LifelineProject
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Management of benzodiazepine misuse

York Service

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Management of benzodiazepine misuse – background

Note: not all those who use benzodiazepines are dependent, and not all those who are dependent will benefit from prescribing. *There is no evidence base to support routine substitute benzodiazepine prescribing.*

Clients may misuse benzodiazepines (and request prescriptions) for a number of reasons:

- **Recreational, for their euphoric effect**
- **To increase the effects of other drugs including heroin**
- **To manage 'come down' symptoms in stimulant use**
- **To manage alcohol withdrawal symptoms**
- **Self-medication for mental health needs such as anxiety, depression or sleeplessness. Some may use them to suppress voices in a psychotic illness**
- **Some have become dependent, and may have to continue using benzodiazepines to prevent withdrawal symptoms, which can be unpleasant and sometimes dangerous**

All prescribing decisions are made individually, based on a full assessment and risk-benefit analysis.

Management of benzodiazepine misuse – background

Prescribing benzodiazepines can lead to negative outcomes:

- **If the client isn't already dependent, prescribing will contribute to tolerance and the development of dependence**
- **Prescribed benzodiazepines have a street value, are easily diverted, and can harm or contribute to the death of others**
- **Clients taking long-term benzodiazepines may develop a 'passive coping style' which can impede their engagement with services and with their recovery**
- **Long term use, especially > 30mg diazepam/day can be associated with cognitive impairment, which may be permanent**
- **Benzodiazepines add to the risk of death when taken with methadone, alcohol and other sedative medication (including prescribed antidepressants)**
- **Clients may resist dose reduction, they may supplement prescribed medication with illicit medication, and may end up in conflict with the service over benzodiazepine prescribing**

The only licensed prescribing option , and the only one that makes sense as a service, is gradual diazepam withdrawal to abstinence.

Management of benzodiazepine misuse – background

Focusing on benzodiazepine prescribing may mean that we're not addressing the real issue:

- **If the client is using benzodiazepines recreationally, to increase the effects of other drugs or to manage 'come down' symptoms in stimulant use, this should be addressed, and prescribing should NOT be considered**
- **If the client is using benzodiazepines to manage alcohol withdrawal symptoms, their alcohol problems need to be addressed**
- **If the client is using benzodiazepines as self-medication for mental health or other symptoms, the underlying issues need to be addressed**
- **If the client is dependent on illicit benzodiazepines, community prescribing may be considered if the potential benefits of prescribing outweigh the potential risks. However, community prescribing is only one option in dependence, and other options include supporting the client to reduce illicit use gradually, and considering residential detoxification and rehabilitation**

Management of benzodiazepine misuse – dependence

Assessing benzodiazepine dependence:

Urgent requests for benzodiazepine prescribing must be resisted

Assessing dependence may be difficult, takes time, and means adding together several sources of information

Take a full history to assess potential dependence:

- Benzodiazepine use diary for two weeks
- History of regular DAILY benzodiazepine use for more than three months
- Description of typical withdrawal when benzodiazepine not taken
- At least 3 out of 6 ICD-10 criteria should be present within the last 12 months
  1. Compulsion/cravings to take benzodiazepine
  2. Difficulties in controlling benzodiazepine use
  3. Progressive neglect of alternative pleasures/interests due to benzodiazepine use
  4. Persistent benzodiazepine use despite harmful consequences
  5. Characteristic benzodiazepine withdrawal state
  6. Evidence of tolerance to benzodiazepine

Use urine toxicology testing:

- Benzodiazepine confirmed by at least two positive toxicology tests within the previous two months. If the client has provided a negative benzodiazepine toxicology result at any time in the last three months without showing withdrawal dependence is unlikely

Where there is doubt about the diagnosis of dependence it is acceptable to suggest the client attends for assessment after 48 hours benzodiazepine abstinence, in order to identify the presence of benzodiazepine withdrawal symptoms (see below and CIWA B scale). Please note, for some clients, withdrawal symptoms may be delayed for several days

Management of benzodiazepine misuse – benzodiazepine withdrawal syndrome

The withdrawal syndrome for dependent benzodiazepine users varies from mild to extremely uncomfortable or painful. However it is rarely life threatening.

The withdrawal syndrome can be complicated to assess when clients are using/withdrawing form other substances in addition.

Withdrawal typically starts within two days of stopping a short-acting benzodiazepine (such as oxazepam), and between two and ten days after stopping a long-acting benzodiazepine (such as diazepam).

For some clients the onset of benzodiazepine withdrawal may be as late as three weeks after stopping use.

Withdrawal symptoms are often protracted and may last over a number of weeks or even months.

Benzodiazepine withdrawal symptoms include:

- Anxiety
- Insomnia
- Irritability
- Tremor
- Sweating
- Depression
- Diarrhoea, constipation, bloating
- Muscle aches
- Poor concentration and memory
- Restlessness
- Occasionally: perceptual disturbances and panic attacks
- Rarely: seizures and symptoms of psychosis

The severity of benzodiazepine withdrawal can be assessed using the CIWA B scale (below)

Management of benzodiazepine misuse – possible responses and prescribing risks

Clinical responses to dependence on illicit benzodiazepines:

- For some clients residential detoxification and rehabilitation may be the most effective option for the management of benzodiazepine dependence, particularly if benzodiazepine use is associated with other drug or alcohol use, or there are significant mental health issues
- Clients with shorter-term use or mild dependence can be supported to reduce their illicit use through psychosocial interventions and structured planned reduction of illicit use (clients can be advised to reduce their use by around 1/8 every fortnight).
- Some clients will benefit from prescribing to support them stopping illicit use in the first instance, and reducing and stopping use. **Some of these clients may need support to reduce illicit use to a reasonable level BEFORE prescribing can start safely**

Prescribing isn't always safe, and isn't always associated with a good outcome. Prescribing is unlikely to be safe effective, and should not be considered if:

- The client's motivation and ability to work towards abstinence from benzodiazepines is unclear
- The client has significant or poorly controlled mental health problems or suicide risk
- There is evidence of ongoing illicit opiate or other substance use: the client is in regular contact with a supplier of illicit drugs; is more likely to be using the benzodiazepine recreationally or in association with heroin or stimulant use; the risks are higher when benzodiazepines are prescribed in the presence of poly drug use; and may be ambivalent about addressing drug use issues including benzodiazepine
- The client has problematic alcohol use. Prescription benzodiazepine may increase risk, and the client may be less able to manage medication safely
- The client is prescribed other neurosedative drugs, including antidepressant tablets and pregabalin/gabapentin. The risks of prescribing are increased, and with pregabalin/gabapentin the client's drug seeking behaviour may be in question
- Any suspicion that the client may divert prescribed medication

Management of benzodiazepine misuse – prescribing practicalities

When prescribing is agreed:

- Make sure the client has already seen the R+D nurse to coordinate detoxification
- Write to the GP to confirm that you are commencing prescribing, and to double check they are not prescribing benzodiazepines
- Use the client agreement form to confirm and record that prescribing is reduction, and aiming for abstinence
- Agree a start dose. The start dose is designed to be the smallest dose to prevent withdrawal symptoms. This is likely to be significantly below what the client says they are taking illicitly. The start dose should not routinely exceed diazepam 30mg/d. Start doses can be titrated upwards during a 'stabilisation' phase if a client presents with documented withdrawal (see CIWA B)
- Convert all benzodiazepines to diazepam (see BNF for up to date conversion chart).
- Prescribe diazepam on daily blue FP10MDA, with daily pick ups for at least the first three months of treatment
- Agree a reduction plan. The rate of reduction is typically between one quarter and one tenth of the daily dose every fortnight, ie higher doses can be reduced more rapidly. Typical reductions might be:

  30 to 20mg/d reduce by 5mg/fortnight (prescribe 5mg tablets)

  20 to 12mg/d reduce by 4mg/fortnight (prescribe 2mg tablets)

  12 to 0mg/d reduce by 2mg/fortnight (prescribe 2mg tablets)

  Sequential doses therefore might be: 30mg, 25mg, 20mg, 16mg, 12mg, 10mg, 8mg, 6mg, 4mg, 2mg, stop, with the client entering the schedule at the lowest dose possible.

- Perform urine toxicology testing monthly while on prescription treatment. Prescribing should stop immediately if test is negative to benzodiazepine. If it is positive for illicit drugs, the value of ongoing prescribing should be questioned (positive implies ongoing contact with supplier, and a likelihood that benzodiazepines are being used to enhance the effects of drugs or to manage withdrawal symptoms).

Management of benzodiazepine misuse – client agreement and information

Please add to Theseus, give one copy to client and keep one copy for filing

I am being prescribed a reducing dose of diazepam to help manage withdrawal symptoms as I reduce and stop using benzodiazepines.

I understand and agree to the following:

- The reason for prescribing diazepam is to help me reduce and stop benzodiazepine use.
- The prescribed dose will be reduced and then stopped
- My prescription is for daily pickups
- The reduction plan will not be lengthened.
- I will attend all my appointments, sober and on time.
- My prescription will be stopped if:
    - I use any illicit drugs (including heroin, crack and benzodiazepines)
    - I drink alcohol in a harmful way or attend the service or pharmacist intoxicated
    - I seek more prescribed benzodiazepines from another service or my GP
- There is any suspicion that I have given or sold my medication to anyone else

Agreed reduction plan: ***(EXAMPLE: 30mg for 2 weeks, 25mg 2w. 20mg 2w, 16mg 2w, 12mg 2w, 10mg 2w, 8mg 2w, 6mg 2w, 4mg 2w, 2mg 2w)***

Signed _____ **Date** _____

Management of benzodiazepine misuse – Clinical Institute Withdrawal Assessment Scale - benzodiazepines

Client report:

Do you feel irritable?	0 Not at all	1	2	3	4 Very much so
Do you feel fatigued?	0 Not at all	1	2	3	4 Unable to function
Do you feel tense?	0 Not at all	1	2	3	4 Very much so
Do you have difficulties concentrating?	0 Not at all	1	2	3	4 Unable to concentrate
Do you have any loss of appetite?	0 Not at all	1	2	3	4 No appetite unable to eat
Do you have any numbness or burning on your face, hands or feet	0 No numbness	1	2	3	4 Intense burning/ numbness
Do you feel your heart racing? (palpitation)	0 No disturbance	1	2	3	4 Constant racing
Does your head feel full or achy?	0 Not at all	1	2	3	4 Severe headache
Do you feel muscle aches or stiffness?	0 Not at all	1	2	3	4 Severe stiffness or pain
Do you feel anxious, nervous or jittery?	0 Not at all	1	2	3	4 Very much so
Do you feel upset?	0 Not at all	1	2	3	4Very much so
How restful was your sleep last night?	0 Very restful	1	2	3	4 Not al all
Do you feel weak?	0 Not at all	1	2	3	4 Very much so
Do you think you didn't have	0 Very much so	1	2	3	4 Not at all

enough sleep last night?					
Do you have any visual disturbances? (sensitivity to light, blurred vision)	0 Not at all	1	2	3	4 Very sensitive to light, blurred vision
Are you fearful?	0 Not at all	1	2	3	4 Very much so
Have you been worrying about possible misfortunes lately?	0 Not at all	1	2	3	4 Very much so

Clinician observations:

Observe behaviour for restlessness and agitation	0 none, normal activity	1	2 restless	3	4 paces back and forth, unable to sit still
Observe tremor	0 No tremor	1 Not visible, can be felt in fingers	2 visible but mild	3 Moderate with arms extended	4 severe, with arms not extended
Observe for sweating – feel palms	0 no sweating visible	1 barely perceptible sweating, palms moist	2 palms and forehead moist, reports armpit sweating		

Interpretation of scores:
1–20 = mild withdrawal
21–40 =moderate withdrawal
41–60 = severe withdrawal
61–80 = very severe withdrawal

Ref: *Busto, U.E., Sykora, K. & Sellers, E.M. (1989). A clinical scale to assess benzodiazepine withdrawal. Journal of Clinical Psychopharmacology, 9 (6), 412–416.*

Management of benzodiazepine misuse summary and check-list

1	Ensure any plans for management of benzodiazepine misuse have been discussed with the recovery coordinator and form part of the client's care plan
2	Carefully assess the client's reason for using benzodiazepines (recreational, to augment the high or manage the come down from other drugs including alcohol, self-medication for mental health or other symptoms, dependent use)
3	Carefully assess dependence – history of use consistent with dependence, description of convincing withdrawal symptoms if doesn't use, consistently positive toxicology tests (if there is a recent negative test, and wasn't withdrawing when tested, the client is unlikely to be dependent), meet ICD dependence criteria. In some cases may ask client to abstain and see to assess withdrawal signs.
4	Ensure the client has had an appointment with the R+D nurse to plan preparation, detoxification and aftercare
5	Subsequent treatment plan may be supported dose reduction, supported dose reduction to a level where prescribing may start, or prescribing
6	Prescribing is not indicated if the risk/benefit analysis is not favourable. This is likely when: • motivation to achieve abstinence is not clear; • there are mental health problems or suicide risk; • there is ongoing other illicit use or alcohol use problems (prescribing only when these are resolved); • co-prescribing of other neurosedative drugs; • risk of diverted medication.
7	If prescribing: • Write to the GP, also asking for details of their benzo prescribing • Agree reduction plan, and get the client to sign the agreement form • Choose start dose lower than 30mg/d (and generally lower than self-reported use) • Prescribe diazepam only, daily pick ups on FP10MDA • Perform toxicology monthly (for benzo – stop prescribing if neg, and other illicit use – reconsider value of prescribing if shows illicit use)