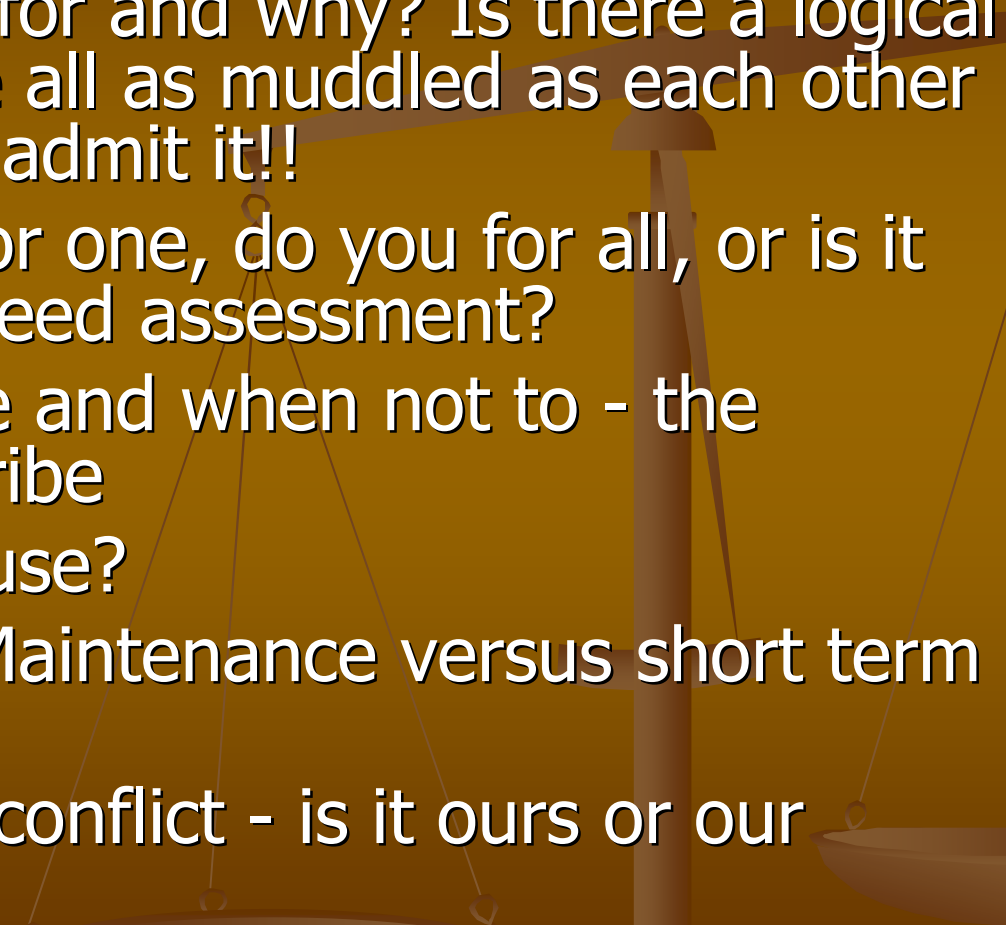


**How to manage patients**  
**using benzodiazepines**  
**when in drug treatment.**

**(A Story of conflict and**  
**confusion.)**

Lisa Stanway  
Stephen Pick

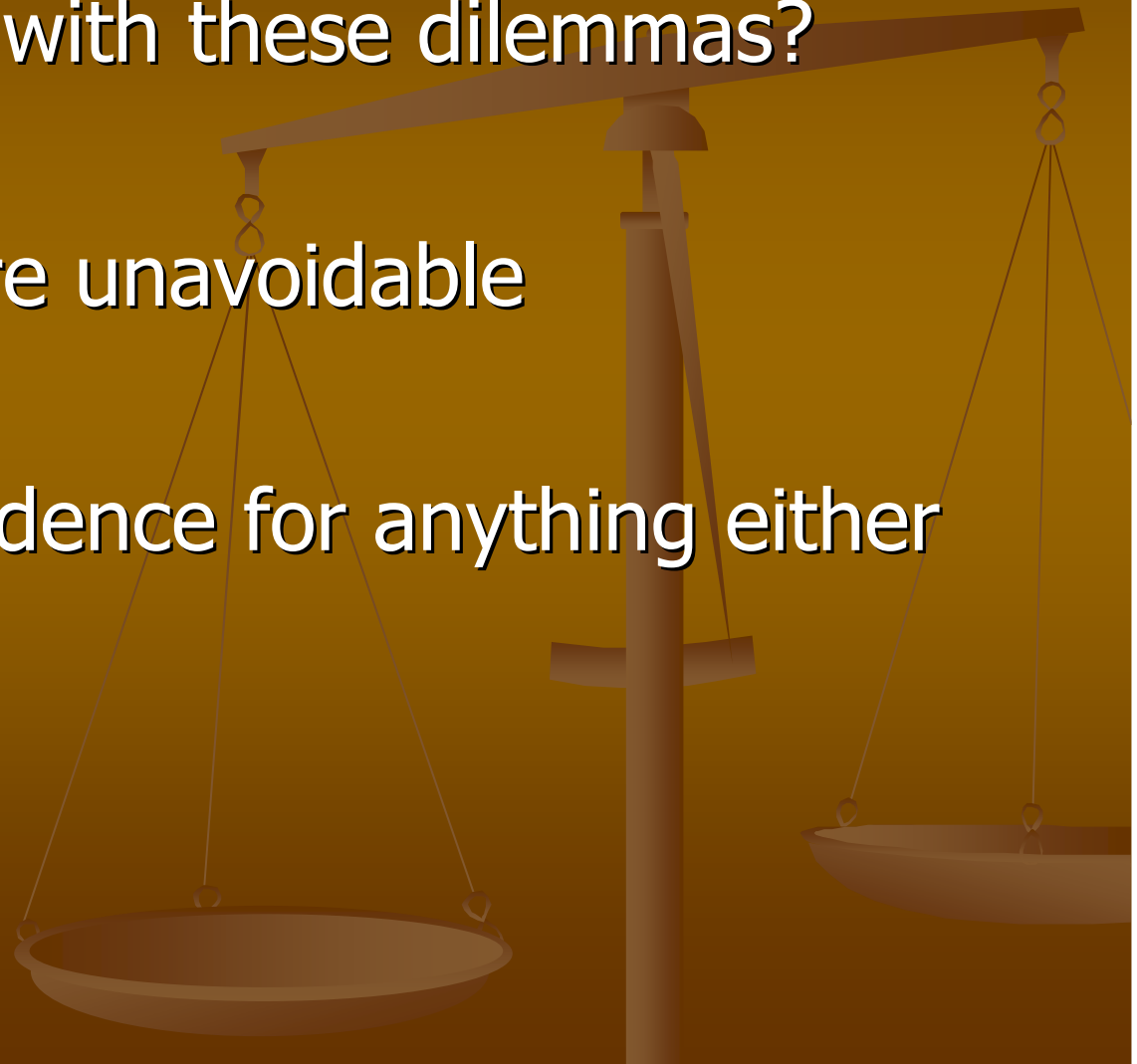
# My Dilemmas

- Who to prescribe for and why? Is there a logical approach? Are we all as muddled as each other but don't want to admit it!!
  - If you prescribe for one, do you for all, or is it on an individual need assessment?
  - When to prescribe and when not to - the pressure to prescribe
  - Which benzos to use?
  - Long term use / Maintenance versus short term use
  - How to deal with conflict - is it ours or our patients?
- 

How to deal with these dilemmas?

They are unavoidable

Is there any evidence for anything either way?

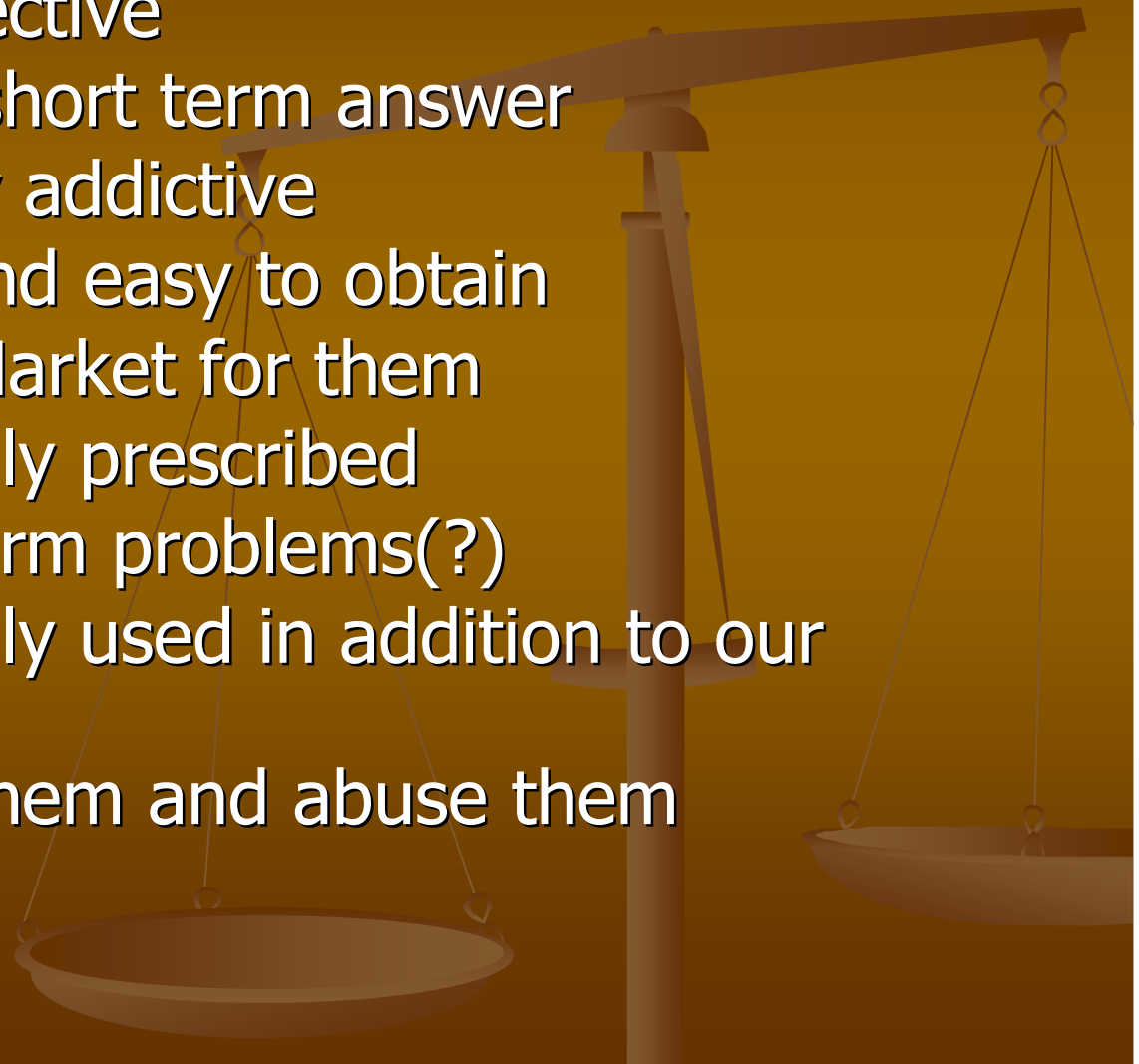


# Some things to consider

- What are benzos? – and which to use?  
Hypnotic, Anxiolytic, Anti-convulsant,  
Anaesthetic, sedative, muscle relaxant.
- What are benzos used for? Our perceptions or  
our patients' perceptions?
- The need for sleep
- When does short term become long term?
- Not dealing with the problem doesn't make it go  
away
- Make sure effective dose of opiate substitution

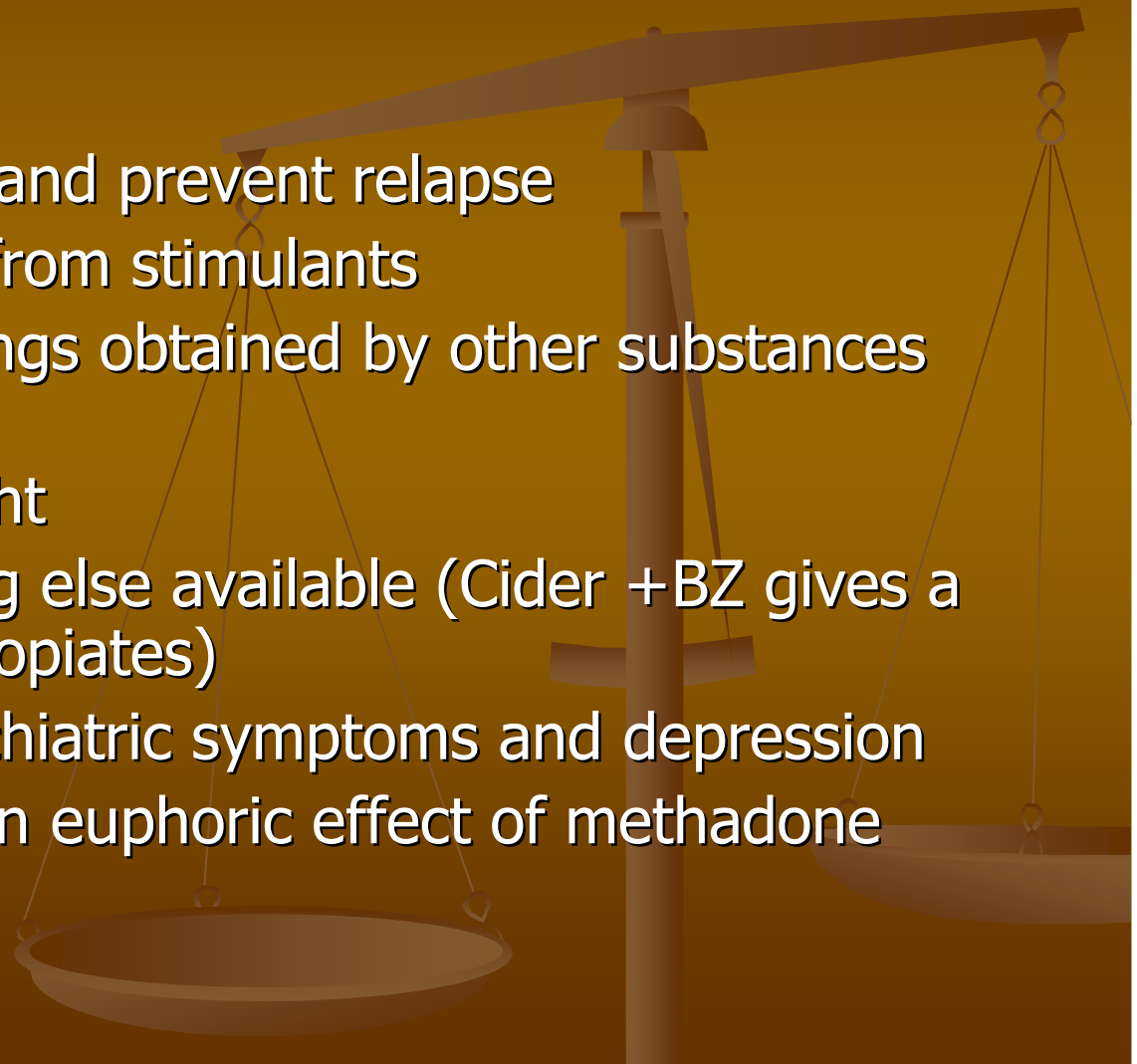
# What do we know about benzos?

- They are very effective
- They are a good short term answer
- They are normally addictive
- They are cheap and easy to obtain
- There is a Black Market for them
- They are commonly prescribed
- They have long term problems(?)
- They are commonly used in addition to our prescriptions
- People binge on them and abuse them

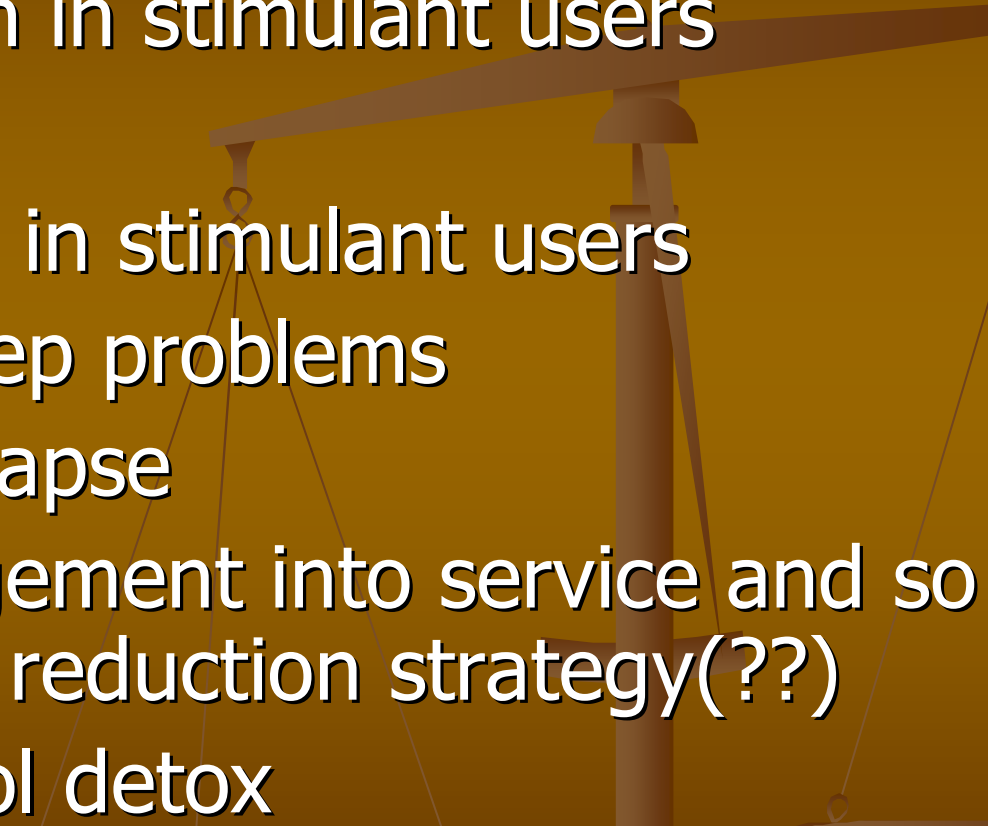


# Common reasons for requesting use.

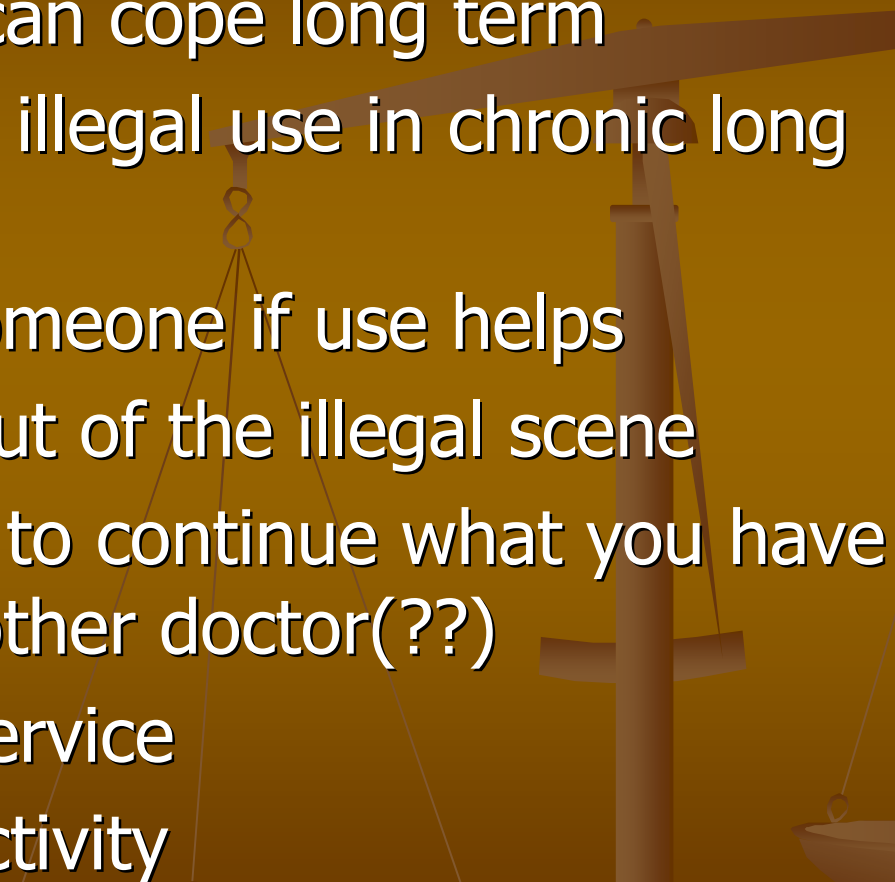
- For sleep
- For anxiety
- To avoid withdrawal and prevent relapse
- To help come down from stimulants
- To intensify the feelings obtained by other substances and methadone
- A habit in its own right
- To help when nothing else available (Cider +BZ gives a “high” in absence of opiates)
- To reduce other psychiatric symptoms and depression
- To counteract the non euphoric effect of methadone

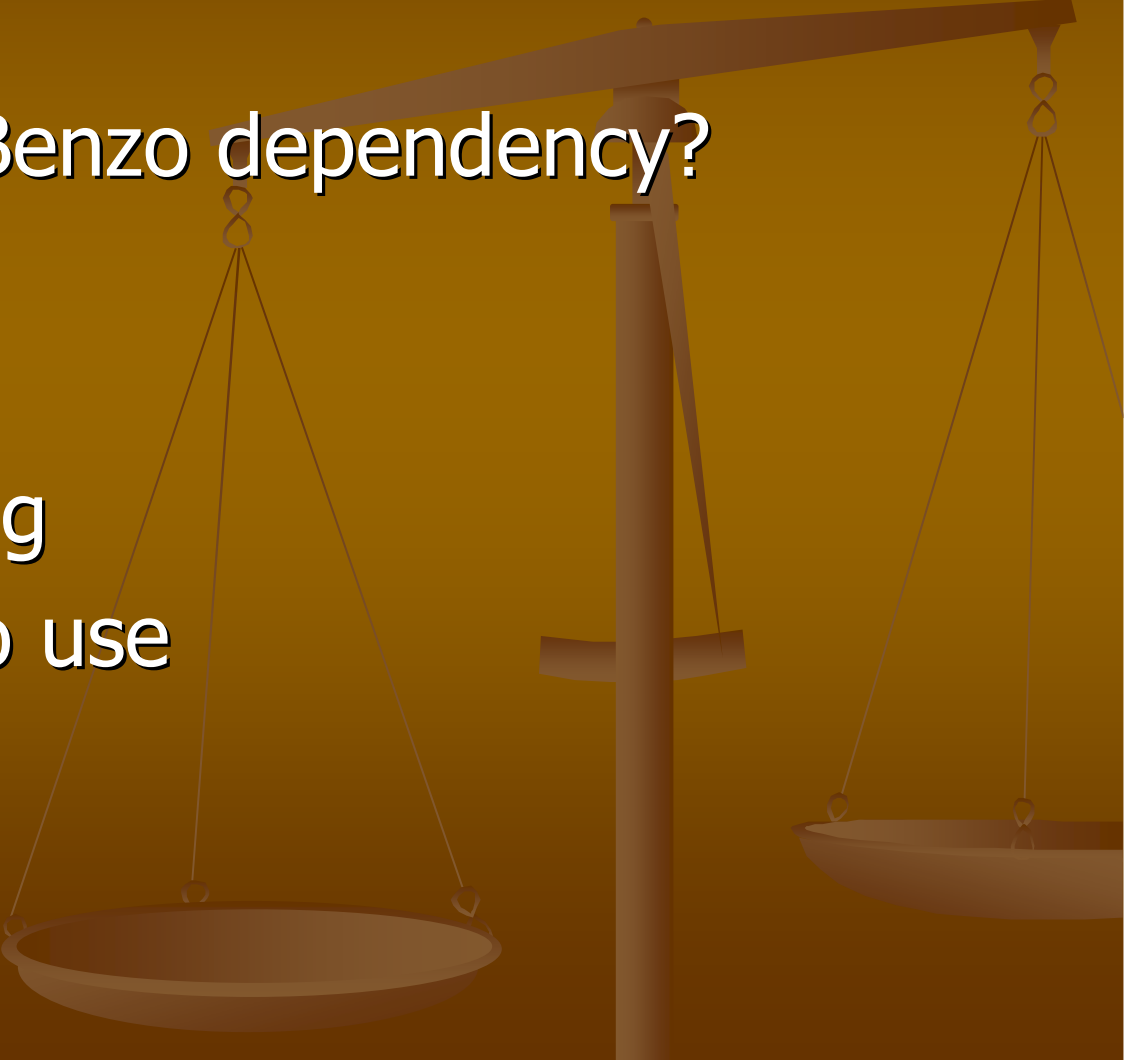


# Short term use

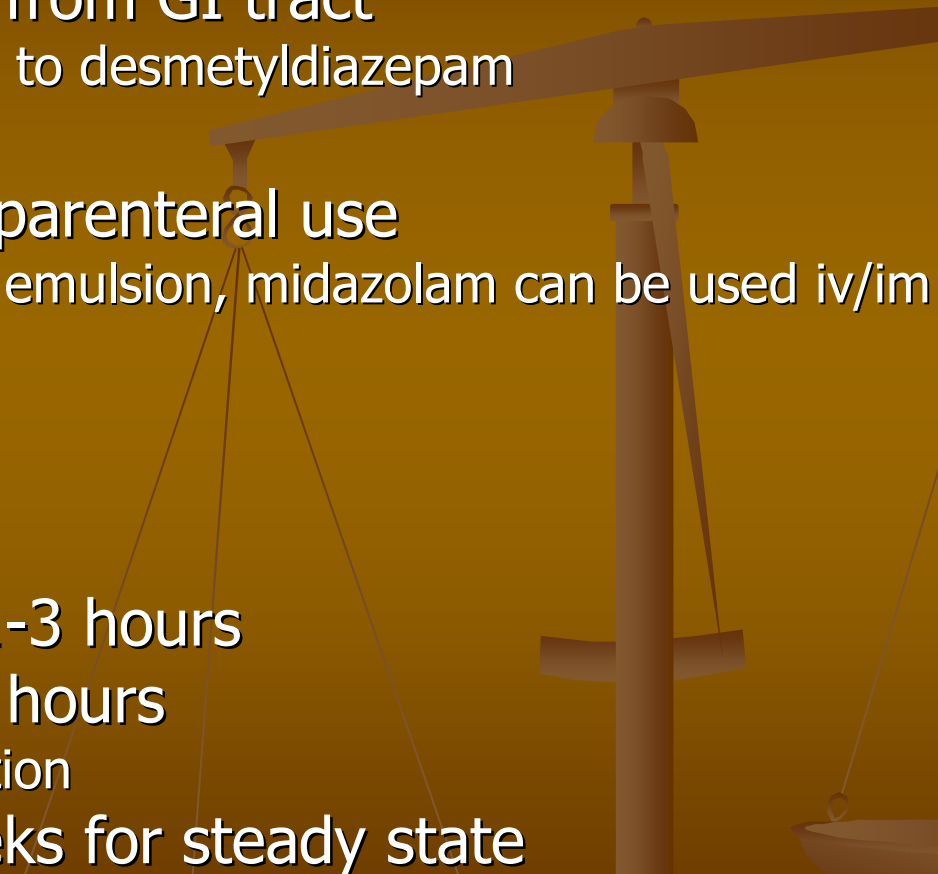
- Reduce agitation in stimulant users
  - Help sleep
  - Help withdrawal in stimulant users
  - Help serious sleep problems
  - Help prevent relapse
  - Help with engagement into service and so be part of harm reduction strategy(??)
  - Help with alcohol detox
- 

# Long term use

- Only way patient can cope long term
  - As a substitute for illegal use in chronic long term user
  - Why destabilize someone if use helps
  - To get someone out of the illegal scene
  - You feel you have to continue what you have inherited from another doctor(??)
  - Attract user into service
  - Reduce criminal activity
- 

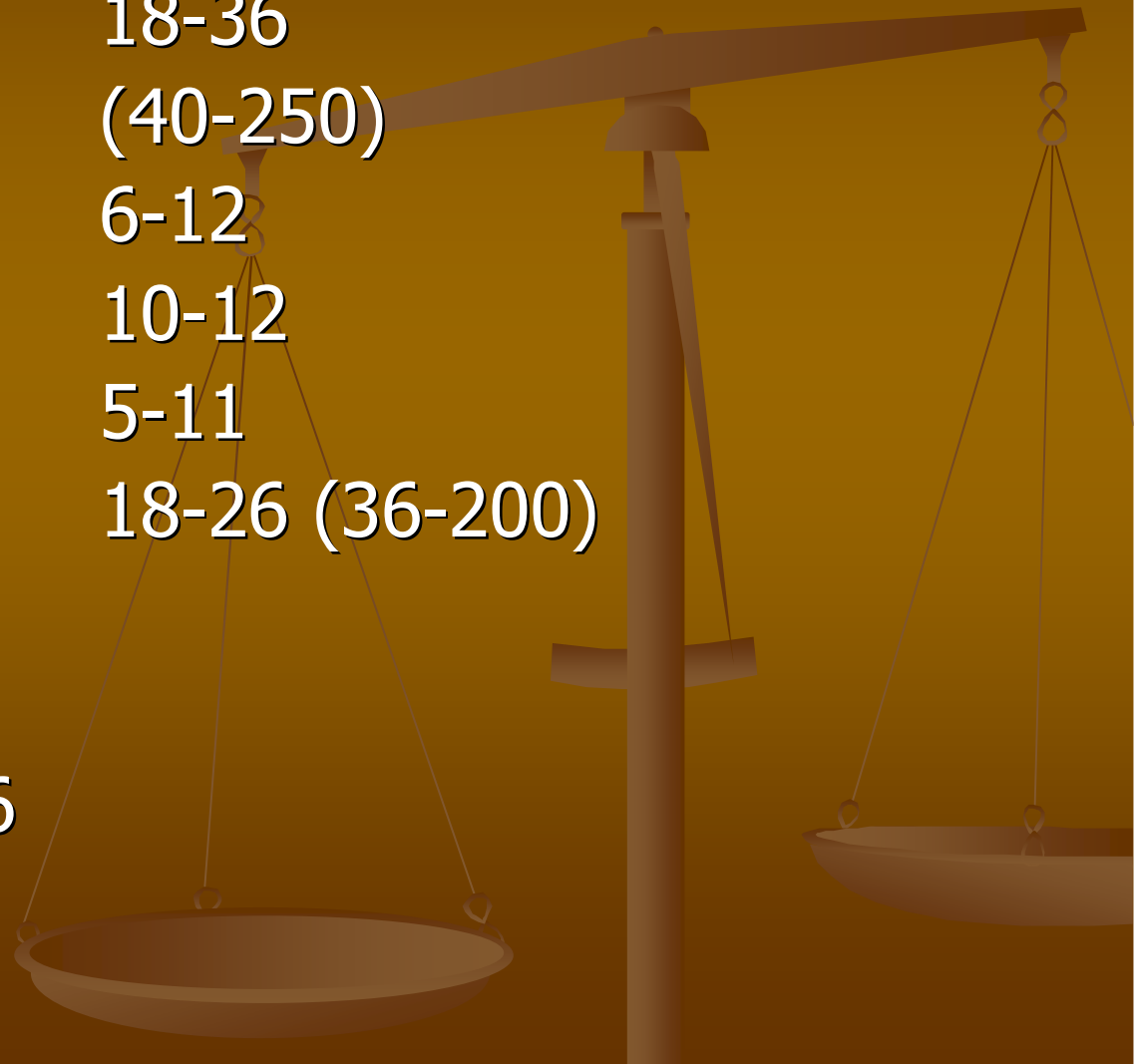
- 
- What confirms Benzo dependency?
    - History
    - Symptoms
    - Urine testing
  - Which benzos to use

# Pharmacokinetics

- Absorbed unchanged from GI tract
    - Clorazepate converted to desmetyldiazepam
  - Highly lipid soluble
  - Most not suitable for parenteral use
    - Lorazepam, diazepam emulsion, midazolam can be used iv/im
  - Rapid onset of action
    - Diazepam
    - Lorazepam
    - Alprazolam
  - Peak plasma conc – 1-3 hours
  - Secondary peak 6-10 hours
    - entero-hepatic circulation
  - May take up to 2 weeks for steady state
- 

# Hypnotics

<b>Nitrazepam</b>	18-36
<b>Flurazepam</b>	(40-250)
<b>Loprazolam</b>	6-12
<b>Lormetazepam</b>	10-12
<b>Temazepam</b>	5-11
<b>Flunitrazepam</b>	18-26 (36-200)
<i>Zaleplon</i>	2
<i>Zolpidem</i>	2
<i>Zopiclone</i>	5-6



# Anxiolytics

**Diazepam** 21-50 (36-200)

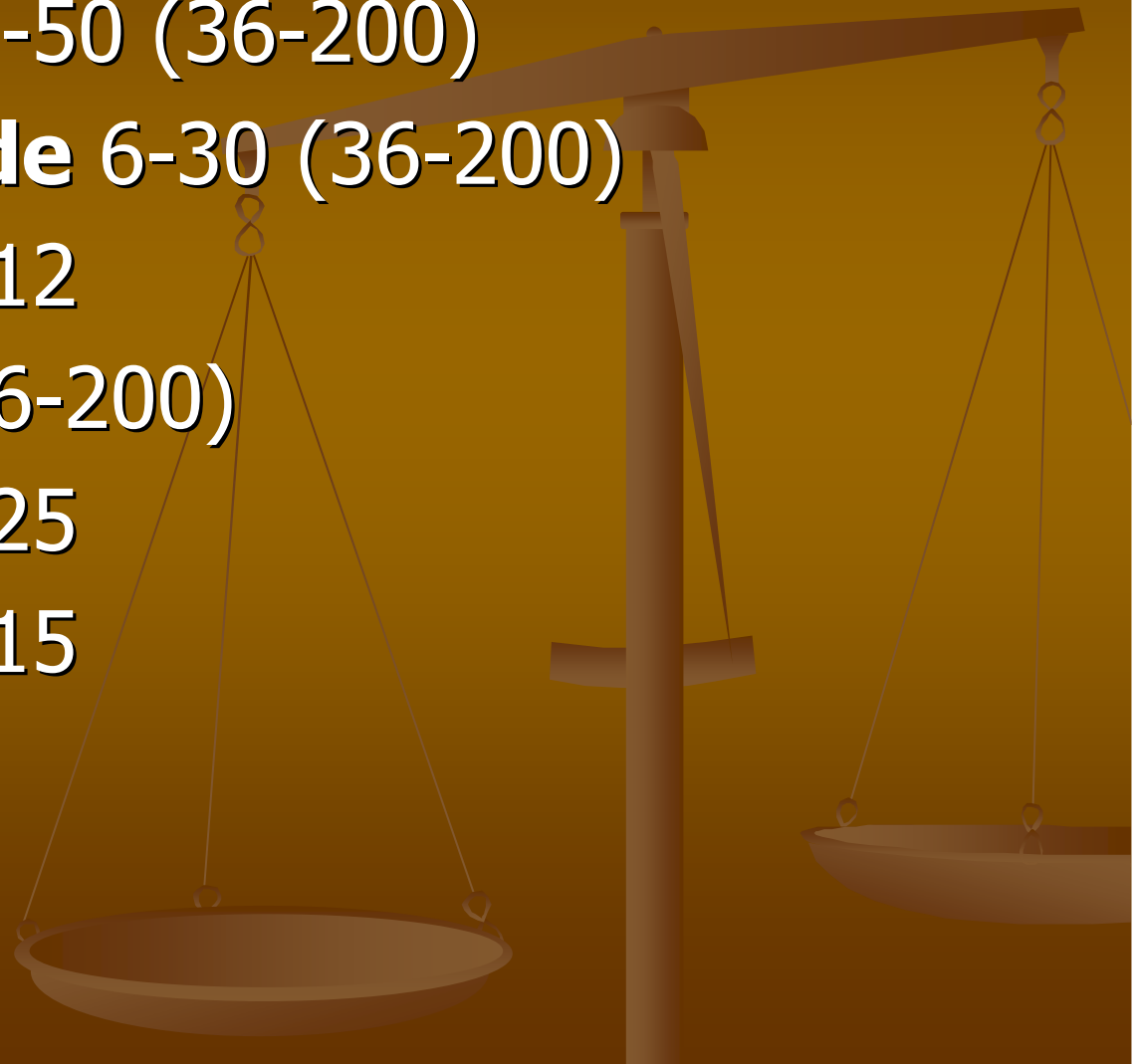
**Chlordiazepoxide** 6-30 (36-200)

**Alprazolam** 6-12

**Clorazepate** (36-200)

**Lorazepam** 8-25

**Oxazepam** 5-15



# Other Benzos

- Epilepsy
  - Clobazam
  - Clonazepam
- Anaesthesia
  - Midazolam
- Benzodiazepine receptor Antagonist
  - Flumazenil



# Equivalent Doses

**Diazepam 5mg =**

Chlordiazepoxide 15mg

Lorazepam 0.5mg

Oxazepam 15mg

Temazepam 10mg

Clonazepam 0.5mg

Nitrazepam 5mg

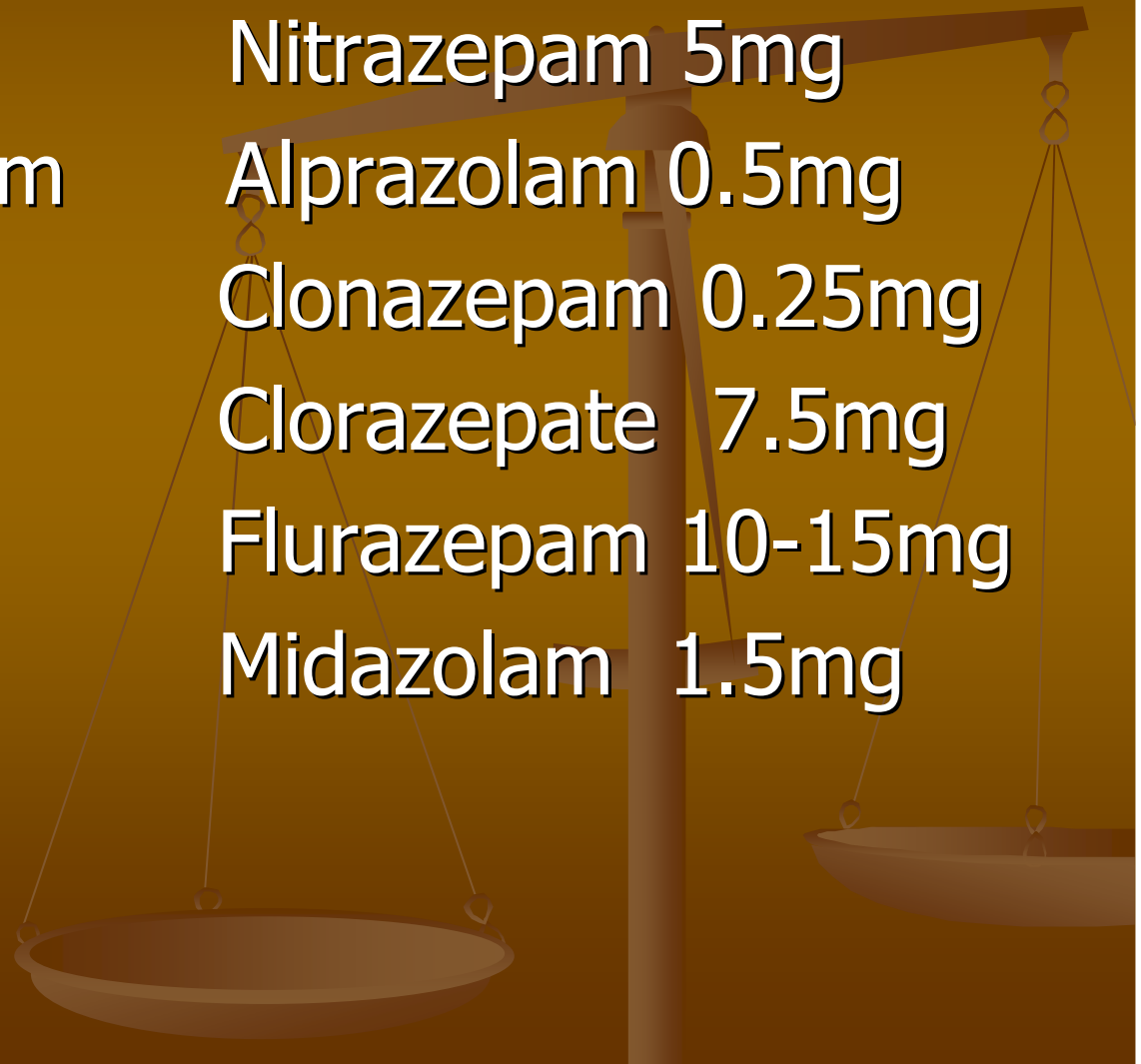
Alprazolam 0.5mg

Clonazepam 0.25mg

Clorazepate 7.5mg

Flurazepam 10-15mg

Midazolam 1.5mg



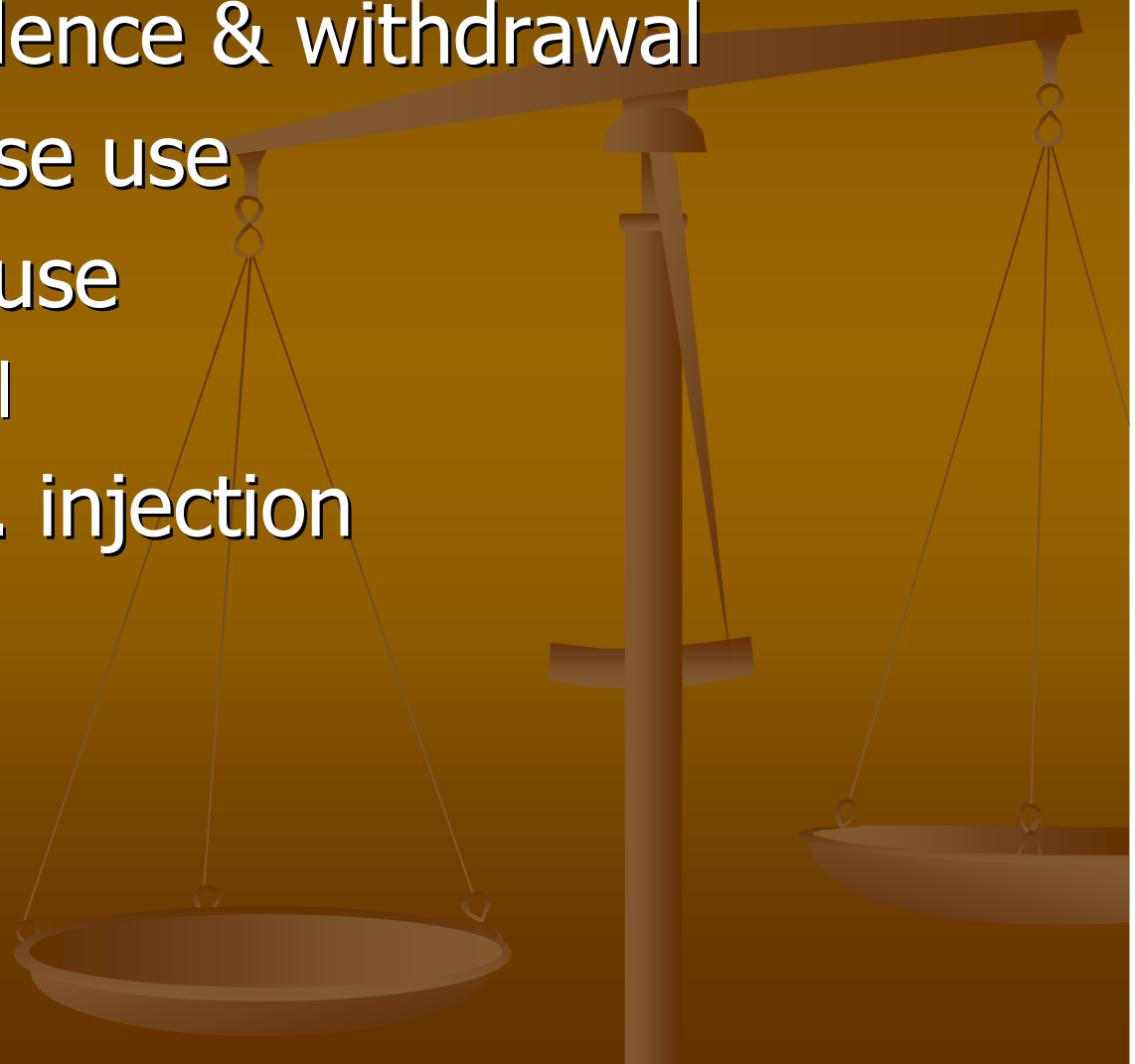
# Safety

- Very safe on their own
- Therapeutic to toxic ratio 200:1

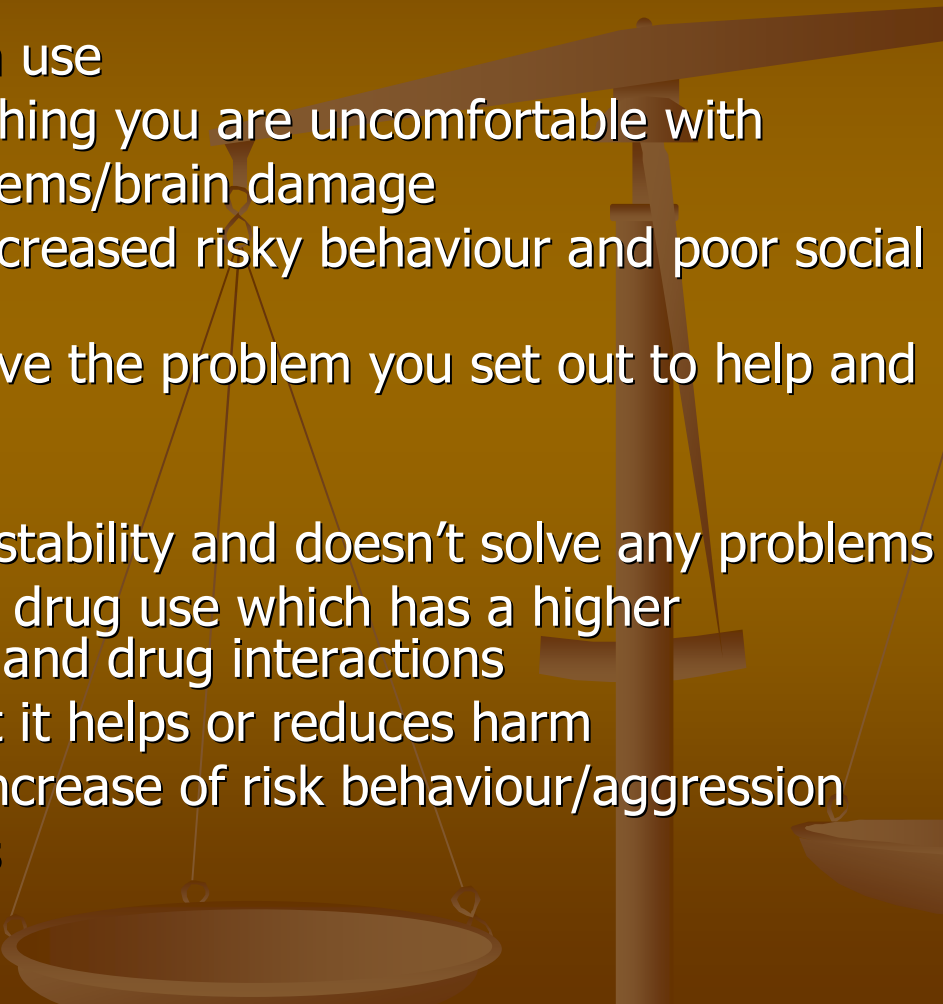


# What makes BZD dangerous?

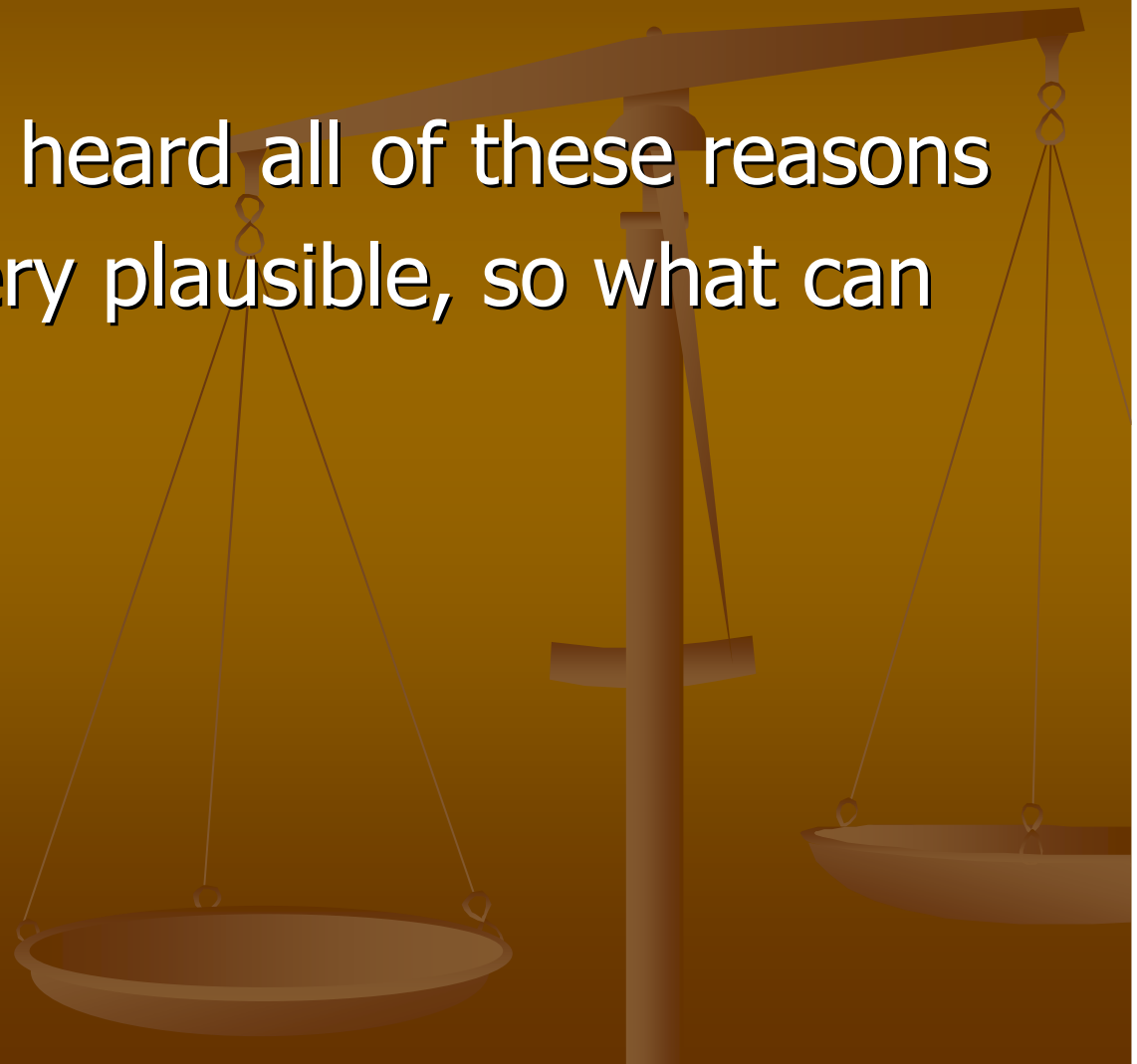
- Physical dependence & withdrawal
- Chaotic high dose use
- Poly substance use
  - Opiates, alcohol
- Possibility of i.v. injection



# Why NOT prescribe

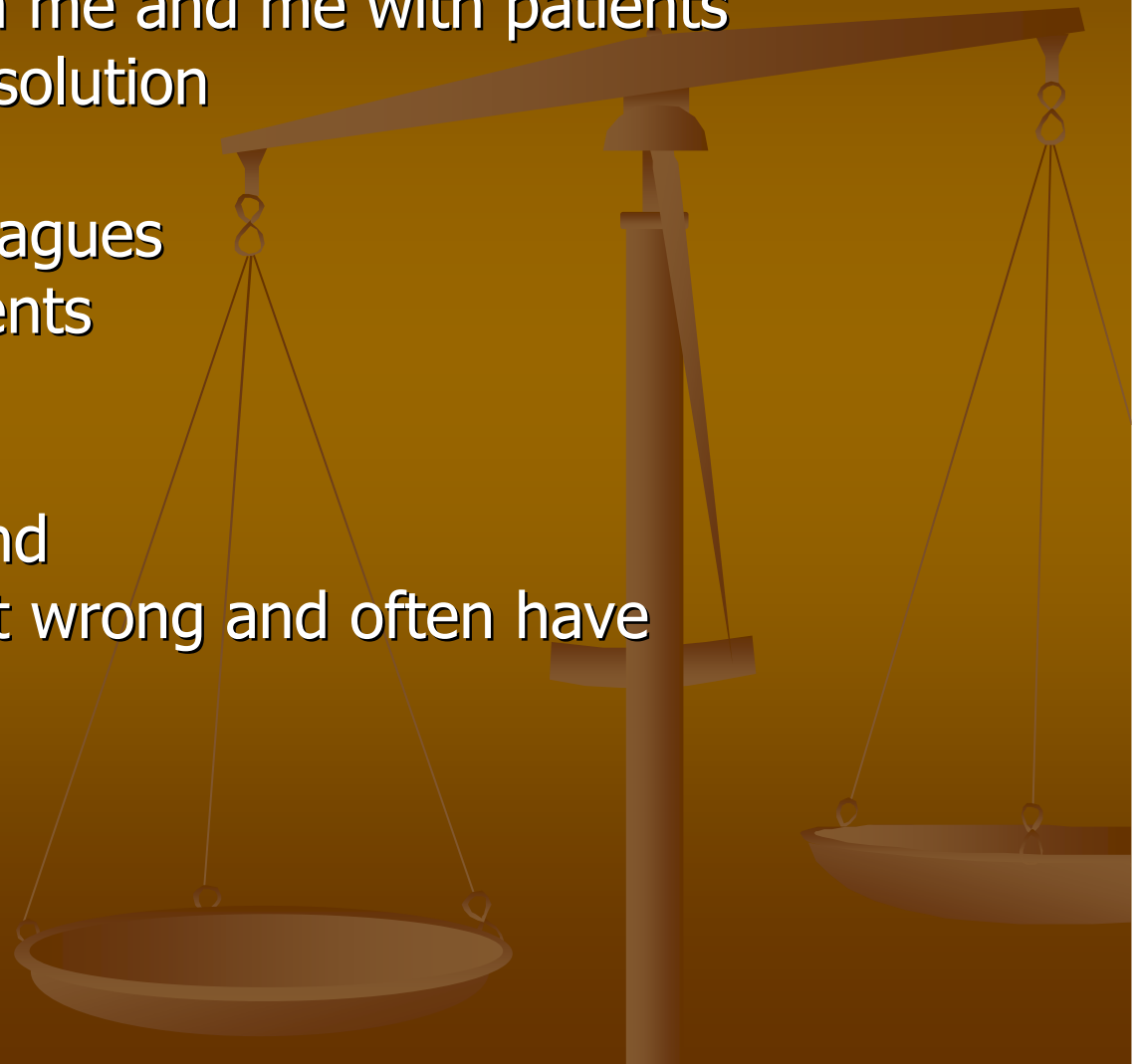
- Creating a dependence
  - Not licensed for long term use
  - Trapped into doing something you are uncomfortable with
  - Long term cognitive problems/brain damage
  - Other health problems- increased risky behaviour and poor social functioning
  - Doesn't really seem to solve the problem you set out to help and only compounds it
  - Feeds the illegal market
  - Doesn't seem to produce stability and doesn't solve any problems
  - Creates a problem of poly drug use which has a higher accompanying death rate and drug interactions
  - There is NO evidence that it helps or reduces harm
  - Loss of impulse control/ increase of risk behaviour/aggression
  - Risk of injection of tablets
  - Respiratory depression
  - Problems in pregnancy
- 

- We will all have heard all of these reasons and they seem very plausible, so what can or should we do?



# 'MOST'

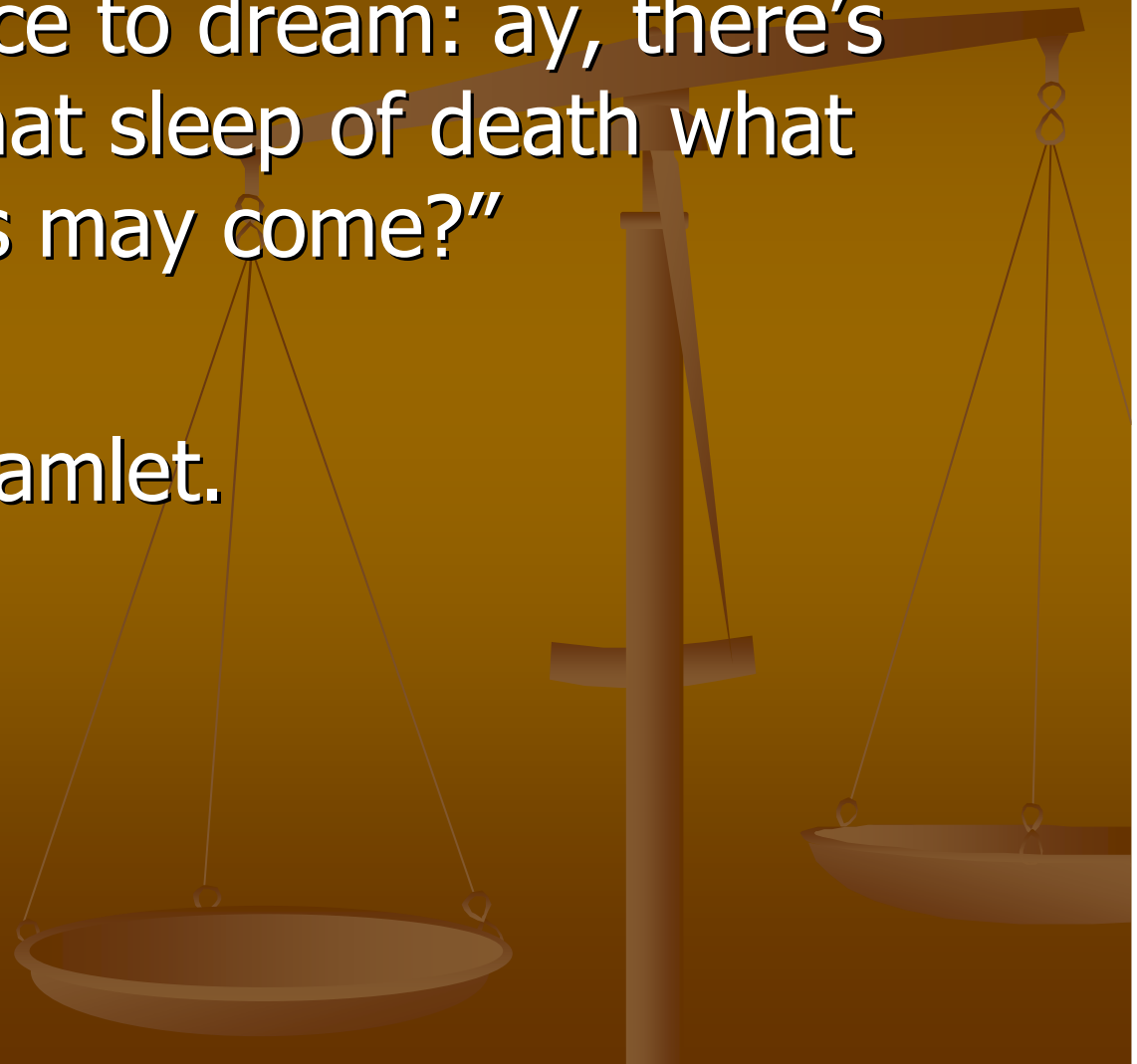
- Anger – patients with me and me with patients
- Discussion and no resolution
- Conflict
- Arguments with colleagues
- Arguments with patients
- Time spent
- Uncertainty
- Often change my mind
- Often think I've got it wrong and often have
- Varied opinions
- Chaotic patients
- Difficult workshop



# Sleep

“To sleep: perchance to dream: ay, there’s  
the rub; for in that sleep of death what  
dreams may come?”

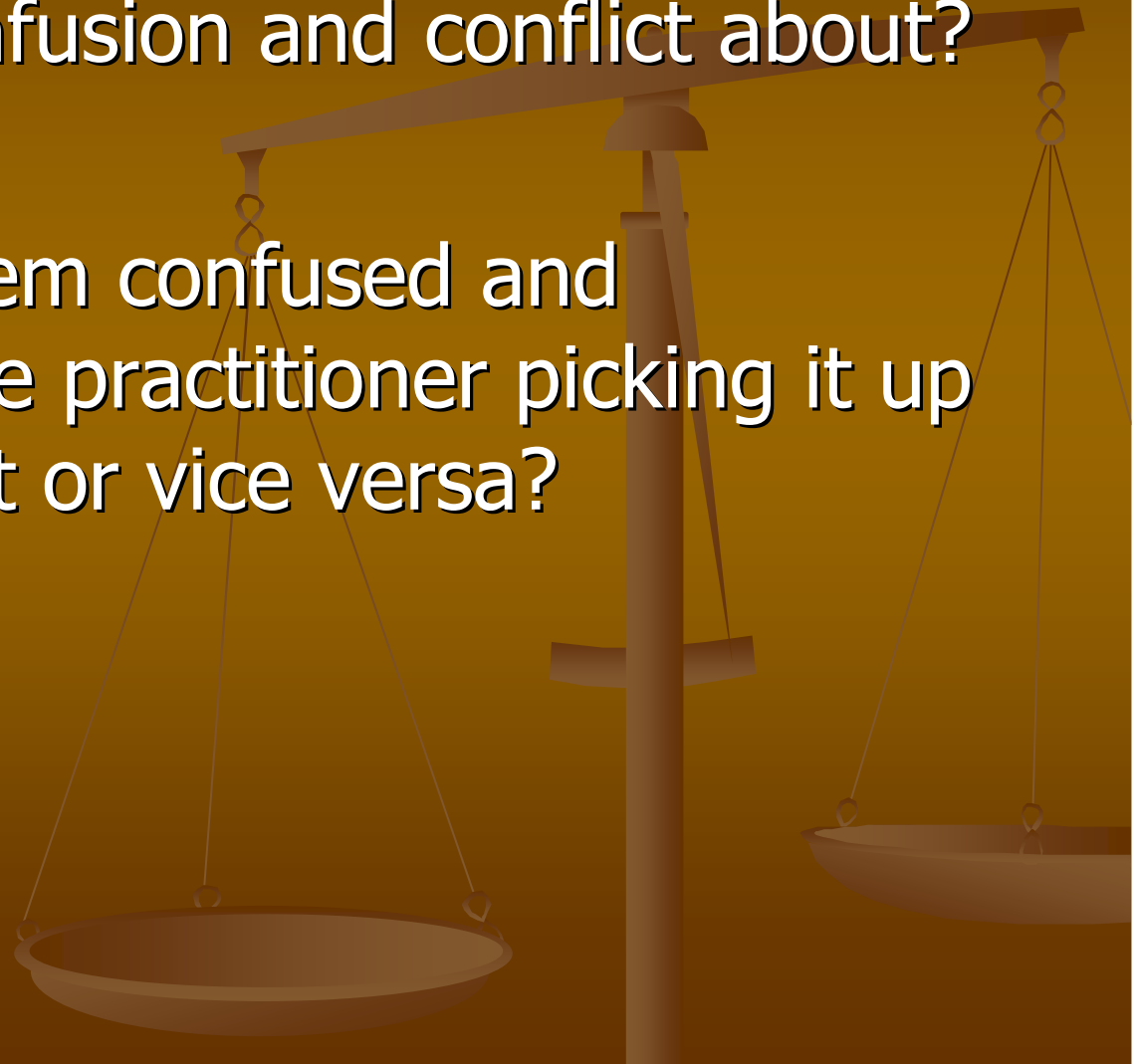
Hamlet.

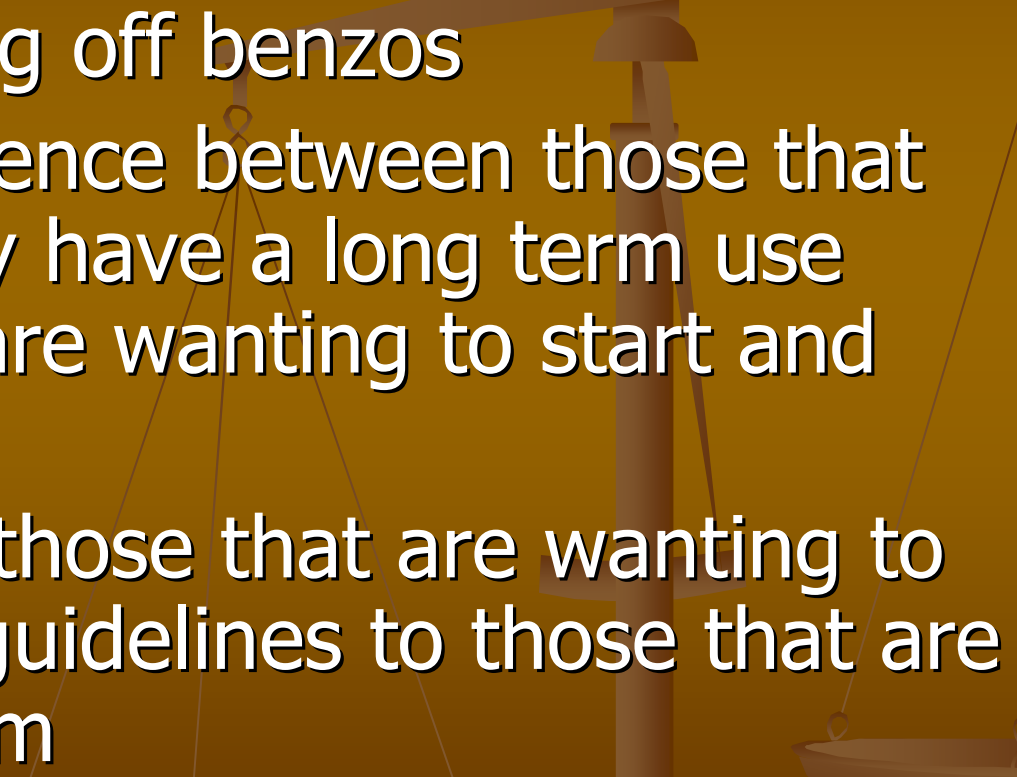


# Confusion

- What is this confusion and conflict about?

Both parties seem confused and conflicted. Is the practitioner picking it up from the patient or vice versa?

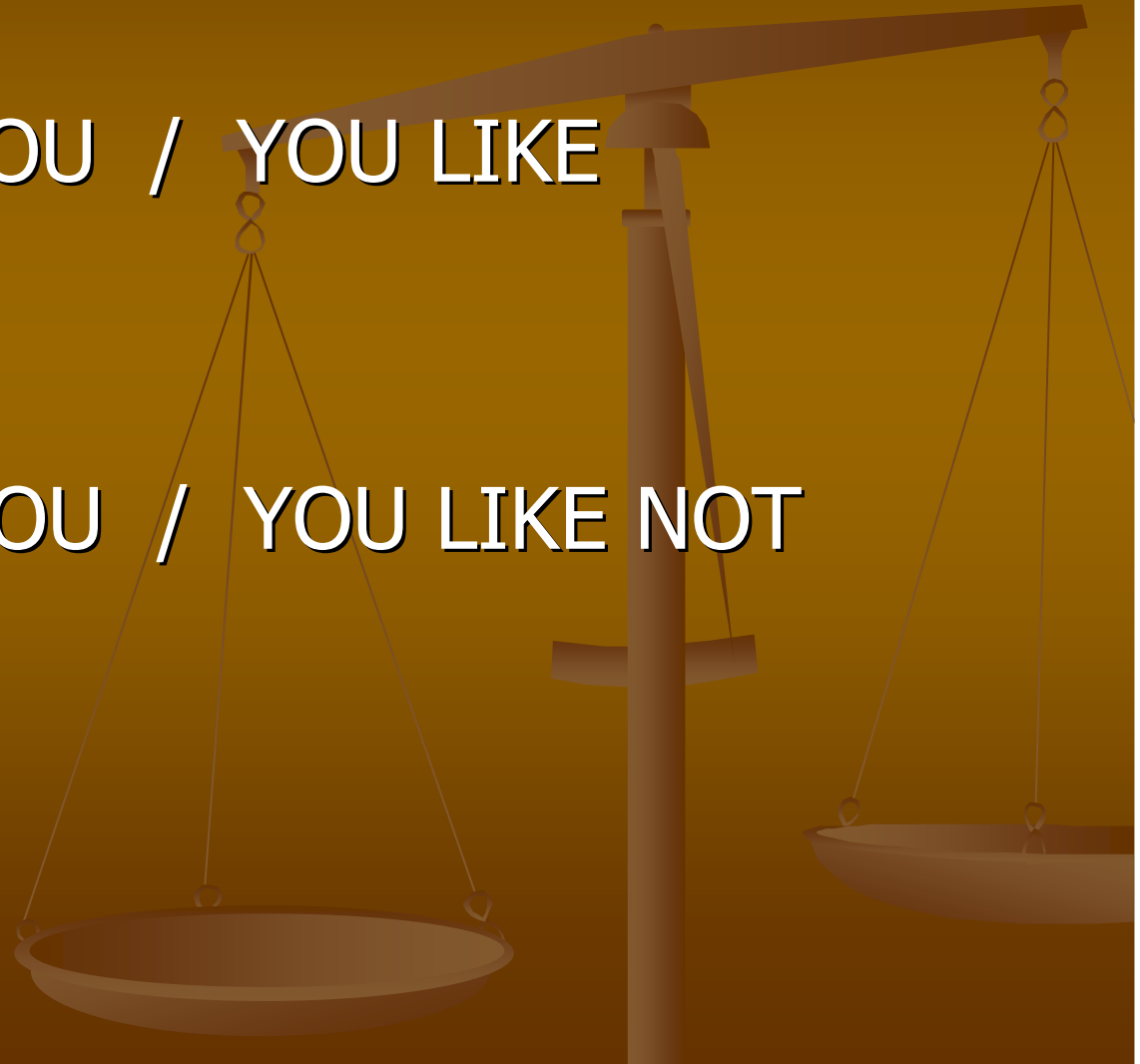


- 
- Help with coming off benzos
  - There is a difference between those that have or say they have a long term use and those that are wanting to start and are short term
  - So is it a NO to those that are wanting to start and what guidelines to those that are already long term

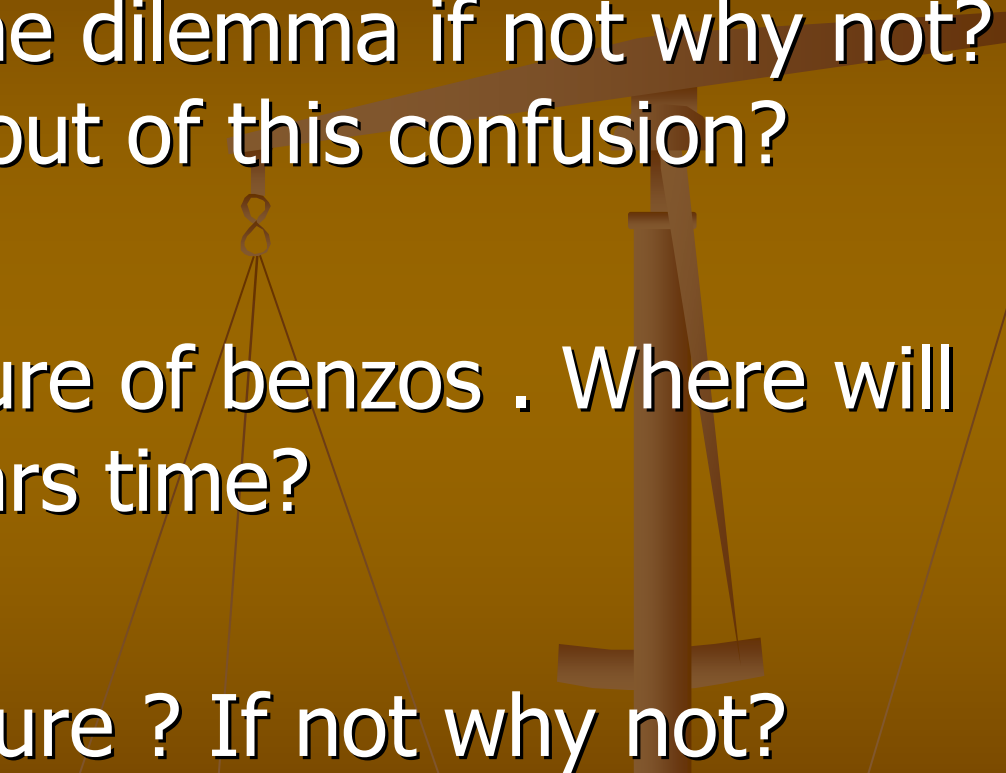
# The problem of prejudice

LIKE YOU / YOU LIKE

NOT LIKE YOU / YOU LIKE NOT



# Questions

- Can we solve the dilemma if not why not?  
Is there a way out of this confusion?
  - What is the future of benzos . Where will we be in 10 years time?
  - Have they a future ? If not why not?
- 

# The wisdom of Solomon (the need for resolution)

- Try and have goals. Be compassionately firm!
- There is a place for short term use
- NO evidence for starting long term use
- Maybe you have to accept maintenance in some
- Its OK to find this difficult. Be prepared to make mistakes
- Try not to go above 30mg diazepam daily
- Keep it simple and to a single drug
- Keep thinking and reviewing
- Keep detox as a possibility

# References(1)

- Oyefeso A, Ghodse H, Williams H 1996 Prevalence and Pattern of benzodiazepine abuse and dependence among patients in a methadone maintenance detoxification programme. A repeated cross-sectional analysis. *Addiction Research* 4 (1): 57-64
- Perera KM, Tulley M, Jenner FA 1987 The use of benzodiazepine amongst drug addicts. *British Journal of Addiction*, 82, 511-515.
- Strang J, Griffiths P, Abbey J, Gossop M 1994 Survey of use of injected benzodiazepines amongst drug users in Britain *British Medical Journal* 308, 1082
- Gelkopf M, Bleich A, Hayward R, Bodner G, and Adelson M 1999 Characteristics of benzodiazepine abuse in methadone maintenance treatment patients: a 1 year prospective study in an Israeli clinic. *Drug and Alcohol Dependence* 55: 63-68
- Seivewright N & Dougal W. Withdrawal Symptoms from High Dose Benzodiazepines in Poly Drug Users'. *Drug & Alcohol Dependence* 1993 32:15-23.
- Budd R.D., Walkin, E., Jain, N.C. and Sneath, T.C. (1979) Frequency of use of diazepam in individuals on probation and in methadone maintenance programs. *Am. J. Drug Alcohol Abuse*, 6, pp.511-514.
- Stitzer M L, Griffiths R R, McLellan T A, Grabowski J and Hawthorne J W 1981 Diazepam use among methadone maintenance patients: patterns and dosage. *Drug and Alcohol Dependence* 8: 189-199
- Preston K L, Griffiths R R, Stitzer M L, Bigelow G E and Liebson I A 1984 Diazepam and methadone interactions in methadone maintenance. *Clinical Pharmacology and Therapeutics* 36: 534-541
- Bleich A, Gelkopf M, Schmidt V, Hayward R, Bodner G and Adelson M 1999 Correlates of benzodiazepine abuse in methadone maintenance treatment. A 1 year prospective study in an Israeli clinic. *Addiction* 94 (10): 1533-1540

# References(2)

- Darke S, Swift W, Hall W and Ross M 1993 Drug use, HIV risk-taking and psychosocial correlates of benzodiazepine use among methadone maintenance clients. *Drug and Alcohol Dependence* 34: 67-70
- Gossop M, Marsden J, Stewart D and Rolfe A 1999 NTORS: Two year outcomes. The National Treatment Outcome Research Study: Changes in substance use, health and crime: Fourth Bulletin. Department of Health: London
- Drug Misuse and Dependence Guidelines on Clinical Management, Department of Health, 1999.
- Seivewright N, Dougal W, Withdrawal symptoms from high dose benzodiazepines in poly drug users. *Journal of Substance Misuse*, 3, 170-177
- Williams H, Oyefeso A, Ghosdse AH 1996 Benzodiazepine misuse and dependence amongst opiate addicts in treatment. *Irish Journal of Psychological Medicine*, 13, 62-4
- Scott R 1990 The prevention of convulsions during benzodiazepine withdrawals. *British Journal of General Practice*, 40, 261
- Seivewright N 2000 Community treatment of drug misuse: more than methadone Cambridge Press 70 -9
- Landry M.J., Smitt D.E., McDuff D.R., Baughmann O.L., Benzodiazepine Dependence and Withdrawal: Identification and Medical Management. *Journal of the American Board of Family Practitioners* 1992; 5:167-75.
- Darke S. The Use of Benzodiazepines amongst Injecting Drug Users'. *Drug & Alcohol Review*. 1995 13:63-9.
- Primary Care Facilitator Team (HIV/Drugs) Managing Drug Users in General Practice 4th Edition, 2003
- Vormea H. et al. 2002, Treatment of out-patients with complicated benzodiazepine dependence: comparison of two approaches. *Addiction* 97:851-859