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Medical Report

Re: Wayne Douglas – Benzodiazepine Dependence

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Clinical Service Director
Alcohol & Drug Service Taranaki

Prepared for: Tokyo District Court

Date: 24/4/08

Signature: .....

Contents

Introduction

I, Graeme Judson, have been invited to provide this report regarding Mr. Wayne Douglas's Benzodiazepine dependency.

I am the Clinical Service Director of the Alcohol & Drug Service Taranaki. I have been working in Alcohol and Drug Rehabilitation for 16 years and I have been involved in assessing patients for Benzodiazepine and other substance dependencies. My qualifications include my undergraduate degrees BHB, MBChB as well as my post-graduate qualifications of MHSc and FAChAM.

This report includes content from the letters that I have provided thus far together with more detailed information regarding Wayne's Benzodiazepine dependence.

This report consists of 3 main sections as follows:

1. Patient Background
2. The Dependence Diagnosis / DSM IV TR Criteria
3. Formal Reduction Program

In order to gain an understanding of the overall clinical picture and the diagnosis for Benzodiazepine dependence we must first examine the Patient Background, including, Prior Medical History, Patient Profile, Substance / Prescription History, History of Symptoms etc, as outlined in Section 1 of this report.

NB: Section 1 also consists of information provided by Wayne and his lawyer, Mr. [redacted]

After examining the Patient Background we can then see how the overall clinical picture relates to the diagnostic criteria for Benzodiazepine dependence, which in this case is based on the DSM IV TR, as outlined in Section 2 of this report.

Section 3 covers the formal reduction program.

The report is concluded with a summary of findings.

Section One

1. Patient Background

1.1 Prior Medical History

1.1.1 Prior to traveling to Japan, for his 5th time, in May 1999 Wayne was fit healthy and well (refer Dr. Barry ter Haar letter dated 19/10/06).

1.2 Patient Profile

1.2.1 When Wayne presented to our service, with the exception of Wayne's use of Cannabis (as noted in point 1.2.3), use of Nicotine and alcohol (as noted in point 1.2.4) the only history of note with Wayne regarding substance use was the Benzodiazepine regime that he was initially prescribed by Dr. [redacted] in 2000.

1.2.2 On detailed questioning by both me and the Detox Nurse, who interviewed Wayne, he had no prior history of hallucinogen use, no history of opiate use, no history of solvent use, no history of stimulant use and had abstained from alcohol since May 2000.

1.2.3 Wayne does acknowledge that he used cannabis between ages of 15 and 21 but has had no cannabis since the age of 21. Wayne reported that he smoked about 1 marijuana cigarette between about 5 people at parties.

1.2.4 Other history included smoking cigarettes, as a minor, and the occasional drinking of alcohol. Wayne reported that he "played with cigarettes a couple of times" as a nine year old without actually inhaling anything. Then he smoked regularly between the ages of 14 and 17, but only about 5 per day. He has not smoked at all since then. Regarding alcohol, Wayne reports that he drank about 4 (less than six standard drinks) glasses of beer occasionally on a social basis at parties. This pattern of alcohol use is well within the recommended safe New Zealand drinking guidelines of no more than 6 standard drinks on any one occasion and no more than 21 standard drinks per week.

1.2.5 Wayne's history did not suggest that he had an addictive personality.

1.2.6 This is further evident in the fact that Wayne was particularly keen to withdraw from his Benzodiazepine regime upon learning of their addictive nature and the fact that they were likely contributing to some of his underlying symptoms at the time.

1.2.7 Furthermore, Wayne made 3 attempts, although unsuccessful, to reduce his drug intake during the course of the drug treatment that he was being prescribed (1st attempt at end November 2000, 2nd attempt at beginning of March 2001, 3rd attempt at end of March 2001).

1.3 Substance / Prescription History

NB: The substance use history between 5th July 2000 and 9th April 2001 is based on information provided to me by Wayne and his lawyer, Mr. [redacted]

Below is a breakdown for the Benzodiazepine component of the prescriptions.

Prescribing Doctor (Hospital)	Period	Prescription Drugs		Dose (mg)
		Trade Name	Chemical Name	
Defendant – Dr. [redacted] ([redacted] Clinic)	5/7/00 ~ 23/1/01	Contol	Chlordiazepoxide	15
		Rivotril	Clonazepam	0.9
		Grandaxin	Tofisopam	150
Dr. [redacted] ([redacted])	22/1/01 ~ 9/4/01	Rivotril	Clonazepam	1.2
		Constan	Alprazolam	1.2
Dr. Whitwell	9/4/01 ~ 19/4/01	Rivotril	Clonazepam	1.0 ~ 0.5
Dr. Judson	19/4/01 ~ 5/5/01	Rivotril	Clonazepam	0.5 ~ 0.0

NB: The prescriptions between 9th April 2001 and 5th May 2001 were all prescribed by Dr. Whitwell. My role was to help Wayne with the reduction process.

On top of the Benzodiazepines (Chlordiazepoxide, Clonazepam, and Tofisopam) outlined above, Wayne was also prescribed the following drugs by Dr. [redacted]

Prescribing Doctor (Hospital)	Period	Drug Name		Dose (mg)
		Trade Name	Chemical Name	
Defendant- Dr. [redacted] ([redacted])	5/7/00 ~ 23/1/01	Tofranil	Imipramine	10
		Ketas	Ibudilist	30

NB: I have been informed that the Benzodiazepines (Chlordiazepoxide, Clonazepam, and Tofisopam) prescribed by Dr. [redacted] were all mixed together in a powder form contained in sachets. The Imipramine was in tablet form and the Ibudilist was in capsule form. The dosages never changed.

NB: the details under 1.4 are based and copied from details provided to me in written form by Wayne.

1.4 History of Symptoms

Pre-Drug Treatment Symptoms

1.4.1 Wayne informs me that he experienced the below symptoms whilst working at a stressful job in Shizuoka. I can confirm that these symptoms are consistent with stress.

Around October 1999

1. Sweaty palms
2. Shortness of breath.
3. Racing / scattered thoughts
4. Sleep disturbances
5. Pressure in temple areas
6. Swelling of temporal veins
7. Fatigue / lethargy

1.4.2 Wayne reports that most of the above subsequently disappeared after changing jobs at the end of March 2000.

1.4.3 Wayne reported the below symptoms following an acute vertigo attack.

11th May 2000

1. A single attack of rotational vertigo
2. Vomiting / Nausea
3. Flushes
4. Initially unable to stand
5. Difficulty walking for a week thereafter
6. Ongoing unsteadiness
7. Subsequent anxiety over not knowing what was wrong

NB: I understand there are differing views as to what exactly caused the above symptoms.

1.4.4 Upon initial presentation, Wayne handed Dr. [redacted] a list of symptoms associated with his vertigo attack; including those above (1.4.3).
As an additional part of this list Wayne wrote the following general history under the title "Other".

"Early 1998 ~
1. Stiffness in shoulders
   NB: following this I (Wayne) began the habit of clicking my (his) neck

April 1999 ~
1. Bad tooth (currently receiving treatment)
   NB: Since late May, the toothache has caused inflammation in my (Wayne's) cheek, eye pain and swelling of glands

June 1999 ~
1. Became a bit lethargic
   NB: Have been feeling lethargic since coming to Japan (due to difference in environment)

Early 2000 ~
1. Shortness of breath
2. Pain in the temple areas and swelling of the surrounding veins (these symptoms disappeared following dental treatment)

Late April ~ 11 May 2000 (time of vertigo attack)
1. Very lethargic
2. Fatigue
3. Eyes feel like they are swimming around"

Post-Drug Treatment Symptoms

1.4.5 Following about 2 weeks of Dr. [redacted]'s drug treatment Wayne reports that he noticed some initial settling of symptoms as below.

Mid ~ End July 2000

1. Settling in dizziness
2. Settling in anxiety levels

1.4.6 Following about 1.5 months of Dr. [redacted]'s drug treatment Wayne reported that he had; continuing symptoms, worsening symptoms and some new symptoms as well. Wayne made regular complaints of his new symptoms, both in written and verbal forms.

Mid ~ End August 2000

Continuing symptoms included (in Wayne's words)

1. Continuing staggering (especially feel queasy when washing dishes, taking shower)
2. Lethargy and fatigue (still the same)
3. Shortness of breath (little improvement)
4. Eyes feeling like they're swimming around (now, only at mornings)
5. Legs feeling weak (they momentarily came right, but now can't seem to get much strength into them)
6. Feeling woozy
7. Summer lethargy
8. Stress & fatigue
9. Stiff shoulders

Symptoms that worsened included

1. Dizziness
2. Feelings of anxiety
3. Worsening levels of fatigue
4. (Worsening of hemorrhoids)

New symptoms included

1. Palpitations / Heart pounding
2. Loss in appetite
3. Mouth ulcers
4. Chronic Thirstiness
5. Reoccurring nausea

1.4.7 Following about 4 ~ 6 months of drug treatment Wayne states that his condition continued to deteriorate and that he developed several more new symptoms as below.

Between October and December 2000 (in Wayne's words)

Additional new symptoms included

1. Tinnitus - from November, started to experience light tinnitus (when trying to sleep and upon wakening)
2. Vitreous opacities - Developed what appears to be a smear on the lens of eyes (In right eye, can be seen even after eye is closed) From October
3. Became sensitive to heat (body temperature seems to change all the time)
4. Pulse rate is higher than usual
5. Flushes
6. Loss in sexual interest
7. Developed habit of always closing eyes
8. Starting to feel detached
9. Pressure in chest
10. Occasional stomach pains
11. Loss in appetite / Anorexia
12. Jaw stiffness and pain
13. Painful & stiff joints, muscles felt tight, heavy and numbed
14. Lost more than 10 kilos in weight
15. Inside of head twitches and pulsates
16. Tightness across forehead and scalp
17. Physical weakness
18. Paresthesias
19. Visual disturbances
20. Increased sleep disturbances
21. Slightly effected speech
22. Hypersensitivity
23. Sensitivity to sound and light
24. Emotional Instability (including panic attacks, anxiety, depression, mood swings, aggression)

NB: Wayne also noticed at this stage that he was now suffering from feelings of emotional instability and panic attack-like episodes - something he had not experienced before. Apparently Wayne continued to complain of these new symptoms in both written and verbal forms.

1.4.8 I have been informed that Wayne changed to the [redacted], where he listed the following symptoms in his Patient Questionnaire Form.

21st January 2001

1. Dizziness
2. Staggering
3. Shortness of breath
4. Lethargy
5. Fatigue
6. Jelly leg sensation
7. Muscular pain/stiffness in neck and back
8. Nausea (periodic)
9. Sparkling sensation in vision
10. Appears to be marks on eye lenses
11. Head seems to pulsate more than usual (especially when sleeping)
12. Sensation of head rushes
13. Deterioration in sense of balance
14. Shoulder stiffness
15. Pressure in sinus
16. Have become prone to mouth ulcers
17. Hemorrhoids
18. Palm of hands sweat abnormally

Section Two

2. Dependence Diagnosis

2.1 Diagnostic Procedure

2.1.1 Testing

When making a diagnosis of substance dependence there is no specific test that gives us a clear defined result. Rather sensible use of diagnostic criteria requires some interpolation and judgment, taking into consideration the overall problem, as highlighted by Wesson, DR, Smith, DE. & Ling, W. in their discussion on Benzodiazepine and other sedative hypnotic addiction in (Principles of addiction medicine third edition). For this reason we have guidelines which assist us in determining a dependence diagnosis.

2.1.2 Basis Used for Diagnosis

The diagnosis that was arrived at in Wayne's case was based upon the following:

1. The Overall Clinical Picture
2. The History - the documents and letters that Wayne supplied including prescriptions and symptoms
3. How Wayne Presented - both physically and mentally in general
4. Other (the referral letter from his General Practitioner)

To make a dependence diagnosis we take into consideration the Patient Background, as outlined in Section One of this report. This helps us to form the overall clinical picture. Furthermore, observations are made during consultation to help in assessing the patient's condition.

2.1.3 Guidelines / Criteria Used to Make Diagnosis

In Wayne's case the guidelines / criteria used to make the diagnosis was as follows:

1. DSM-IV TR Criteria
2. ICD 10 Criteria

To diagnose Benzodiazepine dependence we use the DSM-IV TR Criteria here at the Alcohol & Drug Service. The DSM-IV TR is the standard used by the American Psychiatric Association.
As noted in the DSM-IV TR, drug dependence is a maladaptive pattern of drug use leading to clinically significant impairment or distress, which is manifested by 3 or more of the Criteria occurring at any time in the same 12 month period.

In Wayne's case the clinical impairment included both physical and mental symptoms, and associated with this impairment was the impact on Wayne's life, which included his inability to function at work.

As a back-up to the DSM IVTR Wayne's clinical picture was measured against the ICD 10 criteria which is used more commonly in Europe to diagnose substance dependence.

2.1.4 Procedure Used to Arrive at Diagnosis

The first thing we had to do was consider the referral received from Wayne's GP, which suggested to us that Wayne had a problem with Benzodiazepine dependence.

We then proceeded to assess Wayne and interviewed him to find out about his history. For example: what kind of Benzodiazepines he had been taking, dosages, period of use etc.

NB: The dependence diagnosis in Wayne's case was made easier simply by the fact that he was being prescribed Benzodiazepines (Chlordiazepoxide 15mg, Clonazepam 0.9mg, Tofisopam 150mgs) for over a 6 month period.

We also analysed Wayne's history of symptoms in order to help us identify symptom patterns that are consistent with Benzodiazepine dependence. For example: tolerance, withdrawal etc.

Other general history such as unsuccessful attempts at reduction was also noted.

Once a complete analysis of Wayne's background / history had been carried out we then matched this information against the DSM IV TR Criteria.

The first criteria – tolerance and withdrawal are evident in how Wayne presented to the service and in that the symptoms he reported were consistent with these. Regarding the criteria of loss of control, impact on life and continued use, it was found that Wayne met these based upon the history he gave both myself and the Detox nurse.

Before concluding that Wayne met these criteria we cross-checked his verbal self reports with the documentation that he presented, his Doctor's referral letter and reports from his family.

Matching Wayne's background / history against the DSM IV TR Criteria enabled us to confirm the diagnosis of Benzodiazepine dependence.

2.2 Overall Clinical Picture

In order to determine whether a patient is drug dependent, we must consider the history provided by the patient to help us form the overall clinical picture. In Wayne's case the main points are as follows:

1. The patient was healthy and well up until 1999
2. The patient had no previous history of psychological, neurological or anxiety disorders
3. The patient did experience some work related stress symptoms from around October 1999 for the first time
4. The patient's work related stress symptoms did subside, however, after he changed jobs in March 2000
5. The patient experienced, what was diagnosed as an unrelated acute rotational vertigo attack on 11th May 2000
6. The patient developed anxiety related symptoms after not being able to receive any clear-cut diagnosis for his vertigo attack
7. The patient was prescribed Benzodiazepines, which are addictive medicines, even in small prescription doses, especially when taken over prolonged periods of time.
8. Benzodiazepines have numerous commonly known untoward side-effects, e.g. ocular effects, lethargy, palpitations
9. The patient's overall dose was sufficient enough to form dependence
10. The patient experienced an initial settling of symptoms a couple of weeks into the treatment
11. The patients condition ceased to improve after about 1 month into the treatment
12. The patient complained that his condition was deteriorating and that he had developed some new symptoms after about 1.5 months into the treatment
13. The patient continued to develop new symptoms in this manner throughout the remaining period of the treatment
14. The patient's additional post drug treatment symptoms were all consistent with Benzodiazepine withdrawal
15. The patient had 3 unsuccessful attempts at reducing – The patient showed a desire to reduce but was unable to do so
16. The patient showed an awareness that his condition was deteriorating and sought alternative help on at least 2 different occasions
17. The patient self reported that his ability to partake in social and recreational activities was significantly reduced
18. The patient's GP reported that he eventually reached a state of complete exhaustion and confusion to the point where he was unable to work any longer
19. The patient GP reported that his condition was such that he was forced to return to his home country, where it took about 15 months before he was fit enough to work again
20. The patient required professional assistance in order to be able to reduce

21. The patient displayed withdrawal symptoms during the formal reduction process
22. The patient's condition continued to improve following the completion of his formal withdrawal program
23. The patient had recovered from almost all of his post drug treatment symptoms within the first year of cessation with the exception of some residual anxiety complaints, namely panic attacks
24. The patient's original complaint on presentation back in Japan, namely dizziness, also began to improve significantly for the first time following complete cessation of the drug regime
25. The patient's overall mental and physical wellbeing improved following complete cessation of Benzodiazepines

2.3 DSM IV TR Criteria

As previously mentioned, the criteria we used to diagnose Wayne's Benzodiazepine dependence is that used by the American Psychiatric Association, namely the DSMIV TR. The DSMIV TR has 7 Criteria of which 3 need to be met for a diagnosis of substance dependence to be determined. These 7 Criteria are as follows:

1. Has this person developed tolerance to Benzodiazepines?
2. Has this person developed withdrawal Symptoms to Benzodiazepines
3. Was the substance (Benzodiazepines) taken in larger amounts or over longer periods than intended?
4. Does this person have a persistent desire or made one or more unsuccessful efforts to cut down or control use?
5. Was a great deal of time spent in activities necessary to get Benzodiazepines, take Benzodiazepines or recovery from its effects?
6. Has this person reduced other activities as a result of their Benzodiazepine use?
7. Has this person continued Benzodiazepine use despite problems caused by or exacerbated by use?

Of the 7 Criteria above, Wayne met numbers: 1, 2, 4, 6, 7 above, in other words, Wayne met 5 out of the 7 Criteria, for which only 3 need to be met in order to determine dependence.

1. Tolerance

Tolerance was evident in the fact that Wayne reported some settling of his symptoms (1.4.5, pg 6), but soon afterwards his symptoms started to return along with the others (1.4.6, pg 6). The re-emergence of symptoms in this case is consistent with the fact that he met the criteria for tolerance.

Drug dependence, or in Wayne's case, Benzodiazepine dependence is related to chronic ongoing drug use, which results in an altered neurophysiological state that develops as a result of tolerance.

Tolerance is defined as "the reduction in response to a given dose of a drug after repeated administrations". The effects associated with tolerance are evident in the direction counteracting the acute drug effects to maintain system level homeostasis in the individual concerned.

NB: Tolerance can be formed in as little as 4 weeks on higher doses of Benzodiazepines and with therapeutic anxiolytic doses (up to 40mgs Diazepam daily equivalent) significant dependence can occur after four to six months of daily dosing (Textbook of substance abuse treatment second edition, Principles of addiction medicine third edition). (Wayne's history indicates he was prescribed therapeutic doses of Benzodiazepines for longer than 6 months)

2. Withdrawal Symptoms
As highlighted by Dickenson et al (Management of sedative-hypnotic intoxication and withdrawal in ASAM Principles of addiction medicine); "a withdrawal syndrome can follow discontinuation of short term (2 to 3 months) low dose therapeutic use but most symptoms if present at all, are rated as mild and are easily managed. On discontinuation of long-term (1 year) therapeutic (low dose) use, withdrawal is common and is accompanied by moderate to severe symptoms in 20% to 100% of patients."

In Wayne's case, as he had been prescribed Benzodiazepines ongoing for almost 10 months by the time he was reviewed at our service, it was very likely that he would have had withdrawal symptoms simply based on the length of time he was prescribed Benzodiazepines for.
Wayne met the criteria for withdrawal, which was made evident by the following symptoms which emerged during the course of his treatment, or initially got worse on reduction of his overall dose:

1. Tingling sensation over face
2. Loss in coordination
3. Myoclonic jerks
4. Oily smell in body odour
5. Increased joint pains
6. Tightening of muscles
7. Worsening of dizziness
8. Worsening of pulsating temporal arteries
9. Worsening of visual disturbances
10. Increase in emotional instability
11. Increased palpitations
12. Tightening in chest
13. Flushing
14. Hypersensitivity

4. Loss of Control
Wayne met the criteria for loss of control or unsuccessful attempts to cut down or control his use. This was evidenced by the history of unsuccessful attempts to cut down his Benzodiazepine use on his own (1.2.7, pg 2), which remained unsuccessful until he sought help in a formal withdrawal program from our service.

6. Impact on Life
Following the commencement of Benzodiazepines, Wayne experienced a number of significant impacts on his life, which included the following:

1. Loss in ability to work (over 14 months)
2. Relationship difficulties, including family, friends and romance
3. Loss in ability to take part in recreational activities
4. Loss in ability to socialize

Based on the above Wayne met the criteria for important social occupational recreational activities having been reduced due to his Benzodiazepine use.

NB: I understand that Wayne has comprehensive information regarding his history of difficulties with occupational and recreational activities during the period that he was prescribed his Benzodiazepines.
Furthermore, I understand the above impact on Wayne's life has been confirmed by Senior Clinical Psychologist, Dr. Alan Guy, who has been assessing Wayne periodically since his initial assessment back in August 2001 (refer Dr. Alan Guy's letter dated 27th April 2007).

7. Continued Use Despite Knowledge of Harm
We know Wayne was aware that his condition was deteriorating by the fact that he was making lists of new symptoms and handing them to Dr, [redacted]

Furthermore, Wayne made 3 attempts to reduce the drug regime, but found himself continuing to take the Benzodiazepines that were prescribed for him, despite the knowledge that they could possibly be harming him.

Therefore, Wayne also meets the criteria for continued use despite persistent or recurrent psychological problems due to his use of Benzodiazepines.
NB: These symptoms did not start to remit until Wayne successfully withdrew from his Benzodiazepines and his withdrawal symptoms began to settle.

2.4 ICD-10 Criteria

Alternatively, if the ICD-10 Criteria for diagnosing Benzodiazepine dependence (recommended by the World Health Organisation) is applied, we can see that Wayne also met the criteria for this as well.

As defined by the ICD-10, the diagnosis of dependency is made if 3 or more criteria are met. If one reviews the ICD-10 Criteria one can see that Wayne met the following:

1. Difficulties in controlling the substance in terms of its termination. As discussed above, Wayne had difficulty reducing and stopping his Benzodiazepines on his own without medical assistance.

2. A physiological withdrawal state, as described above.

3. Wayne had evidence of tolerance as discussed previously.

4. Wayne also neglected his alternative pleasures or interest that he got from life. This is evident in his personal statement where he describes withdrawal and his friends' reports that he appears to be losing pleasure from life.

5. He also met the criteria with persisting with use of Benzodiazepines despite evidence of harmful consequences.

   NB: As Wayne met 5 of the Criteria, he clearly also meets the ICD-10 Criteria for "Substance Dependence Syndrome".

2.5 Differential Diagnosis

2.5.1 Anxiety

Benzodiazepines are known to cause the very symptoms that they are designed to treat; i.e. anxiety related symptoms. This is due to tolerance and subsequent breakthrough symptoms.

Wayne had no prior history of suffering from an anxiety disorder, which has been supported by Dr. ter Haar's letter, dated 19th October 2006. He did experience some mild stress symptoms at a stressful job around October 1999, but these mostly disappeared after he changed jobs a few months later.

In my professional opinion, the anxiety symptoms that Wayne developed following his Benzodiazepine based drug treatment were likely to be the result of Benzodiazepine dependence.

2.5.2 Previous Effects of Tobacco, Alcohol and Marijuana

As previously outlined (articles 1.2.3 & 1.2.4, pg 2), we know that Wayne experimented with tobacco, drinking and cannabis during his teenage years. The current research to suggest these are a gateway drug to ongoing further substance use is not yet conclusive either way.

In Wayne's situation they are unlikely to be gateway drugs as Wayne otherwise had no other Psycho-social risk factors (eg peer group, his profession, family history of substance use etc) that would make it more likely of him to develop substance dependencies.

Furthermore, hallucinogen flashback symptoms are not proven to occur in those who have previously used cannabis and ceased its use.

Section Three

3. Formal Reduction Program

3.1 General Reduction History

3.1.1 As outlined in my letter dated 10th September 2004, Wayne was referred to the Alcohol & Drug Service on 19th April 2001 and first presented initially to our Detox Nurse and subsequently the following day to me. He was referred for assessment for his Benzodiazepine dependence with a view to subsequent reduction.
NB: As part of the evaluation process Wayne was also assessed by a Senior Clinical Psychologist, Dr. Alan Guy, who I understand has also provided reports for Wayne's case.

3.1.2 Breakdown of Dosages During Reduction

Period	Observing Doctor	Drug	Dose (mg)	Withdrawal Symptoms
9 April ~ Mid April, 2001	Dr. Whitwell	Clonazepam	1.0	
Mid April ~ 30 April	Dr. Whitwell Dr. Judson	Clonazepam	0.5	
30 April ~ 5 May	Dr. Judson	Clonazepam	0.25	Worsening of: 1. Dizziness 2. Pulsating temporal arteries
5 May ~	Dr. Judson	Clonazepam	0	1. Some tightening in muscles 2. Tingling sensation over face 3. Increase in emotional instability 4. Worsening of visual disturbances 5.Slight loss in coordination 6. Myoclonic jerks 7. Increased joint pains 8. Oily smell in body odour 9. General initial worsening of withdrawal symptoms outlined on page 13.

3.1.3 At presentation it was clear to us that Wayne did not understand about the nature of the drugs he had been prescribed, including what they are normally used for.

3.1.4 Wayne, on presentation, had comprehensive documentation regarding his history and presented it to both myself and the Detox Nurse. Points of note in this history include that Wayne reported the following symptoms:

1. Palpitations
2. Tightness in the chest
3. Flushes
4. Stomach pains
5. Paresthesia
6. Visual disturbances
7. Anorexia
8. Episodes of emotional instability

3.1.5 On presentation to us Wayne was being prescribed Clonazepam 0.5mg tablets one twice daily. Wayne had self reduced this in the previous week to 0.5mg tablets, half a tablet, twice a day. He had reported that he was feeling lousy at that stage and was encouraged to stay on this dose until he could readjust to this level.

3.1.6 Throughout the reduction program we endeavoured to give Wayne all of the advice and support he needed to help him cope with his withdrawal. This included; the provision of information on Benzodiazepines, practical advice on reduction, dietary and nutritional advice, lifestyle advice, etc.

NB: This was the first time Wayne realized that, not only are Benzodiazepines addictive, they also have numerous untoward side-effects. Subsequently, Wayne expressed strong feelings of injustice towards Dr. [redacted] and he demonstrated a strong determination to distance himself permanently from the use of Benzodiazepines.

3.1.7 I reviewed Wayne on 30th April 2001 and at that stage he had reduced his Clonazepam to one half of a 0.5mg tablet taken in the morning. Wayne had noticed the worsening of some of the symptoms that the Clonazepam was initially prescribed for, namely:

1. Dizziness
2. Pulsating temporal arteries.

3.1.8 On 21st May 2001 Wayne had been Benzodiazepine free for 16 days. He had reported at this stage that his sleep had generally been good except for the day before. He also reported the following symptoms:

1. Some tightening in his muscles
2. Tingling sensation over his face
3. Increase in emotional instability

Accordingly, the nature of withdrawal symptoms was generally discussed with him again at this point.

3.1.9 Wayne was additionally worried about his visual symptoms, which had worsened, and it was suggested to him that he see his GP for a check up in case of any other underlying pathology causing the visual symptoms he reported.

3.1.10 Wayne was subsequently discharged from our Service and referred back to his GP, Dr. Whitwell, as he had successfully become Benzodiazepine free.

3.1.11 In general, Wayne made excellent progress in his withdrawal from Benzodiazepines, although a little quicker than I would have recommended, but well within a safe level of reduction.

Summary

In summary, Wayne's presentation was consistent with that of a diagnosis meeting Benzodiazepine dependence in terms of both the ICD-10 criteria and the DSM-IV TR criteria.

Based on the above together with the overall clinical picture, in my professional opinion, Wayne was indeed dependent to the Benzodiazepines that were first prescribed to him by Dr. [redacted] on 5th July 2000 and that he has suffered as a consequence of that dependence.