PRESCRIBING SEDATIVE-HYPNOTICS

In contrast to the use of methadone as a stabilisation agent, there is little evidence in favour of prescribing benzodiazepines on a maintenance basis. Since temazepam capsules ('Jellies') ceased to become prescribable on the NHS, injecting misuse of benzodiazepines appears to have become less common. The street value of black market benzodiazepines is significantly less than that of heroin or cocaine, and illegally available benzodiazepines are all of pharmaceutical origin. The combination of these factors reduces the potential of substitute prescribing to minimise harm in terms of spread of blood-borne infectious diseases, acquisitive crime and use of illicitly manufactured drugs of unknown purity and content. The main arguments remaining for such prescribing are to engage patients in treatment and to reduce their contact with the drug-using/dealing community.

The demographic profile of patients dependent solely on benzodiazepines is different to that of all other drug misusers. Such patients are likely to be older and are much more likely to be female than other drug misusers; typically, daily use of benzodiazepines is in the region of the equivalent of 10 to 30mg of diazepam. The origin of dependency is often iatrogenic, and on-going management frequently takes place in a primary care setting. As such, this group presents a very different challenge for management. Nevertheless the principles of good management as described above should be adhered to, including clear diagnosis of dependence, formulation of clear treatment goals and milestones, regular review and the use of methods to prevent diversion. Abstinence should be the preferred goal but may not be achievable in all cases. If a period of stabilisation prescribing is agreed then shorter-acting drugs such as temazepam or nitrazepam should be converted to the equivalent dose of the longer-acting chlordiazepoxide (this is preferred to diazepam due to its lower street value) (*see appendix* 7, page 123 for conversion table).

The other well-defined group of benzodiazepine misusers are those who use these drugs as part of a 'cocktail' of polydrug use. Up to 90% of attenders at drug misuse treatment centres reported use of benzodiazepines in a one-year period (Perera KM, Tulley M, Jenner FA, 1987), and the doses misused are often very high; diazepam 100mg daily is a typical amount consumed by a heavily dependent polydrug misuser.

- Patients dependent solely on benzodiazepines are likely to be older and are much more likely to be female than other drug misusers. Typical use is in the region of 10-30mg diazepam equivalents daily. Management will usually be in a primary care setting.
- Patients using benzodiazepines as part of a **polydrug** cocktail typically use in the region of 100mg diazepam equivalents daily. Management of this group should involve specialist services.
- Abstinence is the usual goal, and patients should not be maintained on doses of greater than 30mg diazepam (or equivalent) for long periods.

Doctors should be reluctant to inititate prescribing for this group in the absence of specialist advice, and in general such patients should be managed either within a shared-care arrangement or by the specialist team. If prescribing is commenced, the initial aim should be to prescribe a dose to prevent withdrawal rather than to replace the reported 'street' use. The dose should then be gradually reduced to a level of 30mg diazepam equivalent per day or less (Drug Misuse & Dependence – Guidelines on Clinical Management, 1999). The drug of choice for such prescribing should be chlordiazepoxide, due to its relatively low street value. Once the target has been reached, on-going maintenance prescribing may be indicated, but this decision should only be reached in conjunction with specialist services. If the patient is also receiving a long-term prescription of methadone for concomitant opiate dependency, the methadone dose should be kept stable throughout the benzodiazepine reduction period. Concurrent reduction of both drugs is not recommended in a community setting.

Barbiturates should never be prescribed for the treatment of dependency in the absence of documented specialist advice.