breasts. Once again these are common and expected side effects of Largactyl; the two doctors were unaware of this connection even the latter is listed in the British National Formulary as 'gynaecomastia'. I was unaware of this connection; I trusted them and their 'clinical judgement'. It cost me dearly.

When I finally stopped the last half milligram of valium these other drugs were also stopped abruptly. They then packed me off to a drug rehabilitation unit run by a fundamentalist Christian ex pig farmer and his family. This caters for opiate and amphetamine addicts, who have often come straight from prison, and, in the main, have never had jobs. I was treated, as was everybody, as a cross between a criminal and a very naughty boy. Their 'treatment strategy' consisted of manual labour coupled with an attempt to uncover some evidence of childhood physical or sexual abuse - in every case. Their world view was not overcomplicated; they believe that every single word in the Bible is the literal and absolute truth and that anything at variance with this is probably the work of the devil: yoga, for example, is the devil's work.

Many times I was told with a glare that I was an 'addict'; this supposedly to explain my situation. I believe that during my time at the clinic and subsequently at the rehab. unit I was in the middle of complete insanity. I was very frightened and latterly became quite institutionalised. I don't believe a Monty Python sketch could have devised a more bizarre scenario. When I began to surface from the clubbing caused by the drugs and to question the wisdom of what was happening to me I was told that I was 'arrogant'. The clinic and the rehab. unit were entirely unconnected; they knew nothing in practice about each others operations. The latter seemed quite unable to appreciate the possibility that my state of disarray - basically fear and anxiety - may have been directly and entirely caused by 'medications' given to me by the medical profession and which I took in good faith: i.e. an 'iatrogenic' problem. After 20 weeks I had surfaced sufficiently from my drugging to appreciate that I was in a very inappropriate place and I left; that was the best decision I had made for quite some time. I have since been recovering.

During this time the crippling dysfunctionality directly caused by drugs was interpreted variously as some sort of spiritual crisis and/or as being indicative of characterological deficits: as I became progressively more debilitated at the clinic the good doctor advised me that I was 'crippled in thought, word and deed' by my 'acquired addictive tendencies'; he was never able to explain exactly what this was supposed to mean. In retrospect it's very clear to me that I was, in fact, crippled by polypharmacy - Largactyl in combination with Anafranil given to someone who was already addicted to Valium and trying to stop. Largactyl, especially, quite simply disables a person: that's what it does. There is, of course, no guarantee that simply because a person is taking such drugs that they do not have a preceding or entirely separate illness, dysfunction, neurosis, 'emotional problem' or whatever. I would argue strongly that there is no way of identifying any such problem whilst a person is taking such drugs; they completely confuse the issue.

I am extremely angry at what happened to me. I believe it is a complete disgrace. If I can help to prevent something similar happening to even one other person then maybe some good will have come from my experience. I used to believe that grown men and women, bright enough to get a medical degree, must have some minimal understanding of drugs they prescribe, and that they must have sensible level of 'clinical judgement'.

Someone who is withdrawing from a benzodiazepine drug may well find themselves in a very vulnerable position. It can be very tempting to take the advice of a medical person who represents themselves as an expert. I used to be reasonably bright. I have a first degree in Psychology and a Masters degree in Systems Analysis. Also I think that in some ways I am quite a durable

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character. These people, however, fooled me. Don't make the same mistake!

If anyone offers you any of these drugs I would suggest that you check it out for yourself. A good book about how to get off benzodiazepine drugs is (1); summaries relating to antipsychotic drugs can be read in (2), (3) and (4) below. These can all be obtained from a local library (via the inter library loan facility), or the ISDD (Institute for the Study of Drug Dependence (0171 -928 1211); Breggin's book is available from 'Mind Publications'(0181-519 2122).

If a medical person suggests to you or a loved one that antipsychotic or tricyclic antidepressant drugs are safe and would be good for you I would urge that you show them extracts from (2), (3) and (4) and ask them to explain to you whether they have had sight of this information before, and, if they have, precisely why they ignore it or disagree with it.

I am willing to expand on any of the above if it will help someone faced with making a choice about whether to accept these 'medications'. My address is 3, Ray Lodge, Ray Park Avenue, Maidenhead, Berkshire SL6 8DR

I would also be very interested to hear from anyone who has taken an antipsychotic drug for a significant length of time who feels that they have recovered. This bit is personal; I'm scared that I've been permanently damaged and I'm looking for some optimistic feedback.

Colin Hope

1. Shirly Trickett, 'Coming off Tranquillisers and Sleeping Pills - a Withdrawal Plan that Really Works', 2nd. Edition, Thorsons, 1991.
2. Martindale, 'The Extra Pharmacopoeia', 1993, Royal Pharmaceutical Society of Great Britain.
3. Andrew C. Bishop and Garfield Tourney, 'Antipsychotics' - chapter 7 from "Toxicology of CNS Depressants", Ed. I.K. Ho, CRC Press Inc., Boca Raton, Florida.
4. Peter Breggin, 'Toxic Psychiatry', Fontana, 1993.

Dear Reg,

Thank you for your letter of the 20th July. I'm sorry I've been so long in replying, but there has been a huge response from ht programme and there were many distressed people who needed prompt replies.

Thank you for your support and we at ECT Anon in turn offer ours. I should imagine that you have received copies of the UKAN survey on ECT? If not I enclose a copy. Their survey is now open until the end of August and you can still get copies from them.

I think it would be an excellent idea to co-operate. We want to compile written evidence about the true side effects of ECT. We are also concerned that ECT has in fact many long term side effects that are completely masked by professionals as symptoms of the patients conditions. We now believe from the growing mountain of evidence that research should be undertaken to establish the long-term effects of ECT. Any information you can pass onto us about the ECT experiences of your members would be of great value.

Many of our respondents mention drugs as being part of the pattern of abuse they have suffered, and I will begin to extract any information that will support your activities.

Although I would hesitate in sending out a questionnaire routinely with replies to peoples letters (which so often needs a very gentle, empathetic tone), from time to time, we mailshot everyone with a newsletter at which time I'd be happy to include your questionnaire if you care to send me a couple of hundred copies. It will be a few weeks yet before our next newsletter goes out. If you also have a newsletter you'd like to include that's fine.

SKY TV are planning a hard-hitting exposé of ECT later this year, in which we shall probably participate. We'll do what we can to draw the drug question into the overall picture during filming.

We'll keep in touch from now on and give you a call from time to time.

Kind regards,

Pat Butterfield

ECT Anonymous

If anyone has had a problem with ECT please contact ECT Anonymous at the address given in the Contact Addresses

SECTION 11 HUMOUR

One Liners

Doctor to patient on benzodiazepine addiction:

"Your problem is because you were born in the blitz"

"Your problem is you were born in a thunderstorm"

"These pills are OK, it's only the blue ones that are addictive"

"Get down on your knees and pray - you're an alcoholic"

"You'll never see an addict wake up in the night with withdrawal"

"You will take Valium for the rest of your life or I will not treat you"

"If you don't agree to ECT I will put you on a section"

"You have been abused by hospitals and the drug companies.....sue the bastards"

"Go away, I'm striking you off my patients list - I don't want addicts on my register"

Patient to doctor:

"I'm no longer frightened of hell because I've been there"

"It's funny I had a dream last night about the devil and he looked exactly like you"

Legal One Liners

"Don't judge a Judge by his judgement" - Anonymous disillusioned legal gentleman

"I have found the Valium Defence has greater sleep inducing properties than a bottle of benzos". - Venerable legal gentleman

SECTION 12 ADMININSTRATION

List of Co-ordinators and their Duties

Name	Activity
Dr R.F.Peart	Research
National Co-ordinator	Legal media, Press and TV Overseas Doctors Generic case expert contact Political European court
Mr Mike Jones	Legal Legal Aid Helpline/Counsellor Local Support group Media contact Political
Miss Liz Wood	Research Legal Newsletter Editor Overseas Treasurer
Mr Barry Merchant	Research Overseas Legal Counsellor Media Human Rights
Mr Dennis Veale	Political Graphics / Newsletter
Mrs Mary Baker	Helpline / Counsellor Local Support Group Newsletter finance Joint Planning Group Substance Misuse

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	Committee
Mrs Jean Rudge	Research
	Legal
	Overseas
	Prescriber
	Negligence
	Counsellor
Mr David Wheat	Legal
	Political
	Local Voluntary support group activities
Mrs Dorothy Carey	Research
	Legal
	Counsellor
	Local Media

Susan Bibby and John Atkins have withdrawn as VOT co-ordinators. We wish them well in their future activities.

We would like to welcome Jessica Hart who is assisting us in Scotland.

Contact Addresses

VOT CO-ORDINATORS

Midlands
Liz Wood
12 Berkeswell Close
Church Hill North
Redditch
B98 8SF

Leics & Derby
Mary Baker
104 St Marys Road
Market Harborough
Leicester
LE16 7DX
Tel: 01858 432905

Gtr Manchester
Dorothy Carey
22 Highbank Crive
East Didsbury
Manchester
M20 0QR
Tel: 0161 446 2069

Merseyside
Jean Rudge
6 Homestead Avenue
Old Roan
Liverpool
L30 8RW
Tel: 0151 531 1454

South West
Dennis Veale
17B Clarence Street
Dartmouth
Devon
TQ6 9NW
Tel: 01803 832623

Potteries
David Wheat
4 Neath Place
Sanford Hill,Longton
Stoke on Trent
ST3 5AL
Tel: 01782 593860

London
Barry Merchant
12D Worbeck Road
Anerley
London
SE20 7SW
Tel: 0181 778 7081

South:
Dr. R. F. Peart BSc PhD
Flat 9
Vale Lodge
Vale Road
Bournemouth
BH1 3SY
Tel: 01202 311689
Fax: 01202 311689 (By arrangement)
Fax: 01202 301222 (Shop Hours only)

Wales:
Mike Jones
55 Cwm Road
Dyserth, Clwyd
North Wales,
LL18 6BA
Tel: 01745-570076

OTHER CONTACTS

Institute for Study of Drug Dependence (ISDD)
Waterbridge House
32-36 Leman Street
London
SE1 0EE
Tel: 0171 928 1211

National Association for Mental Health (MIND)
Granta House
15/19 Broadway Stratford
London
E15 4BQ
Tel: 0181 519 2122

The Mental Health Foundation
17 Mortimer street
London
W1N 7RJ
Tel: 0171 580 0145

RELEASE
169 Commercial Street
London
E1 6BW
Tel: 0171 377 5905

Litigants In Person Society (LIPS)
Secretary - Janet Cole
8 Stanton Close
Elm Park
Cranleigh
Surrey
GU6 8UH
Tel: 01483 271540

United Kingdom Advocacy Network (UKAN)
Premier House
14 Cross Burgess Street
Sheffield
S1 2HG
Tel: 0114 272 8171

ECT Anonymous
14 Western Avenue
Riddlesden
Keighley
West Yorks
BD20 5DJ
Tel: 01535 661 493

SECTION 13 CONCLUSION

In Conclusion

This newsletter has been an experiment. I have tried to strike a balance between the stories of horror and the stories of hope. Please feel free to send me you comments about the contents and the format of this issue. I may not be able to satisfy everybody's demands but I will try to please as many people as possible.

Further editions will I hope include articles on:

- The Medical Myth Making Machine (M4)
- An Overview of Addiction
- Recovery and Spirituality
- Long Term Cognitive Impairment
- The Psychology of Endurance

There will also be a spirituality profile. The next issue will include an article about Buddhism and Meditation written by Barry Merchant who is a practising Buddhist.

If you have any ideas for articles please write to me with your suggestions or send the finished article to me for printing.

I have a list of people to thank as long as my arm. So in order to be brief, many thanks must go to all who have been involved with VOT and this newsletter whether medical, legal, political or in whatever capacity.

Best wishes to all,

Liz Wood

Editor, 19/8/95

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