battle against tranquillisers

AGM 2014 PANEL transcript

PANEL

- Clive Lewis: Head of Alcohol and Drugs, Public Health England (South West)
- Dr Liz Lee: GP at Horfield health centre
- David Dicks: BAT service user.
- Jenny Scott: Senior lecturer at the University of Bath, and lead Pharmacist at Turning Point.

PANEL INTRODUCTIONS

Jenny Scott

Well, as you heard I have two jobs. I'm a pharmacist by training at Bath where I teach pharmacy students – and I also teach them about medicines and safe use of medicines – teach them how to deal with patients and the public; and I also do research. My main research area is around addiction, and particularly my focus has been on opiates – more recently we have done some work on crack cocaine and Novel Psychoactive Substances – so I'm particularly interested in harm reduction and improving the health of people who have dependences on substances. My other role, as you heard, is that I also work for Turning Point who provide drug and alcohol services in quite a few different locations – the nearest to here would be Gloucestershire. We also have Somerset and Wiltshire as well. I have two roles within Turning Point – I'm lead pharmacist so I look after some medicines management things, the more dull stuff like safe use of medicines – how we handle medicines; organisation and governance stuff. On a Tuesday I work as a practitioner, and I'm also what's called a 'non-medical prescriber'. I trained as a prescriber 8 years ago now and I do clinic on a Tuesday – so a lot of the people I see are opiate or cocaine users but increasingly over the last couple of years we've seen people with dependency on a range of prescribed medications, and of course benzodiazepines feature quite highly in that patient group. We take referrals from GPs or people can refer themselves.

Dave Dicks

I'm David Dicks – I've been a drug user for years since the early 70's when an accident on a building site got me hooked onto these drugs – pillar to post, moved about from different drugs and everything else. In the early 2000's I got a new doctor and she saw that I didn't need the drugs, and she put me in contact with BAT. For the last 13 years I've been trying to come off – and with my GPs help, BATs help, and my family's help I succeeded in coming off since December – and fro the 11th December until now life is so much better – and I'd like to thank all those people.

Dr Liz Lee

I've been a GP for about 27 years and the first thing to say is that I have prescribed a lot of Benzodiazepines myself and one of the things that interests me about being here is to see … sort of, the other side – the consequences – that are sometimes hidden to us GPs. We start things, often in good faith, and end up creating terrible problems that we would never intend to create – so that's part of my work. And then actually working with Dave has been a great learning experience and what I've learnt …. the first time I met Dave, as we have written, he was in incredible distress – (to Dave) you don't mind me saying? I was called on an emergency visit to see him – he was alone in the house clinging on to the bottom of the stairs in a panic attack, and was just incredibly distressed – and I think that experience taught me that people wanting Benzodiazepines weren't just trying to get drugs off me but actually their lives were being ruined – and your life looked like it WAS ruined.

Dave's wife will back us up on that I think. And in a way it was a very useful way of first meeting Dave, because I was immediately aware it was no light matter – it was a sort of life and death matter really. And so then we worked together as a team, with Una and the group, over many years, to get Dave off - and my role has been to allow it to take its own time – and that's what I've really learnt - that there's no quick fix; you can't say 'well have you off on six months' – it will take as long as it takes. And it's taken years, but there's always been progress. So I would like to say I've learnt an awful lot through this experience and it has helped my practice.

Clive Lewis

I head up the public health England alcohol and drug team, and I also have a remit around tobacco control this year – all around stop smoking and working with local authorities to reduce the availability of tobacco. My role I suppose is around supporting local areas – that could be provider agencies, local authorities – prime commissioners – anybody really who has an interest or stake in alcohol and drug related matters. I come at that from a public health perspective, so I am interested in the harm that it causes to general populations but also interested in how individuals can be supported within treatment – looking at effective practice; what kind of practice goes on out there, what's commissioned in each area to meet needs and how practices develop to meet individual need. Part of that, as a bureaucrat, is about thinking what is the best use of resources – ensuring that people in local areas get the 'biggest bang for their buck', if you like. My interest in that started several years ago when I was doing some research into factors that affected English drug policy and looking at the range in which health matters – battles between the home office and the department of health principally, but also how perceptions in media and stigma affect the way in which drug and alcohol issues are reported and the way in which communities then relate to drug and alcohol use. So ultimately that was a thing that made me think this is a VERY interesting area to work in and from there I became a commissioner of services – when I realised I wasn't going to get much money out of this – moved into commissioning of services and then moved to the National Treatment Agency, and oversaw the pooled treatment budget prior to public health England coming in place, and that money coming within a different 'pot' with greater flexibility but some people might say more of a risk about funding being diverted.

QUESTIONS FROM THE AUDIENCE

My name is Judy. I was reading about the increase in suicide in prisons – a massive increase – and I was wondering if any of the panel knows if there is any connection between that and Benzo use in prison?

DD

I know from my experience on benzos that I was suicidal lots and lots of times because the way the drugs work is to destroy the brain functioning properly, and the brain never seems to be 'right' so you want to end it – and there's nothing that people can say to really stop you. I was very luck in that my case I had the support I needed, but in most cases people don't have that support and so unfortunately they do take their lives on benzos. Especially if they mix it with drink.

JS

I don't have any science on this, or any numbers, but it might be useful that I was at a forum last week with mainly nurses from the south west, and there were quite a few nurses from prisons in this area, and yes they did mention benzos - but they actually attributed increase in suicides to use of some of the newer synthetic drugs – particularly synthetic (cannabinines?) because they produce quite severe and enduring psychosis and they said that they are dealing with higher attempts within prison and that's what they attribute it to – its possibly part of the picture

CL

I'm sure that if Nikki (Ralph, HMP Eastwood Park) was here what she would have commented on was a picture which supports that view about new (novel) psychoactive substances (NPS). In my team I have a worker who supports drug and alcohol services, and service development within prisons, and what she has noticed in the work that she has been doing has been an increase around NPS usage and people not really knowing what they're taking, and often in combination. There are often issues because it can get in to prisons relatively easily. We've seen significant reduction in drugs dogs – so possibly getting drugs into prisons is easier than it has been in the past. I can't say that A causes B here but there has been an increase in that sense and I think people are finding it particularly difficult to manage due to the combinations and the distress that people are presenting themselves with doesn't necessarily follow a normal pattern. In addition to that what was highlighted in a report, which has also been noted elsewhere, was around reliance and use of pregabalin and gabapentin, and how that's gone up in pain management. People actually using that and becoming accustomed to using that and seeking other ways to increase their drug use and meet their needs. And again I think that causes particular problems both within a prison environment and outside, and we have been looking at levels of prescribing these. and finally in relation to the points around benzos, all across the South west I've come across comments about the availability of, and how to get access to, benzos via the web – should they want to, and that can either be directly or increasingly vast quantities being made available through normal dealer networks. But people are being exposed to benzos that haven't necessarily been exposed to such quantities at such a low price. in Plymouth I was told that benzos were 2p for 10g recently. So there's a range of factors there I think.

AUDIENCE (CANDY CAROLAN)

Can I add that when I discovered the datasheet compendium in the 90's that Roche openly said that 'Valium may uncover suicidal ideation' – in other words you don't feel suicidal before you take the valium, you do afterwards – they're denying causation … a complete mystery to me … but Roche are a lot richer than I am so I won't say more or they'd be likely to sue me – but certainly benzos are indicated in suicides in that way and I can certainly say that in my case two suicide attempts were in classic as a result of a typical benzo state of mind, I was on a very low dose – id been

prescribed them as sleeping tablets. So if a small amount can have that effect what happens when people are taking more?

AUDIENCE
I've just found out a week ago from my little sister that someone has been selling benzos in her high school and I was wondering whether BAT worked within schools at all, and whether this is something they plan to do in the future?

DD
before anyone else speaks, I should say that I think we should do.

UNA
I think we should do, and I think we should HAVE done long ago. I think probably, and Clive will know a little bit about this because we were both at a public health event yesterday - the wellbeing event – and you will have heard me make that point. I think what's very sad is that schools now have very little time to do anything other than deliver the national curriculum, and where that would have been possible a little while ago, it hasn't been progressively since the national curriculum came in. However, when it DOES come in (because this is about wellbeing) organisations and funders will be saying that its year 6 which is the youngest that you can possibly introduce it – so they will be aiming it at year 6 and 7 really. And of course that's missing the whole point and it should start at reception and infants. as an ex teacher myself I know exactly how it would be done – so I'm really hoping that they take notice of that. Also I think that because the public health agenda is so much more rounded really, I think there's a much better chance of that happening now. And I know that Colin has always been very keen to work in schools.

CL
One of the advantages of public health now seated within local authorities is that there are links between public health and education where I think issues can be discussed and taken forward more easily but people do need to know that things like that are going on. I think the difficulty that Una describes is around being proactive in prevention which is difficult now and particularly difficult with academy structures whereby schools are more easily left to stand alone and be governed on their own rather than within a local authority framework. Obviously there are strengths and weaknesses within that and I think this is a potential weakness. I'm sure that if you had any concerns, if you were to make that information public to local authority health they'd be really interested in wanting to act upon that kind of information.

DD
I can say something that happened with my children – in their teens two of them were given Benzos. one was for flying and was a one off only, and the doctor was concerned that I would be upset and I wasn't because it was a one off. My daughter was prescribed them because she was having problems with her nursing course – and she looked at the doctor and sais 'sorry, my dad's addicted – I don't want to be' and she walked out. That shows that by learning about benzos children would be less likely to take them so I believe it should be taught in schools.

PAUL VOLKER (South Glos Drug and Alcohol Team)
I sit within Public health in the local authority and we have a link with young people drug services. Something that Young Peoples drug services have started to do is send out a pre made up powerpoint display around smoking and alcohol to schools, so that it can go to the PSHE teachers with a brief around how they can deliver the lesson – like a pre-made lesson plan. If you let us know what school it is we can also organise something called a drug intervention group where the YP

drug services will go in and have a chat with the select group so that we can see if it's a much bigger, wider whole year group or if it's just 5 or 6 people. So I can have a chat with you afterwards if you like.

COLIN YOUNG
I'll follow on, on the prison stuff. We have a couple of studies – one shows that 9 out of 12 prisoners who committed suicide in prison have benzos in their system and there was another one from a Greek prison where half of the population who were using benzos were also on anti-psychotic medication. There's a mass of literature to show that people think about suicide/ commit suicide / develop mental health problems, all sorts of stuff. And while I was listening I was wondering if Jenny (pharmacist on the panel) could tell us how much training pharmacists get around benzos. Also, in 2011 I think it was, the NTA recommended that services should be commissioning across the country for Benzo services because of how widespread it actually is. How much commissioning has actually gone on since then? I know were commissioned but across the country how much is actually happening in terms of commissioning for services?

JENNY SCOTT
That's a really good question about pharmacist education. I think I can answer it as a general country wide point for pharmacy schools although obviously I know most about my own work. I think generally when you look at the curriculum pharmacists get a lot of awareness about the risks of dependence across the board on all sorts of medicines but what I think is less well taught is how to respond to that, so actually what to do. I think traditionally they've been taught to take a kind of approach of either refuse sales, or take advice from the GP - but not offer any more advice or signposting to patients so I think generally there's a problem there. I would hope they'd all be able to tell you what drugs were dependence forming but as I said, not how to respond. within our school of pharmacy, I suppose because I have this interest and I run a one semester 12 week course all about addiction and we do cover a lot there about how to respond to patients. It is an optional course and I suppose about half of the students take it, about 70 each year, so I think you've highlighted a good point that there's a lot more that we could do in education about how to respond when people identify problems. Hopefully they should know what the signs and symptoms are and what drugs can cause a problem.

LIZ LEE
It's a really interesting question and what you said resonates with me. We are taught about the risks of addiction and how you should limit your prescriptions to, you know, a short course of two weeks. But we're not taught how were meant to deal with the problem the patient has when we've got 10 minutes …. and we really don't have the education about how to find other ways to help our patients live with whatever it is that's troubling them. And so, rather as with antibiotics where you're tired and it's late on a Friday night and you give the prescription you don't think you should – and that's even though we've all been taught not to do this. So we've had the very first bit of the training but we haven't had any of the other intelligent bits. we also have no training at all about withdrawal and coming off

We learn a bit about alcohol because sometimes we detox by using benzos but were not taught anything about benzo withdrawal. I trained years ago and it's still the same now. We're still creating problems because we don't know what to do. I really don't think we mean to cause this trouble but we still do it, and I'm really interested in what Clive said about pregabalin and gabapentin which we are handing out like Smarties at the moment. they are the latest fashionable drug and were just beginning to hear that there are dependency problems and a black market … were going to have to be taught how not to hand out those drugs and to use some more intelligent intervention instead.

CL

In terms of your question about how much commissioning is going on for benzo services around the country, I can only really say that there's a richness here that there isn't elsewhere. You're very lucky with BAT and with your commissioners who've seen this as s significant enough priority to spend money on it. In many other areas it's just not there. in June 2013 there was a piece of work produced by the National Treatment Agency – a commissioning guidance that came out of public health England – called ' Commissioning treatment for dependence on prescription and over-the-counter medicines' which explains the responsibilities around this. This is set in the context of local is king, we can't say 'shall' and 'must' anymore, we can 'advise people that they might like to consider' and so what we do is support people by suggesting approaches and what that means is that local areas need to look at what their local need is and prioritise accordingly. at the moment there's interest in benzos because of what we're seeing in terms of a ballooning and problems around that and other drugs such as Z drugs, pregabalin and gabapentin etc, and I think we'd like to see more of a fovcus on asking people locally what they're doing to meet this particular need. it's always the case that if you haven't got a service it's difficult to identify a need associated to that particular need group, because they don't KNOW where to go to get support, so you can't count them. It's as simple as that, but that doesn't mean that there isn't a need there locally. Within that guidance there's a suggestion about how you might look to support this. We can look to see what IS being prescribed, by who and where, and that might indicate that more drugs of a particular variety are being prescribed more by some GPs than others, which might suggest there are training needs. So there are ways in which we can shine a light on particular issues and unfortunately – or rather fortunately for you - locally I don't think the picture is similar elsewhere. You're very fortunate in South Gloucestershire.

CY

When you talk about local needs – there was a service in Wales that couldn't find the funding. In our work within prisons we started a group at Eastwood Park Prison and the first 9 people were Welsh. The second time we ran a group – out of 13 there, 12 were welsh. We went into Ashfield prison when it was for young offenders, and they were all welsh – drug of choice. They couldn't get a service funded there. I'm sure if you look across the country a lot of stats come up – Glasgow and a lot of places in Scotland where you're looking at a problem about 4 times the national average you can look at your next door neighbour and it's in your face – but trying to get any kind of funding for it is nigh impossible. And yet the NTA said – as you said – it will come out, and that services will be asked to commission for it. But the reality is that there's us, and very little else.

AUDIENCE MEMBER

On the matter of the Welsh – when I worked at Broadway lodge about 80% of the people at Broadway lodge in Weston, which is a drug and alcohol rehabilitation unit, were welsh. I was really going to talk about the schools when we were talking about that. admittedly a little while ago when my son was doing his PSHE or whatever it's called, they talked about drugs – and they discussed ketamine which was new at the time, and they did about cannabis and heroin and at the time I happened to be working for BAT, they didn't once mention prescription drugs that you can get hooked on, and I actually went to the school about that and they knew nothing about it. Maybe there's something about educating teachers, who can then educate the kids.

CL

Just going back to the point around Eastwood park, Broadway lodge etc. there is an issue in this part of the country about wales and that's because of its proximity and because the welsh assembly

has an entirely different system to us, and funds things differently and we don't operate in wales at all. I'm not saying that's an excuse but there is work going on that has come out of the issues identified at Eastwood park recently. one of my team has met with the welsh assembly to try to identify paths back to treatment because EVERYTHIING is different in wales, from pathways right through to what you can be expected to titrate from in terms of methadone so the whole system is different. And in terms of that Nikki Ralph (former drug treatment services manager at Eastwood park prison) found it very difficult to deal with a group of people from England who had needs and services they could come in from and go out to, and potentially a different presenting group within wales and it's a real barrier. It's a challenge, but it's one we have to find a solution to if we are truly to be providing a person centred service and we're not there.

AUDIENCE
How concerned should we be about pregabalin? I've got three members of my family on it – one mixed with amitriptyline and pain patches and another with benzos … what is the thinking about pregabalin causing a problem? Are they addictive, or just 'habit forming' as they said? And what's the difference between the two?

JS
The story that were seeing with drugs like pregabalin and gabapentin I suppose is repetition of what we saw with benzos years ago and other drugs since, in as when they came out they were deemed to be safe and subsequently we see more of a pattern emerging. We have definite evidence now that people can get dependent on drugs like pregabalin and gabapentin and this is what might be called psychological which is that there are strong cravings and people want to use these but you also have to remember that people CAN be prescribed these medicines and they don't have those kinds of problems, just like with lots of other medication. We're now thinking that we should monitor or be careful of how long people have had these medications ad what kind of effect they get from them particularly with people using more and more to try and get a psychoactive effect and to get a buzz off it in a sense. So it is a problem but I think we have to be careful not to assume that everyone who has been prescribed these has or will develop a problem. I think we need a caution that perhaps wasn't there when they were first placed on the market. They were originally used in pain management I think – originally they were used for epilepsy and things like that but they are used increasingly in pain management which is a very difficult area to treat, and they are quite effective – so I think it's a balance. There's a right to be concerned and those concerns are manifesting in reality but we also have to make sure that people have proper access to medicines I think it's about monitoring and safety. I think Liz's phrase about dishing out like smarties – that we shouldn't treat any medicines like that, but I think GPs have an incredibly difficult job to do and the workload is immense – and I think part of the pharmacist's job is to flag up when these things are registering concern.

LL
Certainly in practice a while ago these things were just prescribed my neurologists and they were very expensive, and generally there's a trickle-down effect and then they're not the new wonder drug just prescribed by neurologists but we start to prescribe them more widely. For nerve pain is what we use them for a lot. People that come in with a bad neck and pain running down their arm – we will now start to use this sort of drug. We've learned from the benzos that you have to have very strict limits and to think of longer consequences and were only just beginning to learn the long term consequences and so when I start them I do not say 'you're only going to have these for a month'. I say 'if these work for your pain you can have them' and what slightly worries me about your family's case is there's polypharmacy going on – there's a patch, then there's gabapentin and amitriptyline that feels like the benzo story – building and building and never getting to the real

problem, just throwing drugs at it. so I think they should stay on them but go back to their doctor and say 'why am I now on 3 drugs for this pain, and it's still there?' but the story's unfolding at the moment and that's why we haven't got an answer for it.

R Lawson
I'd like to underline what Jenny said about the balance. it is very important that we don't just say to people on a certain drug and say 'ooh, you shouldn't be on that' – it might be because of the level of pain they're suffering it might well be that the gabapentin is exactly what they need IF it's working. if it isn't working then there's a question to be asked. We do not need to be categorical about these things. We're not talking about the devil incarnate, exactly – there are medical uses for these things. One thing that is possible that we found with highly addictive morphine is that people who are given morphine for *pain,* when the pain ceases they come off the morphine quite easily. This is only the training that I was given and it tends to be generally what I've found. So we mustn't be black and white about it.

DD
I think to a degree this is why GPs and other people need a lot more training, because if someone like myself is addicted to benzos which cause a lot of pain in the muscles, and I go to a Dr and get pregabalin or gabapentin prescribed I would then be on <u>two</u> drugs. So I think Drs need to be aware of people that are taking them – it might help solve the problem of double prescribing.

AUDIENCE MEMBER
What alternatives do we have in pain management? In regards to services, are there alternatives to tranquillisers? What alternatives have we got? I have found before with clients (I work for Addaction) who have lost limbs and things like that, but still take benzos and are referred to a pain management clinic – and there's not much else to choose from as an alternative to benzos.

CL
I am aware of a piece of work that's been started in prisons because of the amount of pregabalin and gabapentin that's been prescribed for pain management which is looking at just that – what alternatives there are. It might be that its being prescribed in such large quantities that not everybody can be benefitting from this is the way that it was actually intended and given that it seems to be dependency forming and has a currency within prisons that people are therefore using it for dependency reasons and for intoxication rather than simply for pain management. It's currently being rolled out within prisons. It's being piloted in the south west and we're looking rolling it out into general practice we we're ideitifying very high levels of pregabalin and gabapentin appearing to be prescribed in certain settings, and I suppose what its identified is a kind of protocol: if you've got x number of people that you're prescribing a substance to, then a proportion of them will probably benefit from different kinds of pain management techniques. Now I'm not an expert so I don't know what they are but I am aware that there is work being done on this, and in answer to your query about the fact that it is prescribed and drugs do become the drug of choice for particular conditions, and then we find out there are issues.

CC
I just wanted to ask about these new drugs, pregabalin and gabapentin – do they have the same paradoxical effects as the benzos which have been implicated not only in suicide and self-harm, but violence? There was one – halcyon, I think, that was taken off the market because the homicide rate was a bit scary. I just don't know anything about these new drugs and whether they function like that?

LL

I don’t know the answer to that.

JS
Not as far as I am aware, but as we’ve heard things are still emerging. The association with violence and mood disorders that you describe has not been picked up but we are seeing different patterns. We see people who are prescribed these medicines as you describe but then have trouble NOT having them. We are seeing a different cohort such as prison users who are taking vast quantities for different effects – intentionally to become intoxicated – but as far as I’m aware I haven’t read anything about association with violence but it could emerge.

CY
I've spoken to two different service users who were on pregabalin and when he was prescribed 130 ml of methadone and he didn’t take the gabapentin he couldn’t sleep. so that shows you how powerful it is because that’s a lot of opiate. and the second one didn’t get their methadone – they didn’t allow then to get it over the weekend – so they took pregabalin and didn’t notice any withdrawal effects from the methadone so it tells you its wuite powerful. I recently read a study on them and there's only been one long term study in Scotland, as it usualy is, and what it was saying is that when they took so many individuals off them iy was very like benzos in as much as the withdrawal was delayed – 10, 15 … 17 days before the withdrawal kicked in, and when it did it was also similar. Anxiety, agoraphobia, agitation, paranoia – all that stuff was going on. As soon as they reinstated the withdrawals went away so there are a lot of similarities there. Can I also say that we give training and are prepared to travel the country for anyone who needs training.

AUDIENCE MEMBER
I have dystonia and I was prescribed clonazepam for it, and when I developed tolerance I was then prescribed gabapentin by my GP, but they didn’t understand withdrawal so they took me off the clonazepam very quickly and I started having seizures and their conclusion was that the gabapentin didn’t agree with me – but it was withdrawal, which I know in hindsight - but since then the project I have in Cardiff has supported quite a few people … is lyrica one of these drugs?

PANEL MEMBER
Yes

AUDIENCE MEMBER
So as far as I’m aware withdrawal can be just as intense as benzo withdrawal so I wanted to share that.

PAUL VOLKER
My question is a little but different and it’s to do with Novel Psychoactive Substances. from a GP point of view, Liz, if someone presents addicted to something they bought off the internet how easy is it to know what to do with that [person, or is it a really difficult situation? From a pharmacy point of view if somebody comes in and presents in a pharmacy dp you think there's enough training around them for pharmacists who have been in post a long time, to know what to do?

LL
We don’t know what to do, is the short answer. So in the moment we can go and try and find out but we will go to our drug workers and ask them, and generally they will help us. We’re behind the curve and this is the problem – there are things out there and we’re … not the last to know but quite late on to know. So what happens is that whoever comes to us is disappointed with our

response and doesn't come back, on the whole – even if we try that's what happens. So that's their attempt to get help and we're just not up for helping the problem.

JS
I think it's the same with pharmacists. I certainly haven't seen any courses advertised that focus on NPS for active pharmacists. The only time it might be mentioned I think is for pharmacists who are commissioned for needle exchange. most areas tie in with the commissioning requirement to attend training annually and it might be something – some of the NPS's are injected so it might be mentioned but I wouldn't have thought they were close enough to know where to signpost or what advice to give. probably in the same position as GPs.

LL
Any suggestions would be very helpful and we could pass them on!

PAUL VOLKER
I have got a suggestion actually – BAT have signed up to a group called SPACED which basically is across the board – BAT, DHI and SGAS DAT have joined as a group to address it. we will see if we can organise some training if you think that would be useful – for GPs and pharmacies.

JS
You could probably do a joint event. It would be good for both to be at the same one.

CL
Can I just say that PHE is shortly about to publish an NPS toolkit which pulls together the evidence that we've got so far about how to tackle NPS issues

UNA
I've got a whole host of things, actually – some of each! Talking about NPS which as Paul has just said, BAT is part of SPACED. In our annual report you will see about Benzo Analogues. Clive knows…

CL
Because you told me!

UNA
…so that's gone to the Orange Book people because that's interesting – analogues are MADE because there's going to be a profit. So it points to the success of Benzos that analogues of them are now being made – but also its going to join the analogue seen so it's going to have to be included in the SPACED thing – but on the other hand I see it in headshops ' get your downer here … and your upper here' so that's one thing. The thing that isn't in the annual report because it was too late is that the CQC is going to do an audit in primary care, of antibiotics and benzos. It's going to raise the profile of both of those. I've just written to prof Steve Field (head of CQC) because what I thought would happen, has happened – because they've been told by Prof Field that it's going to be like 'OFSTED is for schools' and that GPs are going to be ranked, that a lot of GPs from all over the country are contacting BAT and saying 'I'm not writing another prescription for your client x' – so these telephone clients, and local clients – which of course isn't safe. We are having some success with sending faxes about that and on the whole they stop doing it … but were not going to know about them all in the same way as were not going to know about all the people who need benzo services. My question to you – all the things that you've said; and you're very honest about what goes wrong – what do you think would most appeal to GPs in terms of help, and how would we go about it?

LL
Well what we need is education – and it's difficult to cram it in because we are generalists so the amount of education is across the board – but we need to learn more about … how to conduct a 10 minute consultation that doesn't end with a prescription you don't want to give. That means sometimes not giving your patient what they want or think they need sometimes. They think they need it and that makes you the bad guy. And it's quite wearing being the bad guy all day long. For some people it's very difficult and they will often be the high prescribing GPs – it's almost like we want to be liked, but actually its very difficult to say no. So we need training in how to say no and not to lose our relationship with our patients and that's a huge area. I do think the idea of the CQC starting to audit is tremendous actually, but perhaps what they need to audit is new prescriptions. Because if they take everyone off there's catastrophe waiting, obviously. You'd need two or three BAT groups on every surgery. So I hope if you're talking to Steve Field you could suggest that he audits new prescriptions so that we don't start people on them any more. And from this conversation that were not giving them something that might do them MORE harm, or as much harm - giving them something else. They are the things that would really help – and to have twice as many GPs 20 minute consultations! But in the real world I think that's the way to go.

DD
You might remember I did an interview on TV about benzo withdrawal and they interviewed Steve Field in a surgery. At the time he said that GPs were aware of benzo addiction and that it had to be worked in partnership between the GP and the patient, and that it had to be a very slow, long period to do it. Has he changed his mind?

UC
I think one can say no because of the very fact that benzos are one of the two things that are going to be audited – so that MUST say that no, he hasn't.

AUDIENCE MEMBER
I am an alcoholic but I gave up 11 years ago – I was on the Isle of Wight then, and I got some very good help from a counsellor woman who had been sober 10 years herself.. From what I see and from what I've researched is that there seems to be in society the effect that everyone's out of it, in some way. They're either shopping … nothing's real. Women are getting faker – fake hair, fake boobs fake bums … it's like everyone needs to be out of it and were not coming together and talking, while I was in the drop in centre that I worked in on the isle of wight I was helping loads of other people while I was recovering myself and the success we had there … and all we did there was talk. It didn't cost anything – there was no government corporations involved or people trying to make money out of it all and from what I see now with everything we pay so much for war but the people that are sat needing help don't get it. If we want to kill people we'll pay for it but anything to do with helping people or saving people and funding people – not important. It's like it's a problem-reaction-solution. It's like the corporations think 'the more people we get addicted, the more solutions we can implement. And we can sell, and sell, and sell' …all this stuff. Why don't they encourage children in schools? I've worked in schools with children with horrendous special needs – you know, violence … they're not even taught about where money comes from. They're conditioned to become little workers. You must be a slave all your life. Everyone knows where a baby comes from, but no one knows where money comes from. No one knows how it's created – no one knows how to deal with anything emotional – no one knows how to talk to anyone … no one knows their neighbours – nothing. We've become drug mad. We're obsessed with celebrities – there's nothing real. we're escaping from everything that's real. Man has evolved for millions of years and he didn't need any pills. And now kids, the minute they're born you've got to have a pill …

got to be inoculated … have all these vaccines … money money money, for corporations. How did we get this far without all this ebola crap and everything else? We should be encouraged to get together, because it's a damn sight cheaper …. humans talking.

LL
As you were talking, that's what I was thinking … about community. Community is really hard to establish and maintain. in a way if peoples housing is sorted out … if one can identify a community – I don't know if you can say this in Lockleaze (to Dave) there are more and more local places that people can go and it seems to me that's the only answer I can think of that you don't look to outside people to help you all the time – that you start with yourselves and then NHS England comes along and recognises what's happening and helps support it.

DD
Years ago people didn't hsve pills. They didn't have psychiatrists. They had their next door neighbours or the person down the road. That's how they solved their problems. But the way houses are now, its not that simple. So they see other things and they go off and take drugs.

AUDIENCE MEMBER
At the risk of being very unpopular I'm a smoker, and I'm quite happy being a smoker and I fully understand the risks I take. There a lot of money being spent on anti-smoking but wouldn't some of that money be better spent on helping people deal with their benzo addiction which is far more troubling to the individual than smoking ever will be. I've had all the psychiatric medicines you can name, probably – and I've now had none for probably 20 years, and I'm quite happy to carry on smoking – which I know is antisocial for many people – but I'd much rather smoke than be stuck on that – in benzos, or whatever – I just wondered if the man from public health had anything to say?

CL
In very crude health economic terms one in two smokers will die of a smoking related illness and it's the single biggest contributor to mortality and morbidity in the UK. You'd be surprised how little is spent on smoking cessation – it's far less than drugs and alcohol. I was amazed when I learnt about it. A third of the public health grant – that is everything that is spent in public health is drugs and alcohol, and that doesn't include tobacco control. The costs are absolutely astronomical. I've only recently come in to tobacco control and I was amazed at what I found. I think that's why the focus is on it in terms of there being a real concern - it's a pure economic health argument about it. But I think you're absolutely right when you talk about benzos – prescribed, and over the counter medicines, where we haven't got a clear response in all areas about how you do that. And I think the point that was made around GPs and pharmacists not necessarily knowing what to do and the important of training in that is really important. We don't have a system like we do around illicit drugs and alcohol. We don't have a consistent approach with prescribed and OTC medicines. Professionals do need to know what they can do when the opportunity arises, because that's when you need to put people in contact with help. So sorry about the one in two – but that's just a fact.

CC
I was just going to say to the person behind me that the current policies mean that the rich are getting richer and the poor are getting poorer, and according to the Wilkinson and Trickett – the spirit level people, you get far greater mental health problems the greater the extremes of wealth, which means actually that things are just getting worse for doctors at the moment. The other thing I was going to say that I was talking to a practice manager the other week and he pointed out that people who are on benzos and similar drugs and always knocking at the doctors door - because you just feel so ill, and you don't know why. I pointed out then once people are OFF benzos they hardly

ever go to the doctors and he could save lots of money, he got very excited about that because you don't need the doctor presence any more – and that's a real incentive I think.

DD
I'd like to add to that. It is true! The doctors became my second home – and now I go twice a year, if that – and I used to go once a fortnight. So it does show that benzos are a scourge. I think if we could give the training it would save doctors and everyone else a great deal of time.

AUDIENCE MEMBER
My name is Chris and I used to work in LIFT psychology talking therapies. I think it's very interesting being here and having a look retrospectively because we can understand the damage that benzos do – and now were also talking about pregabalin and gabapentin and finding out that there might also be issues here. Something I see a lot is a lot of people being prescribed antidepressants – and Liz, you said you seem to be always behind the curve – and I wondered what the panel felt about the way we medicalise and try to prescribe with a pill, the way of moving away from things like depression – just your thoughts about where we may be around things like antidepressants in say, 10-15 years time?

LL
I think this fits a bit with the guy in the middle talking about how society is a mess. Rates of depression are huge everywhere, on any scale. There's an awful lot of depression around. I think the studied that I read show that … well, there's arguments about it – but they show that antidepressants work for severe depression and that there's an argument about how much it works for milder depression. and we know that CBT and LIFT therapies work too. so I do think antidepressants are an important part of my armoury, if you like, because I think they work – but I think LIFT and CBT which has been studied widely, because it's easier to study, and I think it's great to be able to have both, personally I'd say you can have one or the other – why not have both. And then there are people who have treatment resistant depression which is a huge group of people who are on antidepressant, who have had psychotherapy and just don't get better - and that's an interesting group to look at, and there's work to be done there. Those are people who start on an antidepressant and stay on it for 10 years. And they're really not that much happier on it than off it, but somehow we get caught up in prescribing. That's the group id be really interested in looking at. Part of me wonders if you'd need old fashioned psychoanalysis but that's something we can never afford to go for an hour three times a week. But something really deep to find out what's underpinning the problem – but that's terribly expensive. I don't know if that answers your question – that's just my personal view.