Can I keep myself safe?

Experiences of Benzodiazepine/ Z-drug and Opioid Co-use

Research findings and recommendations for drug treatment and mental health service provision

INTRODUCTION

The number of people dying because of drugs is rising in the UK. Many of these deaths involve a combination of drugs, especially opioids (heroin, methadone) and sedatives like benzodiazepine (benzos) or zopiclone (z-drugs). This is known as co-use. These drugs are either prescribed or obtained as street drugs.
In this booklet, we share our research findings, stories based on them and our recommendations.

What did we do?

- 48 interviews with people who use benzos or z-drugs and opioids in Glasgow, Bristol and Teesside about how and why they use these drugs together, what effects they have and what role they have played in their overdose experiences.
- 24 interviews with healthcare professionals in primary care, drug treatment services, support and mental health services across England and Scotland to learn their views on how to support people who take benzos or z-drugs and opioids.
- 4 workshops with national experts to develop recommendations.
- The interviews were used to design laboratory experiments to help us understand how combining these drugs interacts in the brain and influences breathing control and respiration

WHAT DID WE LEARN?

How people co-use

We learnt that there are lots of different ways that people might co-use these drugs - at the same time or separately at different times of the day. Even if they are taken separately at different times of the day, they still interact with each other because of how long they last for.

Why people use these drugs?

People used these drugs together to help them function - to stop withdrawal, address poor mental health, control emotions and manage pain.
People also wanted to feel a **'glow'** (feeling comforted) or **'oblivion'** (forgetting or escaping previous or current trauma and adversity).

Beliefs around reducing risk

Most people in our study had experienced a non-fatal overdose. Some felt they were able to do things to keep themselves safe, but many felt there was nothing they could do to avoid overdoses. The lack of support for people taking benzos or z-drugs and opioids increased the sense of hopelessness that people felt, often leading to more co-use.
Some staff felt conflicted about how best to support people, as prescribing benzos or z-drugs with opioids carries risk. Some felt this was not recommended. They were unsure what alternatives there were, and felt there was no specific advice or support for this type of co-use. All staff felt the gap in mental health provision for people who use drugs made the situation worse.

***Dave, Sally and Peter's stories** and illustrations have been developed with help from Nicky and Zoe, our experts by experience.*

Dave's story (48 years old, Bristol)

'I have been prescribed 30mg diazepam for many years and that held me fine and I didn't need any more benzos than this. It helped my anxiety and I split my dose which helped me sleep. I can get support for my methadone, but the GP wanted me to reduce my benzo dose. I didn't feel I could say no, so it was 2mg less every month 'til I detoxed. Within a couple of weeks, I was buying massive amounts online. I'm taking 60 tablets a day now and going into overdose mode. I have to rely on street tablets because my doctor won't prescribe a detox starting from the dose I am taking.'

John, GP

'We have supported Dave to gradually reduce his benzodiazepine dose and stop. I know that has been really difficult for him but I think it had to be done, I was concerned about the long-term risks of taking benzodiazepines. They can affect his memory, his balance and there is the overdose risk that combining benzodiazepines and opioids carries. I don't want to be the one responsible for causing these harms to Dave.'

Sally's story (28 years old, Teesside)

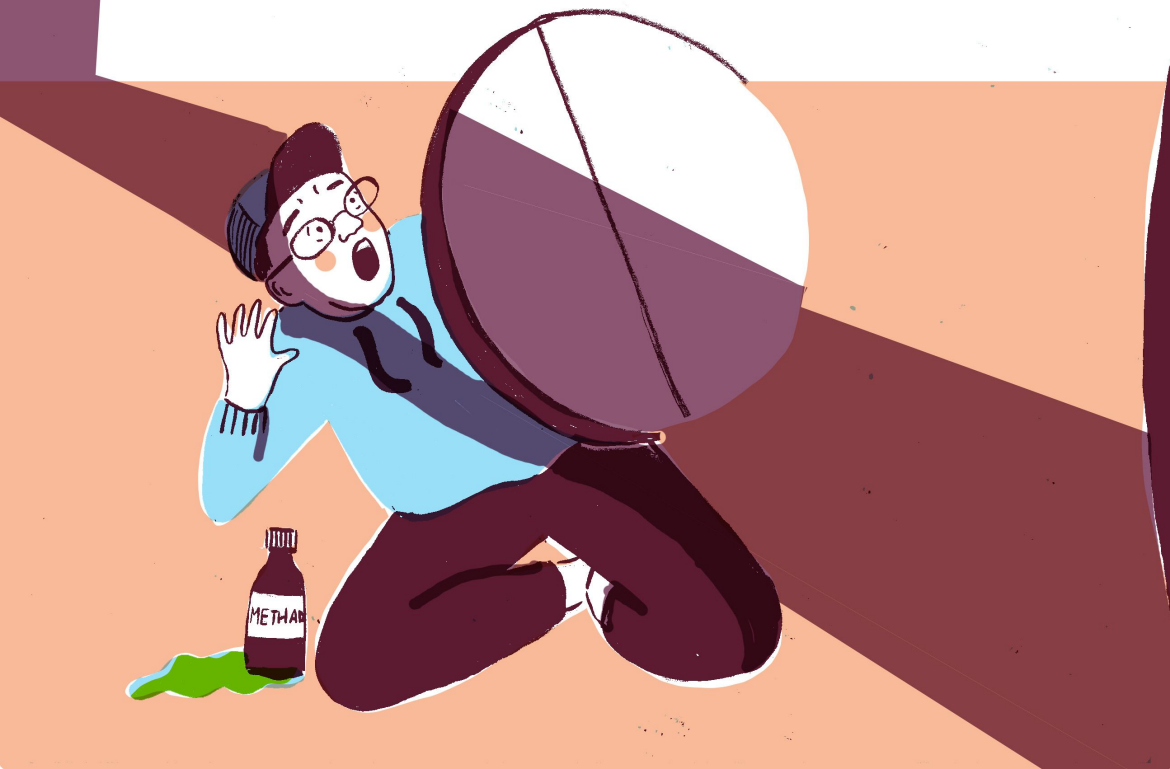
'I just want to be safe, I feel on my own trying to deal with it all. I've told my drugs worker that I'm on blue zoppies (zopiclone). They're stronger than the white ones at the minute, maybe they're cut with something else, I don't know. All she's told me to do is to **reduce by myself** before I can go to detox. **They don't know how to help.** I can't go to my GP because they will think I just want some Diazees (diazepam). I don't think they will let me do a detox outside (from home) I'll have to go in (hospital). I've been trying to reduce down so that I can go to detox, but it's harder than last time and zoppies help me feel normal and do the things I need to do to get through the day.'

Mike, Harm Reduction Staff

'I am not sure how to help Sally. She is on methadone. We can advise that she sends her zopiclone for testing and give general advice around staying safe – don't take drugs alone, stay low, keep it slow, carry naloxone. I am **frustrated about the lack of evidence** on how best to help her. I can advocate on her behalf for a residential detox place, but she needs to reduce her street zopiclone dosé before she can go to that. I worry for Sally, because **she is left with no other option than to detox on her own** with street tablets which **could be cut with other substances.'**

Peter's story (39 years old, Glasgow)

'My childhood wasnae great, but that's the case for many people here, especially when you stay in the poor neighbourhoods. My mum and stepdad used drugs. I didnae really mind until my stepdad started abusing me, and my mum didnae believe me when I told her. I didnae know what to do, and my pal at school gave me some pills. I didnae feel quite so bad when I was on benzos, but I ended up having to take more and more - **I wanted oblivion**, to get away from all my problems. I know this isnae working for me, I need help but when I asked to see a therapist, they said I couldn't unless I stop taking benzos. **I have nowhere to turn for help,** ken, I'm on methadone the noo, but it isnae the same and I often struggle. No one is listening and I am tired.



Carol, Drugs Worker

'Peter needs trauma focused psychological help. There is a **lack of resources** to pay for this help or to think long-term, so **you work on the short-term issues**, just trying to **keep people safe**. Specialist psychological care is simply too expensive with our limited budgets. We have trained our drug team in psychological formulation, to help them understand why people are co-using. This is just a small step in making our care more psychologically informed. But it's not yet helping people with their trauma as **we don't have services to refer to.**'

RECOMMENDATIONS

Our recommendations support what we already know about how to provide good services to people who use drugs. We recognise the importance of asking about people's motivations and patterns of drug use, and the ways people try to keep themselves safe.

WE RECOMMEND:

1) Benzo prescribing for people who co-use dependently as part of a flexible and individually tailored care plan

2) Providing **structured, supported detox plans**, when people are ready, that work with where they're at and their specific needs.

3) Providing clear, accessible, engaging and relevant **harm reduction information** including counselling on the effects of different benzos and drug administration routes, so they know how long to wait to see if a drug has taken effect or not.

4) Upskilling staff to better understand the effects and interactions of benzos or z-drugs with opioids and other drugs

5) Providing **holistic psychosocial interventions** aimed at improving people's everyday health, resilience and wellbeing, alongside harm reduction.

6) Ensure **drug use is not a barrier** to people getting the **specialist mental health support** they need, through adapting interventions, and creating rapid referral routes to specialist mental health services.

Find out more:

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https://arc-w.nihr.ac.uk/research/projects/understanding-how-benzodiazepines-and-opioids-interact-in-order-to-develop-harm-reduction-strategies/

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