Patients love them, GPs fear them and drug services ignore them – what is possible with benzos?!?

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The 14th National Conference: Working with Drug & Alcohol Users in Primary Care

Aims

- To discuss the use and non-use of benzodiazepines by people who use drugs and the professionals who work with them

- Using collect experience develop a consensus of how and when to use them

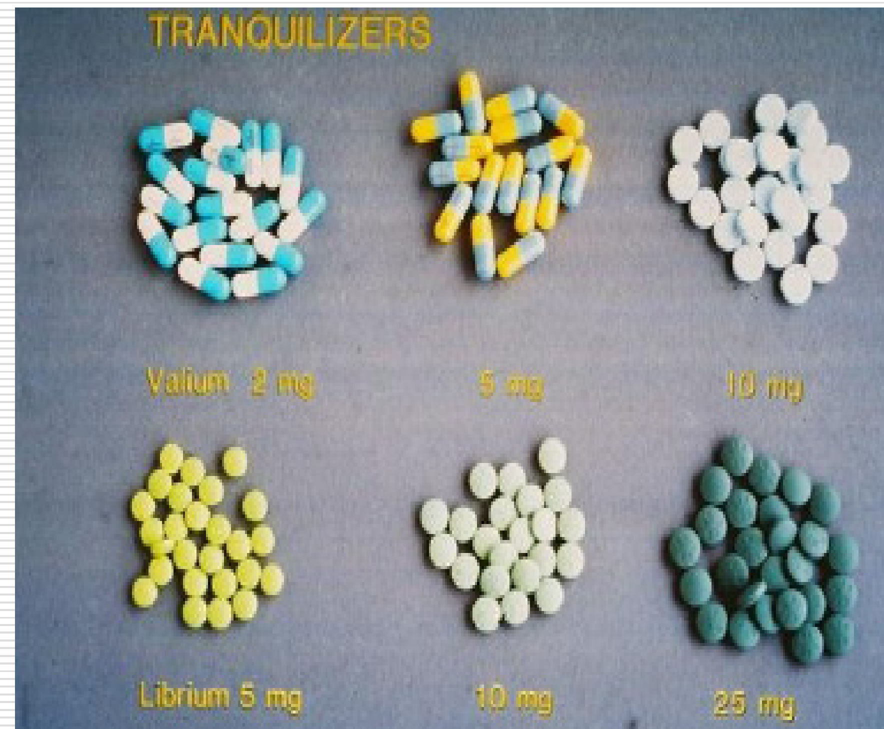
Marie 29 years

- Used drugs for 15 yrs, started diazepam 14yrs, heroin aged 18 and crack aged 20yrs
- Lived in care, no children and known HCV PCR positive
- In treatment 6/52 with you and settled well on 100mg methadone
- Always open about diazepam use – 30-40mg / day
- All urines positive for benzodiazepines
- Requests BZ cause helps her mood and sleep and reduces her alcohol and asks you again to prescribe
- ***Who would prescribe benzodiazepines for Marie?***

Benzodiazepines in poly drug use

- Are they a problem?

- Why?



Are they a problem?

- Is prevalent and is now the largest group of users of benzodiazepines
  - Studies show between 80-97% of people attending services used BZ in the last year, third used 70mgs or more and about 40-50% had injected them
  - Methadone maintenance patients using non-prescribed benzodiazepines on higher doses and more risk-taking behaviour
- Place in drug-related deaths
- Major problem to some users

Why do patients love them?

- Most loved Addiction. 99(2):165-173, February 2004 *Jaffe et al*

1. Anxiety and Insomnia
2. Because of their own effects of intoxication / pleasure
3. As a primary drug
4. To enhance a drug, such as methadone
5. Self medication to help mood, coping skills and / or reduce voices
6. To help come down from amphetamines, ecstasy, crack cocaine or cocaine

Why do we fear or ignore them?

- Addictive, misuse, dependence (Ashton 2002, NICE 2004)
- Tolerance develops & effectiveness wears off (Ashton 1995, Lader 1997)
- Withdrawal symptoms (30-45% after long-term use Ashton 1995)
- Can be snorted, injected (Lader 1997)
- Serious problem in many drug users (Strang, NICE)
- Anxiety, hallucinations, depersonalisation
- In MMT more risk-taking behaviour, social dysfunction, fatal overdose (Strang, NICE)

Long-term effects

- Medication becomes the problem:
  - Underlying issues avoided; BZ seen as the solution
  - Anxiety may reduce if BZ stopped (Rickels 90, 91, Schweizer 90)
- Emotional suppression:
  - Reduced use of coping skills for emotional problems & problems coming off
- Cognitive effects:
  - Tolerance to most cognitive effects on long term dosing (Lucki & Rickels 1986, 1988)

Tolerance to BZ Effects
(Argyropoulos & Nutt 1999, Lucki & Rickels 1986)

- Rapid tolerance to sedation, cognitive and motor effects (but may never be complete)
- Little tolerance to other therapeutic effects:
  - Anxiolytic & antipanic effects (& amnesic effects post dose)

Effect of Tolerance on Behaviour

- If rapid tolerance occurs (high, sedation):
  - Escalate dose
  - Use in binges (with gaps in between)
  - Use route with more rapid speed on onset e.g. inject rather than oral
  - Use in combination with other drugs that potentiate each others effects e.g. opiates
- If little tolerance occurs (anxiety):
  - No need to increase dose, binge, increase speed of onset, polydrug use

Who escalates their BZ Dose?

- **Primary drug / pleasure** associated abuse of BZ:
  - Seeking buzz/high & sedation, often escalate their dose
  - Includes bingers & those who use to potentiate drug effects
- **Self-medication** not associated abuse of BZ:
  - Seek relief from negative symptoms, rarely escalate dose
  - Includes those who use BZ regularly, & use to treat withdrawal & medication or drug side-effects
  - Typically take BZ 3-4 times a day
- **Combined** self-medication & pleasure seeking:
  - Characteristics of both groups, i.e. may abuse BZ
  - Need to be aware if using for pleasure, self-med or both

How Addictive are BZ?

- Depends on population being considered:
  - Ordinary populations: Risk very low
  - Psychiatric patients: Intermediate risk
  - *Addictive populations: Risk higher but little firm data*
- Also depends on non-drug factors:
  - Non-pharmacological factors: patient factors such as personality, gender, vulnerabilities, health, anxiety trait and depressive diagnosis (Rickels et al 1990)
  - Pharmacological factors: drug factors (Rickels et al 1990)

What is our experience with BZ and drug-using patients?

- Does everyone have access to benzodiazepine prescribing?
  - If not would they like to?
- How do we decide if and when to prescribe benzodiazepines?
  - What can help us with our decision?

Benzodiazepines: what is our current practice?

- Why such wide variation in practice?
  - Postal questionnaire to Drug Services (75% detox, 35% maintenance Williams 2005)
  - Sometimes BZ given rather than opioid in general practice

Should we prescribe BZ to people who use drugs and / or alcohol?

- Polarise practitioners into
  - ‘purists’ and ‘realists’
- Most people who use drugs and / or alcohol have use BZs
- Most of us have found ourselves in a position having to judge whether to start or continue BZ prescription
- Common but little and old literature

YOU HAVE ONLY
TWO CHOICES...
JAIL
THERAPEUTIC
JUSTICE

Marie 29 years

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- Always open about diazepam use – 30-40mg / day
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- ***On what heard so far anyone changed? Would you decide whether to prescribe benzodiazepines for Marie or not?***

What are the possible values of prescribing BZ to Marie?

- **Is it a big problem to her?**
- Yes! Started diazepam 14yrs and has used them for 15yrs and all urines positive for benzodiazepines
- **Is she self-medicating or pleasure?**
- Self-medicating: Lived in care
- **Might it help her settle?**
- Some people settle better on combination of methadone and DZ and Marie has settled well on methadone but still requesting BZ
- **Does it help an alcohol problem?**
- She feels it does and helps her mood

What are the possible harms of BZ to Marie?

- **Is there evidence of harm?**
- Long term prescribing may cause harm and little evidence prescribing helps effective harm reduction
- **Do we have evidence she is buying?**
- Yes! May continue to buy on top
- **Is she at risk of drug related death?**
- Drug deaths more common in poly drug use e.g opiates, alcohol and benzodiazepines
- **Are her children at risk?**
- Risk to the children if binge use

What else do we know?

- Little but some research on benzodiazepine use in drug users
- Most BZ research on psychiatric patients
- Largely unknown how addictive they are in addictive populations
- Minimal evidence who uses BZ and then go on to have problems
- Little evidence to support long-term use
- ***But much of current practice based on opinion rather than evidence***

Do the Clinical Guidelines 2007 help us?

- Own addictive potential and taken in combination with opiates
- Little evidence of reducing harm
- Increasing evidence can cause harm
- Normally detox regime
- If long term same principles as other prescribing
- Sudden stopping can lead to a withdrawal state
- Methadone should be kept stable through BZ reduction

Substitute prescribing of benzodiazepine: the evidence

- On the one hand:
  - Can help DU to control their BZ use
  - Not all users become dependent
  - Takes people out of illicit drug markets
- On the other hand:
  - Long term prescribing of BZ is of uncertain benefit
  - Long term high dose may cause cognitive impairment
  - Some continue to buy in addition

Evidence for:

- Study: BZ prescribing in MMT patients (Weizman 2003)
  - 79% on maintenance BZ stopped illicit use compared to 27% when BZ tailed off
- Study: opiate overdoses (Anoro 2004):
  - 2 risk factors associated with respiratory arrest:
    1. prior abstinence from opiates
    2. prior abstinence from benzos
- Study: Reduced injecting in Edinburgh (Rosenberg 2002)

  - ***Could this endorse maintenance benzodiazepine prescribing?***

Evidence against:

- Study: long-term effects (Nystrom 2005)
  - 30 psychiatric patients – increased passive coping in users, reduced psychiatric symptoms in stopped and more active coping
- Study: cognitive effects (Barker 2003)
  - Most improved cognitive function after withdrawal but not all at 6 months

Evidence lacking

- No controlled studies of additional benzodiazepines
- Limited guidance (ACMD 2000 , DH 1999, MOC 2002)
- SMMGP guidance 2005

General Advice On BZ

- Only prescribe if a clear clinical goal in mind with an agreed time frame
- Target psychiatric and psychological disorders (e.g. anxiety) with non-BZ Px
- Resist pressure to prescribe BZ precipitously
- Be clear about your boundaries of treatment e.g. prescribe only if clear diagnosis or if likely to improve outcome

General Advice (cont.)

- Convert all BZ to single (long-acting) BZ
- Never prescribe more than one BZ
- Enter a collaboration with the patient
- Only prescribe if:
  - Urine is positive for BZ; evidence from history & symptoms that patient is dependent
  - Dispense daily on FP10 interval prescription

Precautions For Use of BZ

- Continue to assess patient while in treatment:
  - Are goals being achieved within agreed time frame?
  - Is on-top BZ use occurring?
  - Any new psychiatric comorbidity developed?
- Monitor patient especially for:
  - Behavioral disinhibition
  - Withdrawal reactions
  - Inhibition of psychological progress
  - Side-effects

Justification for long-term BZ use

- Defensible when:
  - Alternative treatments have failed
  - Benefits of treatment outweigh risks
  - Decision taken in conjunction with patient
  - Treatment is strictly individualised
  - Need for treatment reviewed periodically
- Use must be for treatment of diagnosed problem

What to prescribe?

- Diazepam is the drug of choice
- Change all benzodiazepines to **diazepam**
- Start low and work up to generally a maximum of 30mgs
- *Instalment prescribing for diazepam available*

Maintenance or detoxification

Reduction

- Usually short-term prescribing (maximum 6 months)
- Give the evidence to the patient and explain the risks of long-term prescribing
- Establish at the beginning that this is short term and will be reduced and stopped

How to reduce?

- Change to the equivalent dose of diazepam
- Reduction regime varies with patient
- Reduction may need to be slower if experiencing withdrawals
- While reducing, counselling, support groups, relaxation techniques etc

Suggestion of reduction regime

- More than 60 mg of diazepam, working with the patient, reduce by 5-10mg/fortnightly
- Between 30-60mgs reduce by 5mg/fortnightly
- Between 20-30mgs reduce by 2-5mg/fortnightly
- Less than 20mg reduce by 2 mg/fortnightly
- When down to 5mg reduce by 1 mg every 2 weeks

Don’t forget insomnia

- Often a large problem
- Give general advice – sleep hygiene
- Try herbal teas, relaxation
- Treat any underlying depression with sedating anti-depressants
- Z drugs – increasing reports of misuse in poly drug users, no added value, more expensive (NICE 2004)

Maintenance benzodiazepines

- What is your current prescribing policy on maintenance benzodiazepines?

Conditions Where Long-Term BZ Use is More Common

- Treatment resistant persistent severe anxiety or insomnia:
  - Panic disorder, GAD, social phobia, dysphoric disorder, anxiety due to medical illness
- BZ withdrawal symptoms:
  - If persistent debilitating BZ withdrawal syndrome
  - Long term BZ users on prescription unwilling to stop
- As harm reduction treatment:
  - Inability to stay off alcohol or illicit BZ or contact with illicit markets despite them causing considerable harm (but able to stop this harm when on a BZ prescription)
  - Help passive coping skills
  - Settle better on a dose of opioid substitute drug and BZ

Would you change your mind about prescribing for Marie?

- Used drugs for 15 yrs, started diazepam 14yrs, heroin aged 18 and crack aged 20yrs
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- Always open about diazepam use – 30-40mg / day
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- ***What do you now decide?***
- ***Prescribe benzodiazepines for Marie or not?***

Change to Mario

- Started heroin aged 19yrs and crack aged 20yrs
- Been in treatment 4 times but never engaged
- Uses diazepam to come down from crack
- Urine positive for benzodiazepines on one occasion only
- Requests BZ
- ***Prescribe benzodiazepines for Mario or not?***

To Martin

- Came on 80mg diazepam and 40mg temazepam and 40mg methadone
- Diagnosed personality disorder

- ***Prescribe benzodiazepines for Martin or not?***

Summary points

1. Poor evidence base in drug-using populations and who becomes dependent
2. Often try to oversimplify
3. Wide variability in clinical opinion (purists v realists) exists about treatment
   - Treat physical dependence, in similar way to other drugs with BZ
   - Try treat harmful use/dependence with psychological strategies
   - Assess patients for risk of problems from BZ use, including abuse potential

Summary points 2

4. Often used for a reason: to reduce anxiety and help sleep but are addictive
5. Short term prescribing probable some benefit
6. May be benefits of long term prescribing but may be more questionable
7. Need to think careful what is hoped to achieve before starting a prescription of benzodiazepine
8. Large problem in many so don’t ignore them

What is possible with benzodiazepines?

- Lots!
- Thank you

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