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I care for my son who was a mental health patient with the NHS. However his treatment was so bad and caused him so much suffering as a result of medication he was prescribed, that despite living on benefit, due to his poor health, he was compelled to borrow in order to finance help from outside the NHS or see his health destroyed. During the time he was being treated by the NHS his condition deteriorated seriously but once he ceased to take all the medications he had been prescribed and sought treatment in the private sector by a consultant that cared he showed an almost immediate improvement. The evidence of his condition speaks for itself. The following is based on my experience whilst caring for my son.

I ***"judge the risks and benefits of medicinal products."*** based on:-

- my son's reaction to treatment,
- the evidence I am given by those responsible for his treatment
- the evidence I have found by making my own enquiries of manufacturers and
- medical research.

As a result I have found that much of the medication prescribed had almost immediate detrimental side effects, was not appropriate and was of little or no benefit. I also have found what I believe is a widespread substantial lack of even the most basic knowledge or understanding by those within the NHS treating mental health patients of :-

- **The rationale for prescribing.**
    - Whilst I cared for for my son and he was receiving NHS treatment he was prescribed two different benzodiazepines at the same time together with a number of other drugs including quetiapine. When I requested why medication was being prescribed the clinic was unable to supply any rationale. Later the Chief chemist within the Trust was likewise unable to give details of the rational and found there were no records setting out the rationale.
    - Further the chief pharmacist found medication was prescribed for off licence use without obtaining the consent of the patient or carer. Quetiapine is not licensed for any condition my son had and to date we have no rationale for why quetiapine was prescribed at such a grossly high dosage. The best rationale we have been able to obtain has been that the doctor was following a system.

- **The side effects of medication**
    - It was obvious almost immediately after treatment commenced my son was suffering side effects and that those treating him had insufficient understanding of his condition or of the medication initiated.
    - I brought up the issues of side effects as the medication was obviously effecting my son and was astounded to hear the Consultant in charge of the clinic together with the doctor prescribing admitting they were unaware of the side effects and they would need to seek advice on this elsewhere. Many of the side effects, as you are no doubt aware, are set out on the slip of paper which accompanies medication

and is there to advise the patient or carer of known possible problems and side effects.
    - Both manufacturers and NHS Trust guidelines set out the requirement for blood tests to be carried out in order to monitor possible known side effects but none were carried out.

- **<u>The guidelines and warnings in respect of medication.</u>**
    - The doctors ignored advice and guidelines to the detriment of the patient. The following are examples of guidelines which were ignored as a matter of course and they appear to continue to be ignored.

- **<u>Initiating of medication in Breach of Nice Guidelines.</u>**
    - The NICE guidelines state:-
        - *'Medication in secondary-care mental health services should be initiated under the supervision of a Consultant Psychiatrist'*
    - However medication was initiated without any supervision of a consultant and at no time during my son's treatment was a consultant ever involved in his treatment or in the supervision of any the initiation of any medication or change of medication.
    - Benzodiazepine was prescribed at the request of a member of staff who was not qualified to prescribe medication. The prescriber had never set eyes on my son let alone having carried out a proper examination. The benzodiazepine appeared to cause an immediate deterioration in his condition together with other side effects.
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- **<u>Manufacturers guidelines</u>** which clearly state benzodiazepines should only be used for short term use. IE 4 – 6 weeks.
    - My son was prescribe two different benzodiazepines at the same time for a period of two (2) years without any record of the rationale for initiating it. This would have continued had he not ceased treatment with the NHS.
    - I have anecdotal evidence of patients who have been prescribed benzodiazepines for upward of ten years.
- **<u>The UK Government bulletin and update</u>** from the committee on safety of medicines contains the following:-
    - *'Doctors are reminded that benzodiazepines should only be prescribed for short term treatment **in light of continued reports about problems with long term use**.' (my bold)*
    - The bulletin sets out that benzodiazepines should only be prescribed for between 4 – 6 weeks.
    - The above shows there can be no honest dispute that the Committee on the safety of medicines has been fully aware for many years of the *'**continued reports about problems with long term use**.'*

The evidence benzodiazepines are a major problem has been there, for all to see, for over 30 years. Despite this various authorities have ignored the evidence or where they have been aware (see above) they appear to have taken no positive action to tackle the problem. The considerable scientific medical evidence these drugs can cause not only dependency but serious physical and mental harm is freely available from manufacturers and reputable research institutes in a form that can reasonably be understood even by those without medical training. In my expedience

despite all the guidelines and all the warnings medication is recklessly prescribed in breach of them and they are simply ignored.

This raises serious questions as to why why are doctors are initiating medication which is detrimental to their patients. A number of major reasons leap out to me:-

- Those responsible for treatment fail to carry out proper examination before leaping to the use of medication and as a result disregard many possible causes of the condition they are supposed to be treating. As a result further harm is caused to the patient who is prescribed inappropriate medication or an inappropriate dose of medication.
- Those responsible for initiating medication have a serious lack of understanding why a particular medication is being prescribed, what it is licensed for or the guidelines and warnings applicable to it.
- Those responsible for treatment have a serious lack of understanding or knowledge of the side effects of the medication they prescribe and so are unaware when side effects arise or they simply ignore them.
- Medication is often used as a chemical restraint and not as treatment. It is a simple way to keep a patient quiet.
- Patients and carers views and information they supply are ignored.
- But in my personal view the major issue is those in authority and responsible:-
    - For the ensuring guidelines and warnings are issued do little or nothing to ensure the are followed or heeded. The failure of the Committee on the safety of medicines is a classic example.
    - There is little or no proper supervision of medical staff on the ground to ensure they follow guidelines, heed warnings and consider side effects seriously.

My own expedience, anecdotal evidence from sufferers and press reports related to mental health over a number of years suggests to me that the failings in the treatment and prescribing of medication my son received was not an isolated case but is widespread throughout the NHS and is typical of the lack of concern and reckless treatment of mental health patients I have found.

Gordon Jarvis
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