

SMMGP

Substance Misuse Management in General Practice Newsletter

Reviewing Benzodiazepine Prescribing in General Practice

Many doctors are more comfortable with prescribing benzodiazepines than methadone, whereas the reverse should be true. The evidence for the value of methadone maintenance is overwhelming. There is no such evidence for the value of substitute prescribing of benzodiazepines.

Short term prescribing of benzodiazepines may have some benefit in supporting drug users to control their intake of benzodiazepines and stabilise their lives. The benefits of long term prescribing of benzodiazepines to drug users are more questionable. Drug users often continue to buy benzodiazepines in addition to their prescribed drugs and often continue to use chaotically regardless of how much is prescribed.

We can often offer support and advice to benzodiazepine users so they can control and reduce their use. This does not always need to include the prescribing of substitute drugs.

There is increasing evidence that long term prescribing of benzodiazepines may cause harm. There is some evidence of cognitive impairment and neurological damage in those prescribed high doses of benzodiazepines.

In the absence of evidence of benefit and with increasing concern about the possible harm of prescribing benzodiazepines in the long term:

- great care should be taken before deciding to initiate a prescription for substitute benzodiazepines
- if a decision is made to prescribe, this should be:
 - * no more than 60mgs daily
 - * for a short time (no more than 6 months)
 - * with a clear goal in mind
- there is no indication for prescribing two benzodiazepines rather than diazepam alone
- those currently on high doses of benzodiazepines should have their dose reduced gradually e.g. 5-10 mg monthly

A few people may benefit from being left on a small dose (no more than 30mgs diazepam daily). This will include:

- those with an alcohol problem who have come off alcohol using benzodiazepines and who find it difficult to stay off alcohol unless they are on a small dose of benzodiazepine
- some people with mental health problems

In this case, continuing to prescribe diazepam may cause less harm than stopping the prescription.

There are several useful guidelines on prescribing benzodiazepines. We include below one version produced by SMP, Brent & Harrow:

Why drug users use Benzodiazepines :

1. Anxiety
2. Insomnia (a real problem when trying to stabilise or reduce drug use)
3. To potentiate the effect of methadone (especially temazepam)
4. 'To get a high'
5. Depression
6. To help come down from amphetamines, ecstasy or cocaine.
7. To reduce 'voices in the head'.

Only consider prescribing benzodiazepines if:

1. Goals of the prescribing have been established:
 - a) stabilisation of lifestyle
 - b) stabilisation of drug use
 - c) patient able to remove self from the illicit drug market
2. Benzodiazepines taken daily.
3. Urine screen confirms the presence of benzodiazepines. (Can stay in urine for 3-4 weeks)
4. Evidence of dependency from history and symptoms.

Value of Substitute Prescribing: see goals above

PROBLEMS (to the prescriber and to the using patient) :

1. High risk of dependency - Benzodiazepines are more addictive than opiates.
2. Coming off benzodiazepines is more difficult than opiates.
3. Withdrawal symptoms usually occur (1/3 rd significant symptoms 10 months - 3.5 years)
4. Risk of withdrawal symptoms increases with length of use.
5. Withdrawals worse if high doses have been used.
5. Withdrawals less severe if tapered withdrawal.
6. Can be injected - Risk of tissue damage and risk of death if tablets injected.
8. Evidence of cognitive damage from high dose prescribing (>30mgs diazepam) over a long period.
9. Side-effects and long-term problems need to be explained.
10. Can be used to exchange for other drugs.

Some doctors are more willing to prescribe benzodiazepines than methadone**BUT:**

Methadone may be what patient wants.

Substituting opiates with benzodiazepines does not prevent illicit opiate use.

Doctors should be **LESS** willing to initiate benzodiazepine prescribing than opiates.

WHAT TO PRESCRIBE ?

1. Only prescribe one benzodiazepine at a time.
2. If using more than one benzodiazepine change to one preparation.
3. Change all benzodiazepines to **diazepam** (because stability better because of longer 1/2 life).
4. Stabilisation of benzodiazepine use difficult on short-acting drugs such as temazepam.

How to change one benzodiazepine to another:

1. Convert all other benzodiazepine to equivalent diazepam.
2. Make change all in one go, very rarely, if the patient is very anxious, it can be done over 1-2 weeks.
3. Prescribing of any other benzodiazepine is actively discouraged and should only be done in very rare instances.

Conversion of equivalent BZ :

Diazepam 10 mgs =	Temazepam 20mgs (Euhypnos, also known as 'jellies')
(valium)	Nitrazepam 10mgs (Mogadon, moggies)
	Lorazepam 1mg (Ativan)
	Oxazepam 30mgs (Serenid-D)
	Chlordiazepoxide 20-30mgs (Librium)
	Flurazepam 30mgs (Dalmane)
	Flunitrazepam 1mg (Rohypnol)

How Much to Prescribe?:

Starting: Aim at lowest dose possible.

Start at 20-30mgs daily of diazepam.

Rarely need to start above 40mgs diazepam daily.

If the street use is very high start on 2x10mgs tds (60mgs) and reduce to 10mgs tds within 6 weeks.

May need in-patient detox for large doses.

Divide the daily dose.

Keep some of the dose for helping sleep at night.

The patient should not be intoxicated, 'stoned' or drowsy during the day.

Review after 2 weeks:

If experiencing withdrawals increase in steps of 5- 10 mgs.

Doses above 60mgs should not be prescribed.

Other Drugs:

If insomnia continues to be a problem use a non benzodiazepine hypnotic for a short period (+/- 2 weeks)

Use:

Thioridazine 25- 50mgs nocte.

Promethazine 25 - 50 mgs nocte

Perphenazine 2mgs x2 nocte

Anti-depressants may be helpful : amitriptyline 25-75mgs nocte

loferamine 70mgsx2 nocte

zopiclone & prothiaden have now become drugs of abuse in some areas (zopiclone London, prothiaden South Wales and Dublin)

MAINTENANCE:

Maintenance prescribing of benzodiazepines has not been shown to have any definite medical value (unlike methadone) and is rarely justified.

1. It was hoped that it would help the drug user to achieve the goals mentioned above (stabilisation of drug use and lifestyle, removal from the illicit drug market), but there is no evidence of this i.e. no evidence of harm reduction.
2. Dependence and tolerance are significant problems
3. Withdrawal symptoms are worse with longer use.
4. HIV and other infections are more common in users using opiates plus benzodiazepines and there is no evidence that these risks reduce if all drugs being used are prescribed.
5. Using benzodiazepines, prescribed or not appears to lead to higher rates of risk behaviour.
6. Real risk of diversion into illicit market.
7. Preparations (especially temazepam) not meant for injecting may be injected.

But it has to be remembered that:

1. Benzodiazepine use is a large problem, especially to poly drug users and prescribing can attract drug users into services.
2. There is a long-acting variety available (diazepam).
3. It can reduce alcohol relapse in a few individuals.
4. A few people with mental health problems are better on low dose maintenance.

REDUCTION:

**Because of long-term effects reducing off benzodiazepines must be constantly reviewed.
Concurrent psychiatric problems may come to light when dose is reduced.
Dual diagnosis is increasingly recognised and needs to be considered.**

HOW TO REDUCE:

1. Change to equivalent dose of diazepam.
2. If more than 30 mgs of diazepam start at 5-10 mgs / month.
3. Reduction can be quicker if shorter use.
4. If 20mgs or less 1 mg every 1-2 weeks.
5. When 5 mgs reduce by 0.5 mgs every 2 weeks.
6. Reduction may need to be slower if experiencing withdrawals.
7. While reducing, suggesting counselling, support group and relaxation techniques can be helpful.

DISPENSING:

1. Daily at first - can't use blue MDA FP10 but can be done on repeat prescriptions on the computer.
2. Discuss dispensing with the pharmacist - they will sometimes dispense daily if requested on the prescription.
3. If prescriptions have been lost or the drugs have been used before the next is due they should **not** be repeated.

Chris Ford and Judy Bury

'The 4th National Conference: Management of Drugs Users in General Practice' Friday April 23rd 1999

Royal Institute of British Architects, Portland Place, London

"A Time of Change - Has Anything Changed?"

Royal College of General Practitioners

HIV / AIDS Working Party

A one day conference to continue the debate about working with drug users in primary care

- The Government drugs strategy and its implications.
- Treatment works - but what and how?

The conference is for those who are currently working with drug users or want to become involved, to examine and explore current practice and concerns.

Applications for the above conference will be sent out to all on this mailing list early in the New Year.

Or details and application forms from Courses and conferences, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU. Tel No: 0171.581.3232 Fax: 0171.225.3047

Survey of Drug Agency Involvement in Pregnancy Liaison Services

A survey of Pregnancy Liaison Services is being undertaken to increase understanding of how pregnancy liaison services involving drug services are organised and run in England and Wales.

If you are a GP, midwife or agency involved in pregnancy liaison for drug users and have not been sent a questionnaire could you please contact:

Kim Clarke, Substance Misuse & HIV Directorate, Lewisham & Guy's Mental Health NHS Trust, 307 Borough High Street, London SE1 1JJ

'What's the Crack' for Professionals and users

The British drug scene has a history of poly-drug use and crack cocaine seems to be moving into most areas of use within this country. Crack is now being used in the 'rave' scene and also within the established heroin scene. Crack users may use a bag of heroin to alleviate the feelings of the come down. Crack has not limited itself to particular sections of the community, but moved through them all with little respect for culture, class, age or background.

The Blenheim Project have produced two books on crack, one for professionals and one for users. They are both welcome in a complicated area of drug use, where there is a lack of useful literature. Both can be obtained from: The Blenheim Project, 321, Portobello Road, London W0 5SY. Tel No: 0181.960.5599

DRUG WARNINGS

NUROFEN PLUS: A possible drug of misuse? The codeine part of the drug is clearly visible and amounts to 12mgs of codeine. It can easily be scrapped off and used for injection.

FLUOXETINE (Prozac) is a useful anti-depressant. Work is showing that it may be useful in a few people after using drugs like cocaine and amphetamines to lift them out of depressed states. But concerns about its addictive nature seem to be increasing and using it with methadone may increase the 'rush'.

Newsletter edited by Chris Ford, Brian Whitehead and Rima Chowdhury. If you have contributions or suggestions please let us know. Or if you would like to join the mailing list for this newsletter, please contact: SMMGP Newsletter, Brent & Harrow Health Authority, Grace House, Harrovia Business Village, Bessborough Road, Harrow HA1 3EX P:0181.966.1109 Fax:0181.426.8646