BRISTOL & DISTRICT TRANQUILLISER PROJECT

Company Limited by Guarantee No: 5126531
Registered in England and Wales

Registered Charity No: 1104033

ANNUAL REPORT

2012 - 2013

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Patron: Professor C H Ashton, D.M., F.R.C.P, of Newcastle University

EXECUTIVE COMMITTEE/DIRECTORS:

Jacquie Jones	Chairman
Jocelyn Mignott	Vice Chairman
William Liew	Treasurer
Anthony R Burton MBE	
Victoria Greenhouse	
John Gunn BA, FCA	
Valerie Stevens	

STAFF MEMBERS:

Jayne Hoyle BSc, MSc, CPsychol	Project Manager
Ian Singleton, BA (Oxon)	Senior Project Worker
Roy Jones	Project Worker
Iris Murch	Administrative Assistant
Bianca Edwards	Administrative Assistant

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INTRODUCTION

PROBLEMS WITH BENZODIAZEPINES

- Benzodiazepines are the most commonly prescribed minor tranquillisers and sleeping pills.

- The main ones are Diazepam (Valium), Temazepam, Nitrazepam (Mogadon) and Lorazepam (Ativan).

- They are highly addictive drugs, and their side-effects and withdrawal symptoms can lead to breakdown and temporary mental illness.

- There were 11.1 million prescriptions of benzodiazepines by community pharmacists in 2012 in England alone.

Benzodiazepines were prescribed by doctors from the early 1960's, when they were unaware of the dependence potential. In January 1988 the Committee on Safety of Medicines issued an advice note to all doctors, stating that benzodiazepines were indicated only for 2 -4 weeks and only for severe anxiety or insomnia. The message has been reinforced by regular warnings from Chief Medical Officers since then.

There are estimated to be at least 1½ million people in England taking benzodiazepines regularly, most of whom are undoubtedly addicted. Around a third of patients are still being prescribed benzodiazepines for longer than the 2 – 4 week guideline, despite continued warnings from the Department of Health.

No effective national campaign has ever been undertaken to help people withdraw from these drugs. Bristol is one of the few areas in the country to acknowledge and try to remedy the situation and deserves huge credit for this.

PROBLEMS WITH OTHER PRESCRIBED PSYCHOTROPIC MEDICATION

There has been a rapid increase in recent years in the prescribing of psychotropic medication other than benzodiazepines, especially of antidepressants:

- Prescribing of antidepressants has quadrupled over the past 20 years.

- In 2012 over 50 million prescriptions for antidepressants were issued by community pharmacists in England. This number is increasing by 10% every year and there is no sign of this trend changing.

- It has been estimated that over 4 million people in England are taking antidepressants regularly.

- The cost to the NHS of antidepressants was £270 million in 2011, an increase of 23% on the year before.

- The Uppsala Monitoring Centre database lists 3 SSRI antidepressants – Prozac, Seroxat and Sertraline – amongst the 30 highest-rating drugs for dependency.

- There has also been a big increase over the past 15 years in the prescribing of the newer sleeping pills such as Zopiclone, Zolpidem and Zaleplon. GPs issued over 10 million prescriptions for sleeping pills in 2011. Roughly half of these were for the 'Z' drugs and half for benzodiazepines.

These newer drugs can cause side-effects and withdrawal symptoms that are every bit as bad as those caused by benzodiazepines. New guidelines for the prescribing of antidepressants were issued by the National Institute of Clinical Excellence (NICE) in December 2004. These urged GPs not to prescribe antidepressants to people with mild to moderate depression unless all other treatments failed.

OBJECTIVES OF THE PROJECT

1. To assist those involuntarily addicted to benzodiazepines to understand and cope with their addiction, to plan and make a safe withdrawal where appropriate and to lead normal lives without recourse to any psychotropic medication.

2. To help those taking other prescribed psychotropic medication to come off this medication where appropriate.

3. To inform, advise and support the families and friends of those affected.

4. To inform and advise those professionally involved in the problems of involuntary benzodiazepine addiction.

SERVICES PROVIDED BY THE PROJECT

1. One-to-one prescribed drugs counselling especially for those new to the Project and those undergoing particular difficulty.

2. Withdrawal groups at the Project led by counsellors but with a strong user involvement.

3. Outreach withdrawal groups in Knowle and Southmead.

4. Drop in availability at the Project for those in particular need.

5. A help-line open 4 days a week.

6. A programme of visits, talks, workshops, seminars etc for doctors and other professionals within the Bristol area.

THE WAY THE PROJECT WORKS

The Project provides a safe, supportive atmosphere where people can discuss the problems caused by involuntary benzodiazepine addiction or by other prescribed psychotropic medication with our prescribed drugs counselling staff and volunteers.

At initial meetings clients come to understand better the symptoms caused by long-term dependence on benzodiazepines or other prescribed drugs and usually start to consider withdrawing from the medication. No-one is pressurised to withdraw, but they are encouraged to do so, and the majority of the counselling staff and volunteers are living proof that such withdrawal is possible. The doctor's permission is always sought before embarking on a withdrawal programme.

New clients are also encouraged to participate in withdrawal groups where they can share experiences and information with those who are undergoing the same withdrawal process. Once the clients have started to withdraw they are encouraged to take control of their own withdrawal programme by deciding when and how much to withdraw. Our counselling staff are always on hand to discuss and advise on their withdrawal programme.

The Project's philosophy is that withdrawal from benzodiazepines or other prescribed psychotropic medication should be gradual and clients are advised initially on how to plan a sustainable programme which does not overload them.

Clients are supported throughout the withdrawal process, and also for a considerable length of time after withdrawal. Many clients have taken benzodiazepines or other psychotropic medication for much of their adult lives. Recovery is usually gradual and many life skills need to be learned or relearned. In some cases clients may participate in the work of the Project as volunteers after withdrawal. This often assists those who have been out of work for some time to develop the skills and discipline needed for a return to full-time work outside the Project

COMMITTEE, STAFF AND VOLUNTEERS

The Project puts the highest emphasis on personal experience of the effects of psychotropic medication. The majority of our staff, volunteers and Committee have considerable first-hand experience of the effects of benzodiazepines and other psychotropic drugs. Many of our staff have worked in the field of prescribed drug addiction for over 20 years and they have built up considerable expertise on a wide variety of prescribed psychotropic drugs. Our patron, Professor Ashton, is an internationally respected expert on both benzodiazepines and antidepressants and she provides the Project with invaluable professional advice on these drugs.

REVIEW OF THE YEAR 2012-2013

CHAIRMAN'S REPORT

I commend the Annual Report for 2012/13 to you. It is longer than last year's and even more comprehensive and should be read by everyone who has an interest in the problems caused by involuntary addiction to prescribed psychotropic medication.

The staff continued to perform in their usual efficient and professional manner and weathered all the structural changes within the NHS. I continue to be impressed by how the staff, working as a close-knit team, managed to deal with even more people requiring their help, whether by telephone, emails or face-to-face, than they have in previous years. At the same time they have continued to fundraise successfully in a very difficult financial climate. I am particularly impressed by how they have continued to fund the Helping Older People Scheme entirely from charitable trusts.

Perhaps our biggest event over the past year was the visit to the Project of the Health Minister, Anna Soubry. I was impressed by her open manner and the obvious interest she showed in the work of the Project. I was really proud that this organisation is now obtaining the official recognition it deserves for the work it is carrying out to help those suffering from involuntary addiction to this medication.

Finally, I would like to thank the staff and Committee for their continued support over the past 2 years in my role as chairman. My task has been made immeasurably easier by the spirit of close cooperation fostered within the Project.

Jacquie Jones
Chairman

PROJECT REPORT

INTRODUCTION

This was another year of uninterrupted progress for the Project. There were no changes to the Committee or staff during the year. Our funding continued at a similar level to that of the previous year, with the majority coming from the Bristol Primary Care Trust as usual. Overall numbers of clients helped were broadly similar to last year but numbers of helpline calls once again increased substantially. We were delighted to receive the Public Health Minister, Anna Soubry, for a visit to the Project in October 2012.

EXECUTIVE COMMITTEE

This was Jacquie Jones's first full year as Chair of the organisation and she continued to show great understanding and support for Jayne Hoyle and her team. She has grown into the job and has become a very capable leader of the organisation, clear of purpose and an excellent Chair of meetings. William Liew continued as our Treasurer, providing all the necessary budgets, updates and regular monitoring of the accounts. We are particularly grateful to him for his continued involvement with the Project this year, as he changed his daytime job to take over as Finance Director at the University of the West of England (UWE). He attends Committee meetings regularly and always makes very helpful contributions.

Our thanks are also due to all the other members of the Committee for their attendance during the year and their continued support for the work of the staff and volunteers. Particular thanks are due to those who travel to Committee meetings from far afield, such as Valerie Stevens from Cornwall and Tony Burton from Stroud. We greatly appreciate the commitment this shows to the overall good of the organisation.

STAFF AND VOLUNTEERS

There were no changes to the staff or their roles during the year, for the second year running. This was a great help to the smooth running of the organisation, with everyone clear about their individual roles and also their commitment to teamwork.

Jayne continued as Manager supervising the work of the Project and taking particular responsibility for the website, replying to emails and for liaison with the

Primary Care Trust and other official bodies. She needed some time off in the autumn to recuperate from an operation but was able to return gradually to her full range of duties later in the year. Ian continued to specialise in report writing, providing statistics on clients and liaising with other organisations dealing with involuntary prescribed medication addiction. Roy continued his responsibility for the Helping Older People scheme and took the lead on helpline calls. All staff as usual took a hand in fundraising for the Project and all took a considerable number of helpline calls.

The Administrative staff once again played a key role in the organisation. Iris continued to sort out emails, deal with daily correspondence and reports, send out information to doctors and other professionals, liaise with clients over membership, write newsletters to clients and mastermind the arrangements for the Annual General Meeting (amongst other things!). She also found time to reassure clients on the helpline when other lines were busy and to look after clients when they came into the office for groups, drop-ins or counselling. Bianca once again showed both financial and technical mastery of all issues thrown at her and dealt well with the essentials of office life eg making sure our salaries were paid on time. She also drove hard bargains for us with the utility companies and other providers. A final thank you is due to Maureen O'Connor for stepping into the breach for us when other Administrative staff were unavailable and for keeping the clerical work flowing.

Our volunteers once again provided much needed support to our hard pressed staff. As usual our ever-faithful Tom Jones was on hand almost every week to undertake a vast range of jobs for us, varying from computer searches to sorting out leaking taps. We had two new volunteers who started in the latter part of the year, Jean Powell and Barbara Kent Jones. Both had already been through withdrawal with the Project and clients said how much they appreciated hearing new voices and getting a new perspective on their problems.

CLIENTS

(a) General

- Over the past year we helped 51 clients at the Project, 11 at Knowle, 7 at Southmead 175 over the telephone helpline and 18 via email, a total of 262.

- 46 of those seen at the Project commenced withdrawal (90%), as did 10 of those in the Knowle group (91%), 6 of those at the Southmead group (86%), 125 of those in touch by helpline (71%) and 14 of those in touch by email (78%). In all 201 out of 262 commenced withdrawal (77%).

(b) Medication

- 77 clients came off benzodiazepines completely
- 57 came off antidepressants
- 4 off non-benzodiazepine sleeping pills
- 99 came off all their medication (37%)
    - 22 of these were at the Project
    - 6 in the outreach groups
    - 61 of those in touch by helpline
    - 10 of those in touch by email.
- We had 154 new clients during the year.
- We carried out an average of 3 counselling sessions a week and had 5 sessions available for counselling.
- We had 2328 access our website during the year.
- We received and answered a total of 244 emails from clients during the year.

(c) Gender and Age

- Of 69 clients seen face to face over the past year 51 were female (74%) and 18 male (26%).
- Of helpline clients 96 were female (55%) and 79 male (45%).
- Of email clients 11 were female and 7 male.
    - Over all 158 were female (60%) and 104 male (40%).
- Age ranges of those seen face to face
    - 11 were between 20 and 40 (16%)
    - 24 were between 40 and 60 (35%)
    - 34 were over 60 (49%).

HELPLINE

- Over the year a record total of 4,876 helpline calls were taken at the Project. This was a rise of 16% on the number of calls recorded in the previous year (4,204), and a rise of 131% on the number of calls taken in 2009/10 (2,113).
- The average monthly number of calls was 379, as against 350 in the previous year.
- 4,780 calls were taken by staff and 96 by volunteers.
- 46% of the calls were from clients over 60.

KNOWLE OUTREACH GROUP

Ian continued to run this group for the people of South Bristol at the Walk-In Centre in Knowle. Numbers remained high over the year and there was again an excellent spirit of self-help and togetherness in the group. Most clients made good strides towards being drug-free and well.

SOUTHMEAD GROUP

Roy continued to run this group for the people of North Bristol which is based at the New Brunswick Church Hall in Southmead. Clients continued to make good progress in this withdrawal programme. It is hoped to increase numbers over the year ahead.

HELPING OLDER PEOPLE (HOP) SCHEME

The latest year of the scheme specifically to help older people addicted to prescribed psychotropic medication ran from 1 October 2011 till 30 September 2012. During the year we helped a total of 72 clients under this scheme, another record. 23 were helped face to face and 49 via the telephone helpline. 44 were female and 28 male. The number of clients commencing withdrawal was again around 80%.

We would like to thank the following organisations which helped to fund the work of the HOP scheme during the year covered by this report:-

Coutts Charitable Trust
Lloyds TSB Foundation
Society of Merchant Venturers

The Bristol Masonic Charities
The James Tudor Foundation
The John James Bristol Foundation
The Lark Trust
The Sir Jules Thorn Charitable Trust

This funding totalled just over £22,000. The HOP scheme is entirely funded by charitable trusts and we would like to thank most warmly all those which contributed to the scheme this year. All of the trusts have been loyal supporters of the scheme over many years and we cannot emphasize enough how valuable such long-term support is to us.

Visits were paid to the following local organisations under the auspices of the scheme, to advertise our services and give them leaflets to distribute to their members:-

Avonmouth Community Centre
Care Forum Fishponds
Eden Grove Community Trust
Greenway Centre Southmead
Princess Trust Fishponds
Reform Church Henleaze
Romney Avenue Lockleaze Community Centre
Sanctuary Church Staple Hill
Scart Southmead
Southmead Community Centre
Staple Hill Advice Centre

MONITORING AND EVALUATION

From quarterly surveys it emerged that the clients were very satisfied with the overall service provided by the Project and that they consider that the Project was meeting their needs.

1. In the groups, all clients felt either very involved or quite involved in the running of the group.

2. One-to-one clients said that they find the sessions helpful or very helpful.

3. On the helpline 64% of clients who were sent questionnaires responded. 47% of them call the helpline every week. 53% call the helpline less than

once a week. The overall satisfaction of the service provided was very high and most or all needs are met.

4. Suggested improvements to the services were: Services to be available in other areas, more group outings and internet forums.

EDUCATION/VISITS

1. We wrote to all GPs, Practice Managers, Mental Health teams and Pharmacists in the Bristol area with details of our services.

2. We provided particular assistance to 4 GPs on withdrawal from benzodiazepines and antidepressants.

3. We visited local groups, clubs, churches and community centres to provide leaflets and information about our services.

MAIN PROJECT FUNDING

This was the last year of our funding from the Bristol Primary Care Trust, which has funded us over many years and with which we established a close relationship. Fortunately our link officer with the PCT, Grace Elias who has been particularly helpful is now our link officer with the new Bristol Clinical Commissioning Group (CCG). We have been given funding by the CCG for the year 2013/14. This will tide us over until longer-term arrangements are put in place in the following year. We would like to thank Grace for keeping us informed of developments and explaining the changes to us so well.

We would like to thank everyone else, both individuals and organisations, who helped to fund the Project during the year. Details of many of these are given on the back cover of this report. Once again we owe a big debt of gratitude to the Linnet Trust for their continued very generous support. We were delighted to meet up with Jerry Suenson-Taylor from the Trust in April 2013, to let him know more about the work we do and our overall funding arrangements and to answer questions.

We would like to express our thanks to our regular funders Rolls-Royce, Imperial Tobacco and Wessex Water. We also had a donation from the Lloyd Robinson Family Fund just after the end of the year, which will be counted towards next year's totals. This fund has also been a most generous supporter of the Project over many years. We would like to express our thanks to them and also to Quartet Community Foundation which has done such excellent work supporting us and other local organisations over many years.

MEMBERSHIP

Rates for the year remained unchanged, at £30.00 for life membership, £8.00 for waged and £4.00 for unwaged or low waged individuals. At the end of the year we had 95 members of which 56 were lifetime members, 22 full and associate members and 17 honorary members. In all this raised £492.00 for Project funds during the year. We are very grateful to all our members for their vital support.

VISIT OF ANNA SOUBRY TO PROJECT

When Ian Singleton visited the former Public Health Minister, Anne Milton, in January 2012 as part of the Department of Health review of benzodiazepines he invited the Minister to visit the Project later in the year. Anne Milton lost her job in the September 2012 Ministerial reshuffle and was replaced by Anna Soubry. We extended our invitation to visit the Project to her and were delighted when she agreed to come on 25 October 2012.

At the meeting she met members of the Committee, staff, volunteers and former clients as well as Andrew Keefe, Associate Director of the Bristol Primary Care Trust and Paul Mugford, Practice Manager of the Hillview Practice in Hartcliffe, Bristol. She was informed about the work of the Project over the past 27 years and asked a number of questions about the problems caused by over prescription of the benzodiazepines and other psychotropic medication. There was also discussion of the future funding of organisations such as ours in the light of the reorganisation of the NHS.

After the meeting the Minister released the following statement:-

> *'Meeting people who have used the Bristol & District Tranquilliser Project and hearing their stories of how the charity has helped them get their lives back on track is a testament to the hard work of a small group of dedicated staff.*
>
> *Last year the Project helped 261 people addicted to prescribed medication and this shows what a valuable service this is to people in the Bristol area.'*

CONFERENCE ON ADDICTION TO PRESCRIBED MEDICATION IN FEBRUARY 2013

The Public Health Minister Anna Soubry MP announced a change of direction on addiction to medicines at a conference organised by the National Treatment

Agency (NTA) in London on the 28 February 2013. In her keynote speech Anna

Soubry recognised that patients can become addicted to medicines through no fault of their own and form an important group which require specialist support. She thanked Jim Dobbin MP and Eric Ollerenshaw MP of the All Party Parliamentary Group on Involuntary Tranquilliser Addiction (APPGITA) for bringing this problem to her attention and also the patients she had spoken to on her visits to the Bristol and District Tranquilliser Project, Addiction Dependency Solutions, Oldham and Oldham Tranx.

Anna Soubry later told BBC Radio 4 the time had come to put addiction to prescription drugs on the agenda and identified poor prescribing as a main cause of the problem:

> *I think there have been some GPs who've simply not been following the guidelines from their own professional bodies. They have been overly-prescribing these drugs for year after year when they clearly should not be doing that.'*

The minister has, to some extent, recognised the problem of involuntary tranquilliser addiction. However, the Health and Social Care Act 2012 came into force one month later. This reorganisation of the National Health Service has devolved responsibility for any treatment for addiction to medicines away from the Department of Health onto local authorities. At the moment is it unclear where the impetus to create new services for involuntary tranquilliser addiction will come from. None of the new agencies involved in the new commissioning system has been allocated responsibility for making sure new services are created.

On the question of guidelines APPGITA have stated:-

> '*Any newly commissioned tranquilliser services will need consistent national clinical guidances from the MHRA, NICE, the BNF and the RCGP's are inadequate and they have a tendency to suggest dangerous rapid withdrawal. APPGITA is therefore campaigning for the adoption of the Ashton manual as national clinical guidance for the proposed new services.'*

LORD LAYARD RAISES IAPT (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) FUNDING FEARS

Denying people access to psychological therapies causes *'massive inequality'* within the NHS. This states a report from the Mental Health Policy Group at the LSE Centre for Economic Performance, chaired by Professor Lord Richard Layard.

The report published in July 2012 is entitled 'How Mental Illness Loses Out in the NHS'. It repeats Lord Layard's argument over many years that providing a national Cognitive Behavioural Therapy (CBT) service would save the NHS money in the long-term by reducing the burden of mental ill health within the population. This would enable people to recover and return to work more quickly and cut the cost of treating physical illnesses that have a strong mental health component.

The report states that 75% of the estimated 6 million adults with depression or anxiety and 700,000 children with emotional and behavioural problems are getting no help from the NHS, which it calls a *'scandal'*.

The report further states that, even though the Government is funding IAPT up to 2014, some PCTs have been channelling the funds to other services. It urged PCTs to extend the IAPT programmes beyond 2014 to treat people with long-term health problems and medically unexplained conditions.

COUNSELLING SUGGESTED INSTEAD OF SLEEPING PILLS

A similar plea for greater use of counselling instead of medication was made in August 2012 by a leading sleep specialist, Kevin Morgan, Professor of Gerontology at the University of Loughborough. He argued that the NHS should be looking beyond sleeping pills and that it should be training its staff to provide psychological therapies such as Cognitive Behaviour Therapy (CBT) to help those suffering from insomnia. Morgan argued that CBT offers a better long-term solution and that sleeping pills create several dangers:- addiction or dependence, medically-related accidents and spiralling costs for the health service.

Professor Morgan said the CBT works on the basis of understanding and manipulating the two processes that affect an individual's sleep. First, the learned behaviour of spending too long awake in bed trying to get to sleep and second, the thinking that accompanies that time, which can become panicked and obsessive. He said that a mere 5 hours of CBT can deliver benefits in more than 70% of cases.

ROUNDTABLE CONSENSUS STATEMENT ON BENZODIAZEPINES

After many months of deliberation the Department of Health Roundtable Group on Benzodiazepines finally produced a consensus statement on addiction to medicines towards the end of 2012. A copy of this statement is included at Annex 1. It has been signed by the Department of Health, professional groups, Royal Colleges, Specialist Services and some voluntary organisations.

Although the statement is a welcome step forward in dealing with the problems of benzodiazepine addiction, there remain a number of concerns not addressed by the statement. These were summarised very well by Jim Dobbin MP, Chair of the All Party Parliamentary Group on Involuntary Tranquilliser Addiction (APPGITA). Amongst others, these points were made:-

1. The core of the new policy is contained within the Joint Strategic Needs Assessment (JSTA) provided by the National Treatment Agency (NTA) for substance misuse, which provides guidance on drug treatment services for local authorities and on their funding. The NTA, the local authorities and the drug misuse services do not have the necessary expertise to take on the treatment of addiction to prescribed medication. The NTA specialises in illegal drug use and has little idea of what is needed to withdraw people from prescribed psychotropic medication.

2. There is no action plan within the consensus statement and no ring-fenced budget for prescribed medication.

3. The statement suggests that misprescribing will be reduced by referrals to alternative treatments. In practice these treatments have long waiting lists and are not readily available.

4. The statement refers all prescribing issues back into the hands of the doctors. But these are the people who misprescribed in the first place. Student doctors still receive little or no training in pharmacology, so the problem will be perpetuated.

5. These is no specific mention of antidepressants in the statement, which can cause withdrawal symptoms that are every bit as severe as those of the benzodiazepines.

One reason for the shortfalls in the Roundtable Consensus was that there were no medically or scientifically qualified experts on tranquillisers or antidepressants on the Roundtable Group. Professor Ashton was not asked to participate, despite being one of the leading scientific experts in the field.

THE TIMES ARTICLES ON BENZODIAZEPINES

A series of articles on benzodiazepines written by the Times health correspondent Martin Barrow were published in the newspaper from October 2012 onwards. The articles drew attention to the severity of benzodiazepine addiction and withdrawal and the lack of support for those withdrawing from benzodiazepines

in large areas of the country. He interviewed a wide range of experts, including Professor Ashton and Ian Singleton. The articles included several first-person stories of addiction and withdrawal.

In conclusion Martin Barrow said;-

> *'The Department of Health said that the problem is recognised across the NHS and that services for involuntary tranquilliser addiction are available in most areas.*
>
> *However, the Department generally expects support to be provided by drug and alcohol teams that form part of the National Treatment Agency. Significantly, a Freedom of Information request sent to 149 Primary Care Trusts in England and Wales revealed that 77 had no benzodiazepine services at all and a further 10 offered only limited provision.*
>
> *Benzodiazepine addicts depend on a small number of charities, based in Liverpool, Oldham, Bristol and Cardiff. There is just one in London.'*

A letter of support for the articles came from Professor Malcolm Lader, who has been one of the experts most concerned about the issue since the 1970s. This letter is included in full below:-

> *'Sir, I welcome the careful reporting of the use of the benzodiazepine tranquillisers (report and leading article, Oct 1, and letter, Oct 2). This controversy has grumbled on since the first alarms were raised by my research team, among others, in the 1970s. Official warnings have been largely ignored by the prescribers. Over the past 20 years, according to National Health Service data, the prescription of anxiolytic benzodiazepines has increased slightly. The use of hypnotics has continued unchanged but with a switch from the benzodiazepines to the shorter-acting but similar 'z-drugs'.*
>
> *Two approaches are needed. First, the prescription of benzodiazepines should be totally discouraged because it is impossible to distinguish those potential recipients who will use them without problems from those who*

become physically dependent and cannot withdraw easily. Long-term (beyond 3-6 months) usage is being deemed by GP experts in medico-legal cases as possible substandard care, so personal injury law will come to govern these prescribing practices.

Second, specialist clinics should be expanded countrywide, not curtailed. Requiring these clinics to treat the entire range of substance abuse problems is totally inappropriate and even counterproductive, as my patients used to insist.

Malcolm Lader
Emeritus Professor of Clinical Psychopharmacology, Kings College, London'

RESOLUTION ON INVOLUNTARY TRANQUILLISER ADDICTION AT THE EUROPEAN PARLIAMENTARY ASSEMBLY

A resolution on involuntary tranquilliser addiction was put forward by Jim Dobbin MP and several other members in January 2013. The resolution reads as follows:-

'In 1990 the Committee of Ministers of the Council of Europe adopted the Resolution AP(90)3 on the prescription of benzodiazepines. Since 1990 no progress on involuntary addiction has been reported in Europe although all members States of the Council of Europe are affected by the problem.

Involuntary tranquilliser addiction is the unnecessary dependence of patients upon misprescribed mind-altering tranquillisers without informed consent. The Parliamentary Assembly recognises involuntary tranquilliser addiction as a serious illness.

In the United Kingdom an estimated 1.5 million patients are long term tranquilliser users. Tranquilliser addiction is known to cause disabling side effects such as cognitive impairment, pseudo-dementia and damage to the foetus. Addicted patients have suffered the loss of their homes, jobs, careers and marriages.

Involuntary tranquilliser addiction is a physical illness and originates from misprescribing by doctors and psychiatrists. It is not caused by psychological problems and should not be confused with tranquilliser misuse.

Withdrawal from tranquillisers can take twelve months or more. A safe and successful tapering withdrawal method has been designed by Professor Heather Ashton and developed by charitable groups such as Bristol Tranquilliser Project and Oldham ADS in the United Kingdom.

In view of the individual and public health implications of involuntary tranquilliser addiction the Assembly calls on member States to:

- *Recognise involuntary tranquilliser addiction as a serious illness;*
- *Enforce prescribing guidelines according to their own regulations;*
- *Introduce specialist tranquilliser withdrawal services.'*

'BAD PHARMA' BY DR BEN GOLDACRE

Dr Ben Goldacre, a practising GP, published his new book on the pharmaceutical industry 'Bad Pharma' in 2012. This deals with the issue of flawed clinical trials followed by suppression of unfavourable results, diseases invented purely for profit, swollen marketing budgets, and doctors and academics in the pay of pill manufacturers.

On the subject of drug testing he writes as follows:-

'Drugs are tested by the people who manufacture them, in poorly designed trials, on hopelessly small numbers of weird, unrepresentative patients, and analysed using techniques which are flawed by design, in such a way that they exaggerate the benefits of treatments. Unsurprisingly, these trials tend to produce results that favour the manufacturer. When trials throw up results that companies don't like, they are perfectly entitled to hide them from doctors and patients, so we only ever see a distorted picture of any drug's true effects.'

He is also scathing about the lack of regulation of the pharmaceutical industry:-

'Then we look at regulation, and the hoops you must go through to get a drug onto the market. We will see that the bar is very low in that drugs must only prove that they are better than nothing, even when there are highly effective treatments on the market already .....

We will also see how data on side effects and effectiveness can be withheld from regulators, and that regulators, in turn, are obsessively secretive, withholding the data they do have from doctors and patients.'

As for solutions, he advocates the following:-

> *'We need to prevent badly designed trials from ever being run in the first place. We need to ensure that all trials report their results within a year at the very latest; we need to measure compliance with that; we need extremely stiff penalties for companies who transgress; and we need doctors and academics who collaborate in withholding trial data to be held personally responsible, and struck off.'*

GLAXO SMITH KLINE FINED $3 BILLION

The pharmaceutical group Glaxo Smith Kline (GSK) was fined $3 billion (£1.9 billion) in July 2012 after admitting bribing doctors and encouraging the prescription of unsuitable antidepressants to children. The company encouraged sales representatives in the USA to mis-sell three drugs to doctors and lavished hospitality and kickbacks to those who agreed to write extra prescriptions, including trips to resorts in Bermuda, Jamaica and California. The company admitted corporate misconduct over the antidepressants Paxil and Wellbutin and the asthma drug Advair.

Paxil (known here as Paroxetine or Seroxat) which is only approved for adults, was promoted as suitable for children and teenagers by the company, despite trials that showed it was ineffective, according to prosecutors. Children and teenagers should only be treated with antidepressants in exceptional circumstances due to an increased risk of suicide. Critics said the case, involving issues dates back to 1997, underlined the need for tougher action, which could include certain executives being jailed.

Subsequently GSK has been the world's first large pharmaceutical company to commit to publishing clinical trial data. GSK said it would publish clinical study reports (CSRs) for all of its medicines once they have been approved or discontinued from development and the results have been published. It will eventually lead to publication of all trial data dating back to the formation of the company in 2000, when Glaxo Wellcome merged with Smith Kline Beecham.

The commitment to data transparency followed a high-profile campaign by Dr Ben Goldacre, who helped to expose the drug company's manipulation of clinical trial data. He saw GSK's decision to publish CSRs rather than just summary results and academic journal articles was a:-

> *'genuinely historic milestone for the development of medicine.'*

He said:-

> *'that he expected GSK's decision would put huge pressure on the world's other big pharmaceutical companies to commit to publishing their own trial data.'*

US FDA WARNING ON SSRI ANTIDEPRESSANTS

In 2005 the US Food and Drugs Administration (FDA) instructed all manufacturers of SSRI antidepressants to issue warnings about the increased risk of suicide amongst children and adolescents. The FDA asked manufacturers to include in the warning advice that all children and teenagers should be closely observed and monitored while taking the drugs.

The FDA then decided to examine whether adults also faced any similar risks. It began its own review of nearly 3000 antidepressant studies, which involved more than 77,000 adults taking SSRIs. The studies showed that there were 5 additional suicides or suicidal impulses for every 1000 young adults studied. An earlier study showed that the drugs cause 14 additional cases of suicidal impulses per 1000 in those under 18.

As a result of this the FDA has instructed all manufacturers of SSRIs to update their warnings. The labelling now includes the warning that young adults from 18 to 24 taking these drugs may increase their risk of suicidal thoughts and behaviour even during treatment in the first month or two.

ANNUAL GENERAL MEETING

Our AGM was held on Wednesday 31 October 2012 at the British Aerospace Welfare Association (BAWA) Leisure Centre in Southmead, Bristol. Once again BAWA generously waived the fee (£235.00) for the use of the premises which was the equivalent of giving us a donation for that amount.

The speaker this year was Rod Shaw, Chief Executive of the James Tudor Foundation, which has supported our Helping Older People scheme for most of the past 7 years. Rod was appointed to this position in 2005 and established the operation of the Foundation and its policies, procedures and controls.

In a fascinating speech Rod first explained something of the history of the Foundation and how he came to be appointed as Chief Executive. He then spoke about the work of the Foundation, how it helps a number of other voluntary sector organisations and finally about the excellent relationship it has built up with the Project.

ANNUAL OUTING

The Project's annual 'Valerie Stevens' summer outing took place on Wednesday 20 June, this time to Burnham on Sea. The usual mixture of clients, volunteers, Committee members and staff once again enjoyed a very relaxing and enjoyable day by the seaside. Burnham offered just the right mix of cafes, restaurants, shops and beach to keep everyone happy. The weather was a great improvement on the previous year, with everyone able to bask in the sun and no-one having to shelter from the ferocious winds this year.

Once again a huge thank you is owed to Tony Burton for organising the day and to the driver from Stroud Community Transport for taking us there and back.

TARGETS FOR 2013/14

1. To work towards securing long-term NHS funding for the Project.

2. To raise £25,000 for the HOP scheme.

3. To continue our existing helpline, withdrawal groups, drop-ins, assessments and counselling sessions.

4. To advertise our services to GPs and practice staff, psychiatrists, mental health teams, pharmacist, libraries and voluntary sector organisation in the Bristol area.

Jayne Hoyle
Project Manager

Ian J Singleton
Senior Project Development Worker