Earl Howe
Under-Secretary of State, Department of Health
House of Lords
London
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20 Greenacre Court
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20th October 2010

Dear Earl Howe,

I wrote to you in February of this year when you were Opposition Spokesman for Health. I brought to your attention the incidence of widespread involuntary tranquilliser addiction caused by the health service over a period of 40 years. I did this as an ex-involuntary addict of Ativan for 35 years who had to use voluntary organisations to withdraw as my PCT was unable to offer safe withdrawal treatment.

You replied acknowledging that ministers had been alerted to the problems inherent in benzodiazepines in the past and that you were writing to Baroness Thornton, then Health Minister, asking her to consider what more might be done to promote patient safety in this area in the future. You went on further to explain that several possibilities had occurred to you and that the Department of Health was working with the MHRA on some revised prescribing guidelines and that you felt this should be pursued vigorously.

You also stated that you hoped you had shown me that, as a member of the opposition health team, you took my situation extremely seriously. I have not heard from you since.

Revision of prescribing guidelines was one of the items on the original programme of work when the review started in July 2009. Why has this item been removed from the list since you became Under-Secretary of State for Health?

I would also ask you to answer the following questions:

1. In a recent letter to me Professor Field, Chair of Council of the Royal College of General Practitioners, stated that he has not been approached by the Department of Health for any contribution to the review. Why have GPs, as the main body of prescribers of benzodiazepines, been excluded from the review?

2. In August, in a written question, The Earl of Sandwich asked Her Majesty's Government:

'What guidelines they are giving to the medical profession in the light of recent comments by Professor Steven Field, Chairman of the Council of the Royal College of General Practitioners, that benzodiazepines and tranquillisers should be prescribed "only for a few days" because of the risks of addiction HL1952'.

You, as Parliamentary Under-Secretary of State (Department of Health) replied:

'Professor Field's comments are consistent with the British National Formulary's guidance to prescribers on the use of benzodiazepines and tranquillisers.'

Your response was incorrect as Professor Field's comment 'it can be 3-4 days of the drug before they get hooked' is not consistent, as you stated, with the 2-4 weeks current guidelines as originally issued by the CRM in 1980. I am disappointed that the Under-Secretary of State for Health does not know the current BNF guidelines especially when it is the subject of a Parliamentary Question. It is precisely this lack of knowledge and understanding that has caused involuntary tranquilliser addiction to continue for so long. I would like a response to the original question put by the Earl of Sandwich as it remains unanswered.

The following questions arise from the recent debate on the progress of the current review of dependence on, and withdrawal from, benzodiazepines and other prescribed drugs' in the House of Lords on 6th October:

3. You question the validity of the estimate of 1.5 million involuntary addicts given by Panorama ten years ago, but this figure was also based on a study conducted by Professor Ashton, Emeritus Professor of Clinical Psychopharmacology at the University of Newcastle. The prescribing statistics also point to this level of addiction with 11.5 million prescriptions for benzodiazepines and 5.5 million prescriptions for z drugs being issued in 2008.

The only explanation for the issue of these 17 million tranquilliser prescriptions per year must be to sustain widespread long-term addiction. How else do you explain these high prescription numbers for tranquillisers?

You stated that 'The true scale of the problem is hard to quantify' yet in a Departmental briefing to Gillian Merron MP, then Public Health Minister, prior to a visit to Oldham Benzo Withdrawal Clinic on Monday 21st September 2009, under 'Annex G Policy Briefing' it reads:

'Scale of the problem: ***[Redacted under Section [35(1)(a)]*** *are addicted to tranquilisers and sleeping medications.'*

Why did you state that 'The true scale of the problem is hard to quantify' when the figure has clearly been quantified by the Department of Health at least as far back as September 2009 and has been redacted from a FOI document and omitted from your speech? You said that it is a 'hidden problem' but you are the person responsible for hiding it. Please can you now disclose this redacted information which should have been given in reply to questions in the debate?

4. I originally contacted the Department of Health on the subject of prescribed benzodiazepine addiction in February 2010. The Department deflected my enquiries and those of others, including MPs, by referring to this review.

A response to a FOI request regarding the review on 13th August stated that 'The additional information about the three items requested cannot be sent at the present time as work on the first (literature) is not yet complete and the second two items weeks.'

Neither the FOI team nor the Department of Health have denied the accuracy of this statement.

The review started in July 2009. This means that no work has been carried out for a year apart from the vague 'literature' element which is meaningless to patients. Why has so little work been done if the Department takes this problem seriously?

5. You state that you disagree that the Drug and Alcohol Action Teams are not best placed to help people yet it is they who have been responsible for abrupt withdrawals. Only recently, a patient referred to them was placed in a room with a heroin addict, had their possessions removed, was shouted at for not having enough willpower and had their diazepam reduced by fifty per cent in a week. Abrupt withdrawals of tranquillisers have in the past caused seizures and fatality.

Could you please give me your reasons why DAATs should be preferable to organisations with proven expertise and success in safe withdrawals such as CITA in Liverpool, Bristol and District Tranquiliser Project and BAT in Bristol and Oldham Withdrawal Clinic?

6. Would you also provide me with statistics of how many people on prescribed benzodiazepines have successfully withdrawn using services supplied by DAATs.

7. Lord Mancroft stated that:

'What is clear is that responsibility for researching it in order to fill the very real gaps in our knowledge, and for producing a plan to tackle the problem, lies fair and square with the Department of Health, the Royal Colleges in particular those for general practitioners and psychiatrists-and the pharmaceutical industry, which produces and profits from these drugs. It is clear that all three have been guilty of a quite staggering degree of complacency, which amounts to a gross dereliction of duty.

The Department of Health is focussing on the delayed and depleted programme of work of the review and has deflected attention away from other main issues which are not included in the review, some of which are:

a) Long-term or permanent damage caused by benzodiazepines.
b) Disability and inability to work caused by benzodiazepines.
c) Fatalities including suicide, seizures, respiratory depression etc caused by benzodiazepines.
d) Premature death caused by benzodiazepine induced ill-health - use of sleeping pills and minor tranquilizers increases the risk of premature death by more than a third according to a study published in the September 2010 issue of the *Canadian Journal of Psychiatry*.
e) Benzodiazepine teratogenicity - children exposed in utero to benzodiazepines had characteristic dysmorphic features, growth aberrations, and central nervous system abnormalities from birth.
f) Benzo babies usually develop such disabilities as dyslexia, the movement disorder dyspraxia, attention deficit disorder and hyperactivity (J Yanai, ed: *Neurobehavioral Teratology*, Elservier Science Publishers By, 1984).

Their problems are also compounded by a plethora of other ailments, such as chronic fatigue, ME, epilepsy, mental illness, pain and panic attacks. Research also shows that many of them suffer eye problems.

Other problems include undescended testides, craniofacial abnormalities, renal abnormalities, inguinal hernias, cardiac defects and stomach abnormalities (*J Pediatrics*, 1989; 114:126-31).

When will the Department of Health look at these issues?

8. The NTA is due to be abolished in the forthcoming development of the new Public Health Service; will continuity be assured?

Will the review proceed in its current form, who will conduct it and what is the timetable is now?

9. Baroness Thornton stated that:

'I understand that the extended review includes a literature review, an audit of selected PCT prescribing data and a survey of the withdrawal assistance that is available from the voluntary sector. However, many believe the review to be a case of too little, too late. The terms of reference have been shrunk; the completion date is repeatedly extended; and patients have been excluded from the process. This is a far from satisfactory situation and I hope that the Minister will be able to give us more comfort than seems apparent. It is simply not acceptable in these days of sophisticated medication that people should take prescribed drugs in good faith and then find themselves incapacitated when they try to stop taking them.'

This list of items in the review was supplied by the Department in a letter to me on 15th April 2010:

1. prevalence: to help determine the extent and severity of the problem of dependence on prescribed and over-the-counter (OTC) drugs;
2. prevention: to assess the effectiveness of clinical governance in this field, including the provision of guidance for prescribers of benzodiazepines and other drugs;
3. provision of treatment services: to find out what services are available to support people needing treatment for dependence on these drugs;
4. policy leadership: to establish how the Department might improve its communication between interested parties; and
5. discrimination against people who may have become disabled as a result of their dependence on medicine.'

According to the briefing provided to Gillian Merron in Septmber 2009 the Department were also commissioning research into the long-term effects of using benzodiazepines and z drugs.

This has since shrunk to:

1. a literature review on published evidence;

2. an audit of primary care trust prescribing records to assess the scale of over-prescribing; and
3. an audit of addiction clinicians to map the assistance that is available to help people withdraw from prescription and over-the-counter medicines….'

This shrunken review started in July 2009 and no work had been carried out on items 2 and 3 for a year at least and, as Baroness Thornton states, the completion date has been repeatedly extended.

You stated in your speech that 'This is an issue of considerable importance' which 'I and my ministerial colleagues take extremely seriously'. How do you reconcile your views in your speech, and when in opposition, with such inaction, shrinkage and delay?

10. You claimed that the MHRA made improvements as a result of the Health Select Committee's recommendations in their Report on the Influence of the Pharmaceutical Industry. The MHRA made "improvements" to suit the pharmaceutical industry, not to protect patients. Here are examples of relevant HSC recommendations that were not taken up:

Recommendation 18 (paragraph 32): We recommend that there should be a public inquiry whenever a drug is withdrawn on health grounds.

Recommendation 20 (paragraph 36): We recommend that there be an independent review of the MHRA.Recommendation 32 (paragraph 48): We recommend that responsibility for representing the interests of the pharmaceutical industry should move into the remit of the Department of Trade and Industry to enable the Department of Health to concentrate solely on medicines regulation and the promotion of health.

Recommendation 28 (paragraph 44): We recommend that the Government fund: a multi-disciplinary investigation of existing medicines, combinations of medicines and medicines use where there is a reluctance of the industry to fund such research; research into the adverse health effects of medicalisation; and trials of non-drug approaches to treatment.

Recommendation 29 (paragraph 45): We recommend that the extent, cost and implications of illness resulting from the use of medicines be systematically investigated by the Department of Health in conjunction with the MHRA.

The MHRA and its predecessors have systematically defended tranquillisers and the pharmaceutical manufacturers for 40 years; I consider them to be part of the problem.

The key recommendation of the Health Select Committee Report of 2004/5 of the enquiry into 'The Influence of the Pharmaceutical Industry' was:

'In view of the failings of the MHRA, we recommend a fundamental review of the organisation.'

Why have the MHRA been appointed as internal stakeholders of the review when they have such a conflict of interest?

11. You further stated that ‘As a result, the MHRA has made a number of improvements given the concerns in the report. Time prevents me from reading them.’ The government response at the time disallowed any changes which would have enhanced patient safety and only implemented changes favourable towards the pharmaceutical industry. Which improvements were you referring to?

The following questions and points were asked by speakers in the debate and you did not answer them therefore would you please answer them now:

1. Earl of Sandwich:

a) ‘Why do doctors prescribe them so freely if they provide temporary relief for so little time and never cure the original problem? There should be stricter controls and these drugs should be rescheduled and reclassified as class A.’

b) ‘It is pitiful that a problem of this severity, and on this scale, has been allowed to get worse over so many years when so much has been known empirically for so long.’

c) ‘Instead of further consultation within the institutions, why not immediately set up a working party to develop best practice and to set up pilot projects, using the expertise already in place in many areas?’

d) ‘When, for example, will the Government support the largely voluntary services in Liverpool, Bristol, Newcastle, Belfast and elsewhere that are already helping victims of these drugs and bring them within the range of the NHS?’

2. Lord Mancroft:

a) ‘I could argue that the National Treatment Agency's main area of expertise lies in prescribing drugs such as methadone rather than in helping patients off drugs altogether, which could suggest that it is part of the problem rather than part of the solution.’

3. Baroness Thornton:

a) ‘Will the Minister explain what the future holds for psychological therapies? With GP commissioning coming down the track, this seems to be yet another matter that is riven with uncertainties.’

b) ‘Can the Minister assure the House that steps being taken to strengthen the law will ensure that there can be no doubt as to companies' obligations to report safety issues?’

I would ask you to answer this letter personally rather than forwarding it to the Customer Services Centre at the Department of Health. Their responses to date have been inadequate, dismissive and unhelpful, not only to me, but also to many other members of the public, academics and MPs who have written to express their concerns regarding this issue since 1980. I am in the process of forwarding complaints

regarding the Department of Health's response to the issue of involuntary tranquilliser addiction to the Parliamentary and Health Service Ombudsman.

Thank you for your continuing help in this matter,

Yours sincerely

John Perrott

CCs:
Anne Milton MP Minister for Public Health
Jim Dobbin MP Chair of the All Party Parliamentary Group for Involuntary Tranquilliser Addiction
Lord Sandwich Vice Chair
Lord Mancroft
Baroness Thornton
Baroness Bottomley
Eric Ollerenshaw MP
Phil Woolas MP
Kelvin Hopkins MP
Bill Cash MP
Greg Mulholland MP
Professor Heather Ashton
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