Antidepressant Medication

Critical Appraisal
Antidepressants are prescribed on the evidence provided by pharmaceutical companies; this is a dubious source for reliable information due to conflict of interests.

Whilst some antidepressant physical Adverse Drug Reactions (ADRs) are recognised by UK Health and Social Care Practitioners (HSCPs), psychological ADRs remain unknown, primarily due to selective reporting by UK reputable medical sources.

Consequently incomplete antidepressant information filters through mainstream literature and ‘acceptable’ channels to HSCPs, patients and carers. This is unacceptable, as these sources do not provide the full picture exposed by antidepressant research.

This document provides a balanced and transparent report including depression hypothesis, antidepressant science, similarities between antidepressants and street drugs, psychological ADRs informed consent and the politics of medication within UK NICE, NHS and DH.
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Antidepressant “Science”
Chemical Imbalance Theory of Depression

Even though neurotransmitter theories for depression have shifted over time, pharmaceutical companies perpetually promote the chemical imbalance theory for depression.\(^1\) Although an enormous amount of money and time has been spent in this quest,\(^2\) each time a new hypothesis for imbalance arose, it was later proven false.\(^3\)

There has been no convincing evidence that monoamine deficiency or pre-existing imbalance of serotonin, dopamine or norepinephrine, have ever been clearly or consistently confirmed as a source of depression.\(^2\)-\(^5\)

The uncertainty of how antidepressants work is depicted in both Eli Lilly’s Cymbalta website,\(^6\) and The Royal College of Psychiatrists (RCP).\(^7\) Since there is no technique for measuring precise levels of neurotransmitters within the brain, claims about chemical imbalances remain unfeasible.\(^1\)
Chemical Imbalance Theory of Depression

In the 1970 & 1980 the serotonin excess hypothesis was absolute\(^8\)\(^-\)\(^{10}\) but “If it is possible for excessive serotonin transmission to contribute to psychological dysfunction then antidepressants - both serotonergic and noradrenergic - could be quite harmful since they all appear to induce prolonged elevations in the production of and release of serotonin.”\(^{11}\)

Despite there being no consistent body of evidence to demonstrate low serotonin and noradrenaline neurotransmitter levels cause, rather than arise from changes in mood thought and behaviour,\(^{11}\) antidepressants are still prescribed.

**Serotonin Selective Reuptake Inhibitor (SSRI) and Norepinephrine Selective Reuptake Inhibitor (SNRI)** antidepressant disruption of serotonin and noradrenaline neurotransmitters\(^{12}\) could account for the harmful psychological adverse effects, e.g. neuropsychiatric suicide,\(^{13},^{14}\) mania,\(^{15},^{16}\) hallucinations and psychosis.\(^{16}\)
Dangers Involving SSRI Antidepressants

In a lecture (Gothenburg, Sweden 2009), the 2000 Nobel prize laureate, Arvid Carlsson, “promoted the use of ‘kinder’ medicines than the ones resulting from his own findings, the SSRI medicines (i.e. Prozac, etc.).”

“There are too many strong and harsh medicines… the ‘diagnostic science’ used in the psychotropc medicine field is no more a ‘science’ than someone experimenting with spices in their own kitchen.”

“One tries this and that, and the diagnosis is very often arbitrary”.17
Antidepressants and Placebo

Articles exposing drug companies’ undisclosed reports of clinical trials\textsuperscript{18, 19} show that antidepressants work no better than placebo\textsuperscript{20–22}. This pertinent information is not taken into account by NICE Clinical Guidelines for Depression,\textsuperscript{23} which is an acknowledged leading source of authority for treatment of depression.

The suitability of antidepressant medication prescribing is questionable when antidepressants, with all the “side effects” which many patients find difficult to endure, are no better than a harmless placebo.
Street Drug Effects and SSRI Reactions

LSD, PCP and other psychedelic drugs are taken with the objective of inducing hallucinatory ‘effects’. Street drugs are serotonin releasers, and are therefore serotonergic drugs, resulting in serotonin toxicity due to serotonin increase. Since SSRIs are also serotonergic drugs causing serotonin increase, there is potential for SSRIs to induce hallucinatory effects.12

Just as psychedelic hallucinatory ‘effects’ are unpredictable, the current unpredictability of SSRIs in provoking hallucinatory ‘effects’ is left to chance due to lack of genetic metabolism testing, to ascertain SSRIs can be metabolised efficiently prior to prescribing.

Both SSRI drugs and LSD use can cause serotonin syndrome, resulting from serotonin toxicity.27

Because of the similarities between SSRI and LSD ‘effects’ caused by serotonin toxicities; ‘effects’ are more appropriately redefined as ADR (Adverse Drug Reactions).
## Antidepressant ‘Safety’ Issues

Pharmaceutical Industry funded publications are more likely to show favourable outcomes. The incomplete data and lack of information on the quality of industry drug trial design have thwarted researchers in being able to determine whether medications are effective or safe.\(^{28,29}\)

Data outside main-stream literature depicts serious antidepressant psychological ADRs,\(^{30}\) including neuropsychiatric mania and psychosis, altered personality, violence, aggression and suicidality.\(^{11}\) Other neuropsychiatric ADRs include suicide, completed suicide\(^ {31}\) and self-harming behaviour.\(^ {32}\)

Long lasting depression may result from antidepressant use due to chemical disruption.\(^ {11}\)
Antidepressant ‘Safety’ Issues

The mischaracterisation of antidepressant safety is encapsulated by personal experience:

“(people) assert there has never been anything like that in their minds before and yet now they have suddenly become excessively concerned with suicide and may even do it”

The risks of antidepressants for some people far outweigh any perceived benefit.

Dr. David Healy, estimated that "probably 50,000 people have committed suicide on Prozac since its launch, over and above the number who would have done so if left untreated."
Antidepressant Long Term Issues
Pharmaceutical Drug Trials

Antidepressant drug trials are conducted for a relatively short time period, usually 6-8 weeks\textsuperscript{35} in comparison with the length of time a person medicates with antidepressants. Pharmaceutical literature data depicts short-term ADRs only and the industry fails to take into account the long-term ADRs that occur due to brain changes - “plasticity” - in adapting to repeated use of antidepressants.\textsuperscript{17,36}

Once a drug is accepted and marketed there is no incentive for drug companies to research into the long-term ADRs, therefore long-term industry sponsored drug trials do not take place. Consequently in mainstream literature the potential long-term ADRs from long-term exposure to antidepressants are unknown to HSCPs and patients.
Long- term Medication and the Brain

The “plasticity” brain changes resulting from long-term antidepressant use can be found in epidemiology studies\textsuperscript{36} and include:

"...changes in receptor density, changes in receptor sensitivity, and changes in the cellular processes which control neurochemical synthesis and release."\textsuperscript{36}

"...chemical therapies alter gene expression and re-wire brain circuits in ways that can result in delayed or persistent harm"\textsuperscript{36}

Scientific literature rarely discusses how psychiatric medication causes Chronic Brain Impairment syndrome\textsuperscript{37} resulting in long-term ADRs such as chronic neuropsychiatric physical conditions such as Dementia, Strokes and Parkinsons disease,\textsuperscript{36, 38} which by nature of the conditions may incur depression.

These long-term “side effects” indicate antidepressants taken long term are not safe medications.
Suppressed History of Antidepressants

“The possibility that medications designed to alleviate depression and thoughts of suicide might paradoxically induce them, has been known by the medical profession, the pharmaceutical industry and Govt. (FDA) for more than 40 years”\(^\text{11}\)

Drug companies minimise the truth about psychological ADRs or keep them hidden. GlaxoSmithKline practiced selective drug reporting as suicidal thoughts and negative behaviour are hidden by the umbrella term ‘emotional lability’ and mania being edited out.\(^\text{39,40}\)

From the mid–1980s Elli Lilly tried to hide its own evidence of the link with Prozac and suicide by misrepresenting the truth: “Internal documents show that in 1990, Lilly scientists were pressured by corporate executives to alter records on physician experiences with Prozac, changing mentions of suicide attempt to "overdose" and suicidal thoughts to "depression."\(^\text{34}\)
Suppressed History of Antidepressants

In 2000, prior to Prozac patent expiry, Lilly internal documents showed “… previously nonsuicidal patients who took the drug had a fivefold higher rate of suicides and suicide attempts than those on older antidepressants, and a threefold higher rate than those taking placebos.”

In 2001, as the patent on Prozac was about to expire, Eli Lilly, prepared to launch a new and improved Prozac called R-fluoxetine, which would not produce several exiting significant side effects such as "inner restlessness (akathisia), suicidal thoughts and self-mutilation".
Suppressed History of Antidepressants

Despite Lilly’s dispute about Prozac significant side effects, some 200 lawsuits were made against Lilly over the past decade, most of which were settled out of court with the terms kept confidential.\textsuperscript{34}

It is ironic that Lilly’s own studies say otherwise and to compound the situation, Lilly has aggressively sought to discredit researchers who published data linking Prozac to suicide, such as Dr. Joseph Glenmullen, whose book "Prozac Backlash"\textsuperscript{3} has upset and angered Lilly executives.

The new improved Prozac (R-Fluoxetine) was never developed by Lilly whose Prozac drug monogram\textsuperscript{16} reports suicidal thoughts hallucinations, psychosis and mania which are all significant psychological ADRs.
History of Antidepressants

Following the 2002 BBC Panorama on “Secrets of Seroxat” GlaxoSmithKline was asked to clarify the issue of the SSRI miscoded suicides.

Subsequently in 2003, in response to the information received, stern warnings were issued to clinicians in the UK. “Seroxat must not be used for treatment of children…shows increase in rate of self harm and potentially suicidal behaviour…”

2003 Wyeth, who produce SNRI Venlafaxine, voluntarily stated that “In paediatric clinical trials, there were increased reports of “hostility” and…suicide related adverse events such as suicidal ideation and self-harm” with Venlafaxine.
Children and Adolescents

2003 A Medicines and Healthcare products Regulatory Agency (MHRA) press release contraindicated paroxetine (seroxat), venlafaxine, sertraline, citalopram and escitalopram… in the under 18s because the risks of treatment outweighed the benefits in this age group,\textsuperscript{45} risks referring to induced psychiatric disorders depicted in drug monographs such as suicidal adverse events, delusions, hallucinations, hypomania and psychosis.

According to MHRA Prozac is suitable for children 8-18 years as it “appears to have a positive balance of risks and benefits in the treatment of depressive illness…”\textsuperscript{45} despite MHRA reports of suicidal-related behaviour in this age group.\textsuperscript{46} The age range is confirmed in Lilly’s Prozac Patient Information Leaflet (PIL), which states Prozac can “be offered” to children 8 year and above,\textsuperscript{47} but is contraindicated in Lilly’s Prozac Drug monogram\textsuperscript{16} which states “Prozac is not indicated for use for children under 18 year of age.”
Children and Adolescents

Despite the strong links between SSRIs and induced suicide,\textsuperscript{35, 48-50} which is more common compared with suicide in tricyclic antidepressant treatment,\textsuperscript{51} and the many anecdotal experiences of suicide in adults taking antidepressants,\textsuperscript{50, 52} the MHRA does not recognise the risks of SSRI treatment outweigh the benefits in adults.

Whether under or over 18 years of age, if a person is unable to genetically process/metabolise antidepressants efficiently, mania, hallucinations, psychosis and suicidal susceptibility will continue.

Age does not change genetic metabolising status.
Consent to Treatment

All mental health and social care practitioners - doctors, psychologists, social workers and nurses - need to be fully informed about antidepressant treatment because they are the primary contact for health advice, information and treatment for patients. Patients see HSCPs as authoritative and trustworthy.

Prescribers need to be fully informed about antidepressant ADRs before prescribing, to ascertain the chosen antidepressant medication is safe for the patient; they are responsible for writing prescriptions and accountable to patients when treatment causes ‘medical accidents.’

Being fully aware of potential antidepressant negative psychological and physical drug reactions, all HSCPs are in a position to be transparent with patients.

When patients are fully informed they are in a position to weigh up the balance of antidepressant ‘risks versus benefits’, thereby enabling a fully informed choice in consent to treatment.
Being Fully Informed

The difficulty is all patients and health practitioners *are not* aware of all the associated antidepressant adverse psychological ADRs, i.e. psychosis, mania, hallucinations and suicide\(^{13-16}\) long-term adverse physical ADRs\(^{36,37}\) and vulnerability to recurrent depression.\(^{11}\)

Consequently this results in some health practitioners and patients *not* being fully informed.

Practitioners’ lack of awareness of adverse negative psychological ADRs and additionally withdrawal effects is likely to cause confusion over interpretation of patients’ presentation. Negative behavioural conditions - ADRs during treatment could be regarded as psychosomatic when they should be attributable to medication.
Being Fully Informed

Naivety about all the antidepressant adverse psychological ADRs is due to selective drug company reporting and UK reputable bodies such as Choice and Medication\textsuperscript{53}, NICE Guidelines for Depression\textsuperscript{23}, Rethink\textsuperscript{54} and Patient UK\textsuperscript{55} being ‘economical’ with the truth.

It is understandable, but not excusable, adverse negative psychological ADRs are attributed to the patient and not the medication.
Healthcare Professionals, Pharmacogenetics and Antidepressants

Health providers’ main area for naivety about treatment lies with the association of how ADRs are related to pharmacogenetics.

Pharmacogenetics is the science of how medications are metabolised or broken down in the body. 75% of all psychotropic drugs are metabolised through CYP450 2D6 enzyme pathway found mainly in the liver.\(^56\)

Metabolism is determined genetically and variations in the individual affect medication therapeutic response and ADRs.\(^57,58\)

Most antidepressants are metabolised through CYP450 2D6 which is a highly variable enzyme regarding different rates of metabolism.
Healthcare Professionals, Pharmacogenetics and Antidepressants

Susceptibility to ADRs is due to genetic slower rates of metabolism, which incurs a build up of antidepressant toxicities. Medication toxicities appear as ADRs and include serotonin syndrome, mania and psychosis or suicide.

Inefficient metabolising enzyme pathways could account for 60% of depressed patients not responding completely to antidepressants with up to 30% who do not respond at all.

It is generally unknown there is a significant rate of hospital admissions due to antidepressant-associated adverse behavioural effects.
Best Possible Healthcare

Patients put their trust in their doctors and professional experts to provide the best possible health care.

It is inconceivable to patients that prescribed medications may worsen health, as they would in people who are genetically unable to break down medications efficiently.

Treatment related deaths due to unintentional drug related poisoning, when the cause of death remains unclear could be explained by pharmacogenetics.⁶⁰
Patient Safety

When prescribers are fully informed about the association of ADRs with antidepressants they will be in a better position to prevent ‘medical accidents’.

Due to the severe nature of antidepressant ADRs that can occur with these medications, a lot of suffering can be avoided by checking the pharmacogenetic status of patients is compatible with the prescribed antidepressant.

This ensures patient safety and potential misdiagnosis that could occur due to antidepressant psychological ADRs - the neuro-psychiatric reactions of suicidality, hallucinations, mania and psychosis mimicking psychiatric symptoms - is avoided.
Patient Properly Informed Consent

Fully informed consent to medication for all patients is currently not possible because doctors are not fully informed and the relevant full information is extremely hard to come by.
Reasons for Not Being Fully Informed

There are many facets that contribute to the current mainstream limited availability of antidepressant and pharmacogenetic information for HCSPs and patients.

Drug companies provide the primary source of antidepressant information. Before marketing in the EU, medicines have to be licensed by the European Medicines Agency (EMA).

Following the assessment within the MHRA by the Commission on Human Medicines (CHM) that investigates ADRs and advises accordingly on medicine safety, MHRA approves use of medicines in the UK.
**Reasons for Not Being Fully Informed**

Both the EMA and the MHRA rely heavily upon pharmaceutical industry funding receiving 75% and 100% of their funds from the industry. This together with academic institutions also accepting industry-sponsored research funding\(^62,63\) compromises relationships to the point of being incestuous. Such situations are not in the interests of patients, since the industry has a conflict of interests which can result in doctors and patients having little understanding of pharmacogenetics; risking unnecessary antidepressant psychological ADRs.

Within the industry, pharmacogenetics has been known about for 60 years\(^64\) and is used in drug trials to industries’ advantage. Yet drug companies do not incorporate pharmacogenetic information into their Summaries of Product Characteristics (SmPCs)\(^65\) and PILs\(^66\) which are required for each licensed medicine.
The main source of medication information used by UK prescribers is the **British National Formulary** (BNF). The BNF in turn has as it’s basis the SmPC provided by the pharmaceutical industry. As mentioned earlier drug companies exclude pharmacogenetic information leaving prescribers in ignorance about potential medication/gene interaction leading to serotonin toxicities and ADRs.

There are noticeable inconsistencies associated with the information contained within the BNF, SmPC and PILs. In Lilly’s Prozac PIL, the psychological ADRs, namely hallucinations, psychosis and mania are reported. However in Lilly’s SMPC, Lilly omits psychosis although does report hallucinations, a symptom of psychosis.

The BNF remarkably fails to include Lilly’s psychosis ADR which is reported in Lilly’s PIL.
British National Formulary

The BNF is compiled by two reputable medical bodies - The Royal Pharmaceutical Society (RPS) and the British Medical Association (BMA).

The RPS aspirations include recognition of pharmacists being “experts in medicine” and “advancement of science, practice and education in pharmacy”, whilst the BMA claims to “work closely with the Government and strive to make an impact on policy which affects you and your patients.” These aspirations appear to support their own professions in defending doctors’ interests and the development of pharmacists to fulfil their professional potential. However one cannot help noting HSCPs, carers and patients would be better served if pharmacogenetics was brought to the fore in the BNF.

The question needs to be begged – How trustworthy is the BNF for the benefit of patients?
Choice and Medication

Choice & Medication, (C&M) provides “information about medications used in the mental health setting to help people make informed decisions...”, and purports to provide “quality assured content, written by clinical experts based upon published data you can trust.”

When C&M do not acknowledge antidepressant-induced psychosis, mania, suicide, or include pharmacogenetic information, (despite having been made aware of this issue), it is questionable how much trust can be afforded to this organisation.

To make a “fully informed” choice through C&M is impossible because of relevant medication omissions, which could negatively impact upon patients.
Choice and Medication

C&M is a “spin off” from the CMHP\textsuperscript{72} which has a corporate partnership with Janssen, Lundbeck UK, Masters and Shire pharmaceutical industries. The CMHP evolved from The United Kingdom Psychiatric Pharmacy Group (UKPPG) that had members who declared receiving honoraria and fees, as well as monies to attend international conferences.

AstraZeneca funded the Maudsley Hospital psychotropic medication help line, which was actually the UKPPG helpline until 2007 when funding was withdrawn.

C&M and CMHP are popular sources used by UK mental health professionals, carers and patients and many would be unaware both these organisations have shortcomings in providing full information about antidepressants. Readers may be potentially misled into a false sense of security about the benefits as opposed to the serious risks of antidepressants incurred by some patients.
**Doctors’ Training**

**British Medical Schools** do not address pharmacogenetics in undergraduate training. Consequently, newly qualified doctors do not realise patients can have genetic susceptibility to ADRs.

Considering thousands of prescriptions are written daily, this is a huge gap in doctors’ primary training.

After graduation doctors are required to undergo further training - the obligatory **Foundation Programme**\(^7\) where doctors are required to “understand” the ‘genetic susceptibility to adverse reactions’. This one line is slotted in with many of the Safe prescribing competences; there is no indication that conveys ADRs are *toxicities* from medication due to genetic susceptibility. The term pharmacogenetics is absent from the entire curriculum, and therefore remains covert.
Doctors’ Training

The depth and transparency of specialist lecturers’ pharmacogenetic knowledge can only be speculated, particularly when some members of the General Medical Council are concerned about the amount of pharmaceutical company sponsorship available for doctors’ training.

Corporate influence is not always in the best interest of patients.⁷⁴
UK Government

The Health Minister Andrew Lansley and Deputy Prime Minister Nick Clegg, have received literature about pharmacogenetics, neuropsychiatric psychological and long-term physical “side effects” and iatrogenic depression caused by antidepressant drugs; depicted in “Drug Induced DEMENTIA- a perfect crime” a copy of which was given to Norman Lamb, Liberal Democrat Shadow Health Secretary and The Royal College of Psychiatrists in 2010.

UK Government and Professionals:
Key Opinion Leaders (KOL) who lead DH polices have consistently down played the importance of pharmacogenetics. This occurred in DH Mental Health Policies i.e. New Ways of Working for Mental Health Pharmacists, Improving Access to Psychological Therapies (IAPT), Medicines Management: Everybody’s Business and NICE.

NICE and IAPT members received information about antidepressant long-term physical ADRs and antidepressant iatrogenic depression.
Inappropriate Professional Behaviour

Attitudes and behaviour of some KOL leading DH policies, contribute to maintaining naivety.

When presented with research from ‘Drug Induced Dementia’ responses included from ‘You can’t believe everything you read’ to ‘NICE cannot know every thing’. Yet NICE is self acclaimed for its ‘clinical excellence’. ‘Antidepressant ADRs are not incorporated in IAPT and yet in the remit, treatment includes antidepressant medication.

Antidepressant “side effects” were dismissed by HSCPs as ‘No worse than breathing in the atmosphere’s toxicities’ and ‘If patients knew everything about “side effects” they would not take medication’.
Local Policies

KOL working in Care Trusts have influential power over local policy decisions, e.g. the prolific posting of yellow leaflets proclaiming: ‘There are no secrets about medicines’. Some acute wards provide general patient medication leaflets, many of which are selective about ADRs as professionally perceived ‘damaging’ details, which would likely deter patients from taking medications, are omitted. Another unscrupulous policy practice is for staff to address “side effects” which patients experience, but only on patient request. When staff are duty bound to support polices, for fear of reprisals lack of transparency clearly indicates:

‘There are secrets about medication’

Medications and secrecy have a history that is steeped in power firmly in the hands of the professional leaving patients powerless. 78-80
Collective Suppression of Information

To date, Ministers, DH and KOL have merely shelved the information. These bodies have taken a fully informed decision *not* to disclose the importance of the relevant critical information about pharmacogenetics and the ‘unknown’ short and long-term antidepressant neuropsychiatric effects.

Denial, defensiveness, arrogance, inflexibility and a ‘need-to-know’ stance enable DH conflicted initiatives to grow into mental health policies that are not upfront with fellow practitioners and patients.81

Collective irresponsible attitudes and behaviour all contribute to maintain doctors’ and patients’ ignorance about the true picture of antidepressants and pharmacogenetics.

When the ultimate safety of patients is forsaken; ‘jobs worth’ within the DH and the Government seems to become far more important.
Collectively, the public and health & social care practitioners are being misguided into thinking antidepressants are safe to use for all people with depression.
The Influence of the Pharmaceutical Industry

Fourth Report of Session 2004–05
In 2005 this UK Govt. Green Paper stated …

“Our consumption of drugs is vast and is increasing. About 650 million prescriptions are written each year by GPs alone. Medicines cost the NHS in England over £7 billion every year, 80% of which is spent on branded (patented) products. The industry which has produced these drugs has understandably been described as “world class and a jewel in the crown of the UK economy”. It is the third most profitable economic activity after tourism and finance.”

Extract from the House of Commons Health Committee 2004-05
The report continues…

“The consequences of lax oversight is that the industry’s influence has expanded and a number of practices have developed which act against the public interest. The industry affects every level of healthcare provision, from the drugs that are initially discovered and developed through clinical trials, to the promotion of drugs to the prescriber and the patient groups, to the prescription of medicines and the compilation of clinical guidelines.

We heard allegations that clinical trials were not adequately designed – that they could be designed to show the new drug in the best light – and sometimes fail to indicate the true effects of a medicine on health outcomes relevant to the patient. We were informed of several high-profile cases of suppression of trial results. We also heard of selective publication strategies and ghost-writing. The suppression of negative clinical trial findings leads to a body of evidence that does not reflect the true risk: benefit profile of the medicine in question.”

Extract from the House of Commons Health Committee 2004-05
Furthermore...

“...Inappropriate prescription of medicines by GPs is of particular concern. Some have prescribed SSRIs, for instance, on a grand scale. This is in part due to inadequacies in the education of medical practitioners which has meant that too few non-specialists are able to make objective assessments of the merits of drugs and too many seem not to recognise how little is known about the properties of a drug at the time of licensing, particularly about its adverse consequences...

... We recommend that more research be undertaken into the adverse effects of drugs, both during drug development and medicines licensing. The Government should, as a matter of urgency, fund research into the costs of drug-induced illness.”

Extract from the House of Commons Health Committee 2004-05
As a result of this government Green Paper very little has changed.
Horizons beyond the UK DH and NHS

International Coalition for drug awareness
http://www.drugawareness.org/

The Center for the Study of Empathic Therapy, Education and Living.
http://www.empathictherapy.org/

Law Project for Psychiatric Rights:
http://psychrights.org/index.htm

MindFreedom International
http://mindfreedom.org/
Horizons beyond the UK DH and NHS

Working to Recovery
http://www.workingtorecovery.co.uk/

Asylum Associates
http://www.asylumonline.net/

Hearing Voices Network
http://www.hearing-voices.org/

Crazydiamond training and consultancy
www.crazydiamond.org.uk
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http://www.amazon.com/Prozac-Backlash-Overcoming-Antidepressants-Alternatives/dp/0743200624

http://s395229360.onlinehome.us/Articles/LeoLacasseMediaandChemicalImbalance.pdf

(6) Eli Lilly’s Cymbalta website
[http://www.cymbalta.com/Pages/commonlyaskedquestionsaboutcymbalta.aspx#al1](http://www.cymbalta.com/Pages/commonlyaskedquestionsaboutcymbalta.aspx#al1)

(7) The Royal College of Psychiatrists – Antidepressants
[http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/depression/antidepressants.aspx](http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/depression/antidepressants.aspx)


http://www.amazon.co.uk/Rethinking-Psychiatric-Drugs-Informed-Consent/dp/1420867423

http://ecommerce.drugawareness.org/Ribbon/SSRIMeds.html


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http://www.mcmanweb.com/clinical_trials.html


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http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON002045

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http://www.mhra.gov.uk/home/groups/par/documents/websiteresources/con135073.pdf
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(54) Rethink Mental Illness http://www.rethink.org/

(55) Patient UK – Trusted medical information and support http://www.patient.co.uk/


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