

ALL-PARTY PARLIAMENTARY GROUP ON
INVOLUNTARY
TRANQUILLISER
ADDICTION



SUBMISSION TO.
EQUALITIES AND HUMAN RIGHTS COMMISSION

By Michael Behan, Parliamentary Researcher to
Jim Dobbin MP, Chair of the APPG on ITA

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1. Introduction

Thankyou for your letter of 19th June in which you invited the APPG to submit information. This is a submission from the All Party Parliamentary Group on Involuntary Tranquilliser Addiction (APPG on ITA) to the EHRC providing information on aspects of tranquilliser addiction, with regard to discrimination by the Department of Health and Department of Work and Pensions against involuntary tranquilliser addicts, on the basis of their illness and disability.

2. Tranquillisers

Benzodiazepine tranquillisers such as Diazepam (Valium), Lorazepam (Ativan) and Nitrazepam (Mogadon) were introduced by the pharmaceutical companies in the 1960s with exaggerated claims for their indications, efficacy and safety. Benzodiazepines are highly addictive and toxic. At any given time in the UK there are an estimated 1.5 million benzodiazepine addicts.

‘Z’ tranquillisers such as Zopiclone were introduced in the 1990s as a safer option but have proved to be as bad or worse. An estimated 0.5 million people are addicted to Z drugs.

Tranquilliser side-effects occur during addiction as a result of the build up of toxic chemicals within the body. These side-effects are physical, psychological and neurological. They are painful, intense, bizarre and progressive; an addict may suffer 20-30 different side-effects contemporaneously.

If tranquilliser withdrawal is undertaken, additional withdrawal symptoms will occur. When the addict has reduced their dosage to zero, they may be left with numerous symptoms of long-term or permanent damage. This is known as the Protracted Withdrawal Syndrome.

Tranquilliser addiction is a treatable illness - it is possible to withdraw from tranquillisers. Withdrawal has been scientifically studied by Professor H. Ashton, Emeritus Professor of Clinical Psychopharmacology at the University of Newcastle, who ran a benzodiazepine withdrawal clinic from 1982-94 and designed a tapered tranquilliser withdrawal system. That withdrawal system has been produced in a booklet form, “Protocol for the Treatment of Benzodiazepine Withdrawal” and is used successfully and worldwide.

Safe and successful tranquilliser withdrawal can take from 6 months to 2 years. Patients need large amounts of support and reassurance during withdrawal, sometimes on a daily basis.

The benzodiazepine clinical trials show that the problems were well known to the manufacturers from the 1960s. For commercial reasons the negative information was withheld and benzodiazepines were marketed, particularly in the U.K., as a wonder drug, non-addictive, very safe, with few side-effects, and appropriate for almost any medical condition.

Benzodiazepines were granted full product licences in the U.K. without any assessment of safety or efficacy. Licences were issued by the Committee on Safety of Medicines (CSM), which was then a part of the Department of Health. Benzodiazepines were wildly over-prescribed as a result of a promotional campaign by the manufacturers and became firmly entrenched in prescribing practice. The highly addictive properties of benzodiazepine mean that even a short initial prescription can result in a patient becoming an unknowing and involuntary addict for many years or decades.

During the 1990s the pharmaceutical manufacturers gradually conceded, in their prescribing information, many of the previously denied problems with their drugs. Prescribing guidelines limit use to 2-4 weeks. However doctors have continued to prescribe at very high levels. According to a recent answer by the Department of Health to a Parliamentary Question by Jim Dobbin M.P., there were over 17 million tranquilliser prescriptions in 2008, a 2% increase on 2007. Prescribers are ignoring the manufacturers' warning, such as the 2-4 week limit, and have perpetuated the tranquilliser problem.

The manufacturers have taken no corrective action; they are happy to sit back and continue to sell benzodiazepines and 'Z' tranquillisers at whatever demand level occurs.

By Involuntary Tranquilliser Addicts, we mean normal people who have become addicted to prescription tranquillisers through no fault of their own. They have been introduced to these drugs by their doctor without proper warnings of the danger involved, of addiction and side-effects, and have not made an informed choice.

Tranquilliser withdrawal is a complex and painful process and many addicts are unable to withdraw without expert information and support. No treatment is provided by the Department of Health for Involuntary Tranquilliser Addiction, with the exception of two workers in Oldham and three in Belfast. Small tranquilliser withdrawal charities also exist, such as CITA (Council for Information on Tranquillisers and Anti-Depressants) in Liverpool, and BAT (Battle Against Tranquillisers) in Bristol.

3. Discrimination by the Department of Health

This is the first part of the complaint - that the Department of Health systematically discriminates against Involuntary Tranquilliser Addicts by refusing them medical treatment for their illness. It is an illness that the Heath Service has created, through over prescribing by doctors, by not enforcing guidelines and by poor regulation.

The effect of the discrimination of refusing treatment is to abandon patients to continued addiction. Like all drug addictions, tranquilliser addiction is misery for the addicts and they suffer loss of health, jobs, marriage and homes. Tranquilliser addiction is a progressive illness, the longer it continues the worse it becomes. Over time, tolerance and dose escalation can occur, side effects can increase, withdrawal becomes more difficult for each year of addiction, the post-withdrawal period will become longer and the rate of permanent damage will increase.

The Department of Health has resisted the call for tranquilliser withdrawal services for over 20 years and this is well documented. From 1997 the "Beat the Benzos" campaign lobbied for services, led by Phil Woolas M.P., now a Home Office Minister. This is recorded in a long correspondence, in Parliamentary Questions, Early Day Motions, a Parliamentary Debate in 1999, and a BBC Panorama programme.

In the last 18 months Jim Dobbin MP formed the All Party Parliamentary Group (APPG) on Involuntary Tranquilliser Addiction (ITA). The APPG has particularly focussed on requesting treatment services and again this is recorded in Parliamentary Questions, EDMs, correspondence with Ministers and unsuccessful requests for meetings.

The Department of Health response is to say that the 152 PCTs are responsible for providing tranquilliser withdrawal services. The Department of Health does not provide a budget to the PCT for tranquilliser services, and no targets are set, thereby ensuring that, in practice, no services can be established.

Also the Department of Health does not recognise or treat the tranquilliser protracted withdrawal syndrome suffered by many former tranquilliser addicts who have withdrawn by themselves, or with the aid of the charities. This is another form of discrimination, which results in former addicts having to try to treat themselves for a condition that can last many years and can be extremely debilitating, and can be permanent in nature.

4. Discrimination by the Department for Work and Pensions

The second major discrimination against involuntary tranquilliser addicts comes from the DWP, who discriminate in two areas; benefit payment and back to work assistance.

Involuntary tranquilliser addicts often become unable to work as a result of the effects of their addiction. However, they have great difficulty obtaining appropriate benefits from local DWP offices and at tribunals or appeals. For benefit purposes the DWP does not accept that there is such an illness.

Involuntary tranquilliser addicts often have to try and argue their case from first principles. They are required to prove, to a high standard, that there is such a condition, that they suffer from it and certain symptoms have resulted. They often suffer from debilitating symptoms as a result of the drugs. Cognitive impairment and agoraphobia, for example, are very common in tranquilliser addiction, withdrawal, and post-withdrawal. DWP tribunals often rely for medical advice on retired G.P.s who may have spent their own careers over-prescribing tranquillisers and therefore not accept that they are addictive or toxic.

Regarding back to work assistance there is no special programme, rehabilitation or help for withdrawn involuntary tranquilliser addicts who want to return to work. The recent implementation by the DWP of the Welfare Reform Bill has increased discrimination by explicitly excluding ITA from the regime introduced. Pilot projects for only heroin and crack addicts have been set up. In correspondence the DWP

ministers have said that programmes may be extended to ITA if the heroin and crack pilots are successful.

5. Discrimination by statistics

A third form of discrimination against ITA is a virtual prohibition across government on the collection of any information or data on the subject. For example, no government department has ever counted the number of involuntary tranquilliser addicts, the number of ex-addicts, the numbers permanently disabled, the numbers on both tranquillisers and Disability Benefit, the numbers of tranquilliser damaged babies or the number of babies born addicted to tranquillisers.

In comparison there are mountains of official statistics on illegal drug addicts. For example a 200 page statistical report on drug use has just been produced by the Association of Public Health Observatories (APHO), commissioned by the Chief Medical Officer, Sir Liam Donaldson.

6. Human Rights Issues

We also believe there are Human Rights aspects to involuntary tranquilliser addiction. Tranquillisers have very limited medical use, and they do not cure any illnesses. The maximum claim now made is that they can alleviate the physical symptoms of anxiety for a number of weeks.

The overwhelming reason that doctors prescribe tranquillisers is to feed the addictions that they have created. In effect tranquilliser addiction can be a form of torture as patients are slowly and painfully poisoned without their knowledge or consent.

Between 1990 and 1996 the Home Office collected statistics for benzodiazepine related deaths as part of a statistical summary of controlled drug deaths. The statistics show Benzo related deaths to be 300 per annum, during this period they exceed the deaths for all class A drugs added together. Professor Heather Ashton of Newcastle University has calculated that these deaths when added to benzo-related Road Traffic Accidents give a total of 17,000 benzo-related deaths.

The tranquilliser problem has existed for nearly fifty years. Governments from both parties have failed to take action and have allowed the problem to continue.

7. Legislation

I believe that an involuntary tranquilliser addict falls clearly within the definition of a Disabled Person as defined by Statutory Instrument 1996 No 1455, The Disability Discrimination (Meaning of Disability) Regulations 1996 Para. 3.

“Addictions

3. – (1). Subject to paragraph (2) below, addiction to alcohol, nicotine or any other substance is to be treated as not amounting to an impairment for the purposes of the Act.

(2) Paragraph (1) above does not apply to addiction which was originally the result of administration of medically prescribed drugs or other medical treatment.”

8. Conclusion

This submission has identified five different areas of discrimination by government against involuntary tranquilliser addicts.

- 1) Exclusion from appropriate medical treatment by the Department of Health.
- 2) Failure to treat or recognise the tranquilliser post-withdrawal syndrome by the Department of Health.
- 3) Non-recognition of the illness of Involuntary Tranquilliser Addiction or Post Withdrawal Syndrome in processing benefit claims. (DWP)
- 4) Failure to provide back to work support or rehabilitation for tranquilliser addicts and ex-addicts, particularly in the arrangements introduced under the Welfare Reform Bill. (DWP)
- 5) Failure to collect statistics on ITA, by all departments.

Additionally, we believe that there are human rights issues.

The discrimination is large scale, long-standing and deliberate. Government Departments are aware that they are discriminating but reject the available solutions. The discrimination has disastrous effects on the lives of those affected. There is also a social cost to this discrimination in that those affected often become unable to work and have to live on benefit with no productive output.