

**Ballymun  
Youth  
Action  
Project**

## Benzodiazepines – whose little helper?

The role of benzodiazepines in the development of substance misuse problems in Ballymun

Community/Voluntary Sector  
Research Grant Scheme



**NACD**

National Advisory  
Committee on Drugs



## **Benzodiazepines – whose little helper?**

### **The role of benzodiazepines in the development of substance misuse problems in Ballymun**

**This research was undertaken by the Ballymun Youth Action Project Ltd**

#### **Ballymun Youth Action Project (BYAP)**

The Ballymun Youth Action Project, a Community Response to Drug and Alcohol Misuse, was established in 1981 after the drug related deaths of three young people in the area. Since then the Project has continued to respond to the needs of individuals and families in the context of the community in which they live. BYAP offers a range of services on all aspects of drug misuse ranging from work with individuals, families and groups, to education and training courses. In 1996 the Ballymun Youth Action Project established URRÚS, Ireland's first Community Addiction Studies Training Centre.

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## Foreword

I am delighted to be able to introduce these excellent reports from the Community & Voluntary Sector Research Grant scheme. The Terms of Reference of the National Advisory Committee on Drugs (NACD) commits to finding ways “to maximise the use of information available from the Community and Voluntary Sector”. Thus a research grant scheme aimed directly at this sector was developed. Such was its centrality to the work of the NACD that its development and implementation was designated as a key role for the Research Officer.

After launching the grant scheme, the NACD received over 100 enquiries and received 35 applications from across the country. Following a review and short-listing of the applications, eleven groups were invited to participate in a training workshop and finally five grants were issued. Four organisations completed their research projects and this report is one of the four launched by the Minister of State with responsibility for the National Drugs Strategy in October 2004. Clearly the aims of the research grant scheme were achieved: to build capacity; to inform gaps in our knowledge and to contribute to the development of public policy.

The NACD’s Research Officer, Ms Aileen O’Gorman developed the grant scheme and provided ongoing liaison and support to each group helping them to implement their research studies and bring them to publication. My colleagues and I wish to place on record our deep appreciation of the significant contribution she has made to this project. The commitment of all those involved from the community projects and their Research Advisory Groups must be acknowledged and their achievement in producing such valuable information to the NACD and their own communities is to be commended.

The NACD is in the process of commissioning an external review of this scheme and subject to a positive evaluation, hopes to be in a position to recommend continuation of this grant scheme in the future.

I would like to thank everyone involved, the staff of the NACD and finally, Ms Kate Ennals who provided editorial support in bringing the reports to publication stage.

**Dr Des Corrigan**

*Chairperson*

*National Advisory Committee on Drugs*

# Preface – NACD Community/Voluntary Sector Research Grant Scheme

## NACD

The National Advisory Committee on Drugs (NACD) was established in July 2000 to advise the Government in relation to problem drug use in Ireland, based on the analysis of research findings and information. The Committee, whose members are drawn from statutory, community, voluntary, academic and research organisations as well as relevant Government Departments, oversees the delivery of a comprehensive drugs research programme on the extent, nature, causes and effects of drug use in Ireland. The Committee reports to the Minister of State responsible for the National Drugs Strategy in the Department of Community, Rural and Gaeltacht Affairs.

## Community/voluntary sector research grant scheme

In December 2001 the NACD launched a *Community/Voluntary Sector Research Grant Scheme* to generate innovative, community-based drugs research. In a nationwide advertising campaign, groups working in the community/voluntary sector that were interested in conducting research in the areas of prevalence, prevention, treatment/rehabilitation and the consequences of problem drug use, were invited to submit applications to the scheme.

## Application process

The grant scheme was developed with monitoring and support mechanisms built in at all stages from initial application to the conclusion of the research studies, in order to encourage applications from groups who had interesting research ideas but may have had little research experience. For example, a two-phase assessment process was developed to facilitate the development of the research proposals. The first assessment stage focused on the applicant organisation; its understanding of drug issues; its links with the local community, service providers and planners; and the relevance of the proposed research to the NACD's programme of work.

Thirty-five applications were received from groups around the country. From these, eleven organisations were shortlisted and invited to attend a research training workshop to further develop their research idea. Fourteen people from the eleven groups attended the one-day workshop which dealt with issues such as literature reviews, fieldwork, research ethics, data gathering and analysis, costing research proposals etc.

Following the training workshop, the short-listed applicants submitted a fully developed research proposal outlining the aims and objectives of the research, the methodology, project management and costs. While all eleven proposals were highly regarded by the NACD assessment committee, a maximum of five research studies could be funded from the set-aside budget of €125,000. Consequently, five research grants of between €20,000 to €25,000 each were awarded. However, one study was unable to proceed due to the restructuring of the organisation and staff changes.

The research studies began towards the end of 2002 and were completed by June 2004. Throughout this period the groups were supported by the NACD Research Officer and the Research Advisory Groups established to work with each group.

## Research Grant Recipients

### Ballymun Youth Action Project (BYAP)

#### Study of the role of benzodiazepines in the development of substance misuse problems in Ballymun

This research investigates the pattern of benzodiazepine use and misuse in Ballymun, identifies the problematic elements involved, and examines the relationship between benzodiazepine use and the use of other substances. It explores the dynamics of supply and demand in the local context, and highlights the factors that allow the continuance of a relatively high level of benzodiazepine use within the community. In this context the research explores the role played by benzodiazepines in the development of substance misuse problems in Ballymun, and identifies strategies that may facilitate change.

### Kilbarrack Coast Community Programme (KCCP)

#### Research study on drug misuse among 10-17 year olds in the Kilbarrack area

This study establishes the patterns and trends of drug misuse in the Kilbarrack area by young people aged 10 – 17 and examines their attitudes to drug use, and the risk factors accompanying their use. The study also assesses the drug use among a sample of early school leavers and examines the views of community members on the drug situation in the area.

### Merchants Quay Ireland (MQI)

#### Drug use among new communities in Ireland: an exploratory study

This exploratory study examines the patterns of drug use among new communities; explores the reasons and motivations for drug use; establishes risks the users may be exposed to; examines the level of awareness of health promotion/harm minimisation strategies and drug treatment services; and identifies barriers to accessing services.

### Tallaght Homeless Advice Unit (THAU)

#### The links between homelessness and drug use

This research examines the nature of drug use amongst the homeless population in Tallaght; explore the reasons behind their homelessness; examines the policies and practices of local authorities in relation to the housing of homeless drug users; and explores the experiences of homeless drug users with special reference to the policies and practices of homeless services.

**Further information on the Community Research Grant Scheme is available on the NACD website [www.nacd.ie](http://www.nacd.ie) or, by contacting:**

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## Acknowledgements

Many people have made this study possible. The Research Advisory Group have seen the process through from the start, and our thanks go to Mairead Kavanagh, Catherine O'Hara, and AnnMarie Hughes for the insight, clarity and thoroughness that they brought to the research project. Carmel Kelly played a key role in the data gathering stage, particularly in convening the focus groups and working on the presentation and analysis of the findings. Aileen O'Gorman of the NACD provided support and advice throughout the project. Dr. Paul Quigley's involvement in the process from the start has broadened our perspective significantly, and helped us clearly locate the research within a wider context. Dermot King was given the task of pulling the research project together and editing the report.

The focus groups played a key role in the data gathering for this research, and our thanks go very particularly to each person who took part in one of the focus groups or individual interviews. In many ways it is the information given there that puts the flesh onto the bones of the research project.

We are also very grateful to those who came on board to moderate the focus groups and carry out interviews. Thanks to Brian Foley, Joe Merry, Margaret Bowden, Barbara Condon, and to Dave Sheridan and Niall Guy from the Ballymun Regional Youth Resource.

The Pharmacy Survey formed an integral part of the research project, and we are very grateful to Síle O'Connor who undertook that specific part of the research for us. We would also like, along with Síle, to acknowledge the co-operation and support of the community pharmacists involved in the Pharmacy Survey.

It was the funding from the National Advisory Committee on Drugs (NACD), through the Community/Voluntary Sector Research Grant Scheme, which provided financial support for the research, and we are very appreciative of both the funding, and the supportive way in which it was administered.

And finally a word of thanks to the staff and management of the Ballymun Youth Action Project and URRÚS for the constant support and feedback into the research process.

## Executive Summary

The use and misuse of benzodiazepines within the Ballymun community has been an issue of concern for a number of years and this research project seeks to explore the phenomenon with a view to proposing appropriate responses.

The research involved a review of the relevant literature and the collection of data from a variety of perspectives. The project was carried out using a range of quantitative and qualitative methods. Community-based focus groups were held, a pharmacy-based dispensing survey was carried out, and a key informant provided a professional view on medical practice related to the use of benzodiazepines. This three-pronged approach meant that the themes were examined from various different perspectives.

### Community research

A key task facing this research project was to develop a research methodology that would genuinely be community based. Therefore the project sought the active participation of people living and working in the community of Ballymun, not just as participants, but also as researchers and stakeholders. The action research approach allowed a variety of stakeholders to engage with and explore the research topic, to gather information, and to identify possible interventions.

In the light of the research question a number of “target groups” were identified as appropriate and potentially useful sources. These were:

- Local healthcare professionals including doctors and pharmacists.
- Legitimately prescribed benzodiazepine consumers.
- Opiate and multisubstance misusers.
- Young people who are likely to include benzodiazepines in their drug repertoire.
- Community and voluntary organisations who interface with benzodiazepine use.

### Benzodiazepine prescribing in Ballymun

The findings suggest that the level of benzodiazepine prescribing in Ballymun may be notably higher than the national level. They also indicate that a considerable proportion of patients who are initiated on benzodiazepines continue to take them for many years, and that the conditions that would foster the review of benzodiazepine prescriptions, such as available time and an adequate patient load, are not normally present in the Ballymun context. The research identifies elements of the relationship between socio-economic disadvantage and benzodiazepine use in Ballymun, and also suggests that there is a clear gender bias in the prescribing of benzodiazepines in Ballymun, with women being prescribed almost two thirds of the benzodiazepines covered in the Pharmacy Survey.

### Benzodiazepines and the development of substance misuse problems

The research suggests that within Ballymun there is a generalised acceptance of benzodiazepines. If the use of this one specific drug type, which is also a drug of misuse, becomes acceptable or normalised, then this can have a contributory effect when it comes to considering the misuse of other drugs.

The evidence emerging in this research also suggests that there is a significant supply of benzodiazepines, originating in prescriptions, which is available for misuse within Ballymun. The report indicates that this informal benzodiazepine economy seems to be a common and culturally acceptable practice.

The nature of benzodiazepines themselves also appears to play some role in the development of substance misuse problems, given that such a versatile drug does have the potential to generate new patterns of drug misuse.

The research also examines the relationship between opiate use and benzodiazepines and echoes the concerns expressed in various quarters about such polydrug use.

## Whose little helper?

In the light of the data presented in this research it is evident that understanding benzodiazepine use is a complex task. However one question that has remained throughout this research process has been, “to what degree do benzodiazepines allow a wide variety of individuals and structures to “cope” with realities that are unfavourable or inadequate?” Exploring this issue is crucial in dealing realistically with the current situation and the evidence suggests that the use of benzodiazepines is not always the appropriate response. Undoubtedly changing the pattern of benzodiazepine use in Ballymun constitutes a significant challenge.

## Recommendations

The research makes a series of recommendations:

- Examine in more depth the reasons for benzodiazepine prescribing in Ballymun, ensuring that the emphasis on responding to these findings, and the findings of further research, is not directed solely at individual doctors, but addresses the broad range of issues involved;
- Invest in the development of services to complement medical practitioners. There is an urgent need to develop non-pharmaceutical supports for benzodiazepine detoxification and alternatives to benzodiazepine therapy;
- Provide good, high quality information about benzodiazepines to all members of the community;
- Review the current role of benzodiazepine prescribing in the context of methadone maintenance;
- Undertake further research in similar communities in the light of the findings of this research.

It is hoped by the authors that the findings of this research will contribute to a clearer understanding of the role that benzodiazepines play in Ballymun, and that, in the spirit of the community based approach, the research will enable all stakeholders to gain insight and identify strategies which will contribute to effective change.

## Introduction

### 1. Ballymun

Ballymun has been in the public eye since the initial construction of the 2,800 flats and 400 houses in the mid 1960's. While the first years were marked by the optimism of that time, the recession that hit Ireland in the 1970's had a profound impact on Ballymun. Since then there has been a consistent recognition that Ballymun is characterised by significant socio-economic disadvantage. The most recent data<sup>1</sup> indicates that, using the Principal Economic Status criteria, Ballymun has an unemployment rate four times that of the State. The most recent Household Survey<sup>2</sup> found that 42.4% of people in Ballymun received Social Welfare Benefit Payments, and that 58.6% of the population hold a Medical Card. At the moment Ballymun is undergoing an enormous regeneration project, involving the demolition of over 2,500 flats and the building of replacement housing along with other development of the area.

In the early 1980s, described by Butler (1991) as the "Opiate Epidemic", there was a dramatic increase in the use of opiates, particularly heroin, in the Dublin area. In Ballymun, the deaths of three young people in 1980 as a result of drug misuse led to the establishment of the Ballymun Youth Action Project, a community response to drugs. Since then the issue of the use and misuse of drugs has remained firmly on the agenda. The Northern Area Health Board Addiction Service runs a Treatment Centre in Domville House, in Ballymun. The Treatment Centre currently provides medical treatment for opiate use to 281 people with Ballymun addresses, as well as providing for a further 30 people through the Mobile Service [Bus]<sup>3</sup>. The Centre has been in operation since 1996 and treats about 300 persons. In addition, there are approximately 150 people in receipt of treatment through local general practices and community pharmacies under the Methadone Protocol.

Alongside the public awareness of the heroin situation, benzodiazepines have been an issue in Ballymun for a long time. In particular there have been concerns about the perceived level of prescribing within the local community, and concern with the frequent stories of benzodiazepines being used with other substances, particularly heroin and alcohol.

When the National Advisory Committee on Drugs advertised the Community/Voluntary Sector Research Grant Scheme in 2002, it was considered that this was an ideal opportunity to try and establish a clearer understanding of benzodiazepine use and misuse in the Ballymun context. The fact that the Research Grant Scheme was designed to build the capacity of local communities in doing their own research was also considered very appropriate to the community development principles that inform the work of the Ballymun Youth Action Project.

### 2. The policy context

Benzodiazepines are regulated under the Control of Sale Regulations, and under the Misuse of Drugs Acts. They can only be sold by a pharmacist, in accordance with a valid prescription. It is also illegal to possess them without a prescription or to sell or give them to someone else.<sup>4</sup> The more general policy context regarding the misuse of drugs is outlined in the First and Second Reports of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, published in 1996 and 1997. The First Report focuses on opiate use in particular, leaving the consideration of other drugs to the second report. In the Second Report the only reference to benzodiazepines is in Ch 3, the Misuse of Non-Opiate Drugs. There it notes that, "from the evidence which is available, it can also be stated with a reasonable degree of certainty that heroin abuse is never separate from the use of other drugs, such as cannabis, ecstasy, tranquillisers, sleeping tablets, barbiturates, alcohol etc. Opiate users often begin their drug using practices on other substances, although it is acknowledged that many non-opiate users do not progress to hard drug abuse" (p38). The chapter then goes on to examine cannabis and ecstasy. What is striking is that in 1997 there was not yet an official recognition of "benzodiazepines" as a particular category of drug with widespread misuse.

In terms of official policy documents this situation had not significantly changed by the time the National Drugs Strategy document "Building on Experience" 2001-2008 was produced. In that document there is a brief mention of the External

1 Ballymun Partnership. (2003). *Ballymun Fact File 2003. A socio-economic profile of Ballymun for people living, working, investing, researching and delivering services in the Area*. Dublin.  
 2 The survey took place from November 2002-January 2003 to gather the data for the Ballymun Fact File 2003 mentioned above.  
 3 Source: Information Supplied to the Ballymun Local Drugs Task Force Review Day 7th October 2003.  
 4 Corrigan, D. (2003). *Facts About Drug Misuse in Ireland*. Dublin. Health Promotion Unit. p57

Review of Drug Services for the Eastern Regional Health Authority (2000)<sup>5</sup> and the fact that it appears to indicate a growing problem of poly-drug misuse (p22). Within the action plan of the strategy the action regarding benzodiazepines (Action No.41) is to oversee the implementation of the recommendations of the Benzodiazepine Committee “as part of the overall strategy of quality improvement of current services” (p116).

### 3. The Benzodiazepine Committee

Concern about problems of benzodiazepine misuse had been communicated to the Department of Health and Children by doctors, including consultant psychiatrists in substance misuse at the Drug Treatment Centre Board. A warning Circular about benzodiazepine prescribing was sent to all doctors following the establishment of the Methadone Prescribing Protocol in 1998. In 2000 the Benzodiazepine Committee was established by Micheál Martin, Minister for Health and Children. In 2002 this Committee produced the Report of the Benzodiazepine Committee (2002), which noted the ongoing concern about the potential for misuse of this drug group amongst a wide range of users (p6). The Report quoted the External Review of Drug Services for the Eastern Regional Health Authority (2000) which, “while generally positive about the expansion of methadone treatment provision for problem opiate users in the Dublin area, expressed specific misgivings about the high rate of benzodiazepine use amongst this client group, as indicated by urinalysis data” (p6).

The 2002 Report found that there are still many long-term prescribed benzodiazepine users in Ireland, and that “it would appear that these patients receive little support or advice from their doctors, and generally it would also appear that some medical practitioners are not well informed about benzodiazepine withdrawal symptoms or methods of withdrawal” (p6). It also acknowledges the medically recognised reality that benzodiazepines “can cause drug dependence when taken on a long-term basis, even in prescribed therapeutic doses” (p6).

The Report also presented findings regarding estimated prevalence of benzodiazepine usage. One study was based on the National General Medical Services Scheme [GMS]<sup>6</sup>, which covers approximately 31% of the population (p10), and found that 11.6% of the adult GMS population [over 15 years] were using benzodiazepines [including some non-benzodiazepine hypnotics] (p11). Data also indicated that the prescribing of benzodiazepines had increased from 87 DDD’s [Defined Daily Doses]<sup>7</sup> in 1995 to 116 DDD’s in 2000 (p11). The increases were most clearly evident in the case of Alprazolam (including Xanax), Diazepam, Nitrazepam, Triazolam and the non-benzodiazepine hypnotic Zopiclone (p11).

The Report also indicates that most of the GMS prescriptions examined in the study were for a month’s supply, and that this had virtually become the standard practice for the prescribing of benzodiazepines in the GMS scheme (p13).

In a second study used in the Report, undertaken by the Health Information Unit of the Eastern Regional Health Authority [ERHA], GMS data on the prescribing of benzodiazepines in the ERHA area during 1999 and 2000 was examined. This study found that in 2000, of the 492 doctors participating in the GMS scheme, 17% had higher than expected prescribing ratios for benzodiazepines, with 5% prescribing at least 50% more than the average, and 1% prescribing at least twice the average<sup>8</sup>. The same study found that benzodiazepines were being prescribed to approximately one in ten persons overall, and up to one in five in the older age groups. It also found that benzodiazepine prescribing was higher for females.

### 4. Research aims

It is evident that benzodiazepine misuse is a major problem in Dublin. There is also a deficit of knowledge in relation to the role benzodiazepines play in the development and continuation of problem drug use. The Ballymun situation provides an ideal opportunity to undertake this research.

The aim of the research was:

- To explore the role of benzodiazepines in the development of substance misuse problems in Ballymun.

5 Farrell, M. Gerada, C., and Marsden, J. (2000). *External Review of Drugs Services for the Eastern Health Board*. National Addiction Centre, Institute of Psychiatry, London.

6 The GMS Scheme covers Medical Card Holders.

7 Defined Daily Doses is a unit of measurement. It is seen as the average maintenance dose per day for a drug used under normal circumstances by adults.

8 Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. p16.

The objectives of the research were:

- To describe the dynamics of benzodiazepine supply and demand within the Ballymun setting.
- To investigate the relationships between benzodiazepines, opiates and other substances in young person's drug repertoires.
- To examine the impact of benzodiazepine use on the community.

## 5. Conclusion

In introducing this research it is noted that Ballymun is a community characterised by particular socio-economic features, which include a significant level of social welfare dependency, a relatively high unemployment rate, and an established opiate misuse problem. It is within this context that there has been an ongoing concern with benzodiazepine use in Ballymun. At the national level there has also been an increasing awareness of the implications of benzodiazepine prescribing patterns, leading to the establishment of the Benzodiazepine Committee. The research presented in this report is effectively situated at the intersection of these two realities of the local and the national.

## Chapter 1 – Literature Review

There were two key premises underpinning the research. Firstly, benzodiazepines do play some role in the development of substance misuse problems in Ballymun. Secondly, the problem of benzodiazepines is not limited to typical “problematic drug users” but has a much wider impact within a community.

When examining what material was available it became clear that neither of these issues has ever been researched in any very direct way. Benzodiazepines were never presented as a key contributory factor in terms of the development of problematic drug use patterns. Instead the focus in the literature was on the patterns of benzodiazepine use within polydrug users’ repertoires (Fountain *et al*, 1999; Best *et al*, 2002). There were also some studies that focused on use patterns among individuals who were prescribed benzodiazepines in a recognised therapeutic setting and who did not use other drugs (Murray *et al*, 1982; Cooperstock and Lennard, 1979).

The second issue, the suggestion that benzodiazepines could have a significant role in the development of substance misuse problems at all levels of a local community, was again notably absent from the literature. In particular the complex interrelationships which support the supply chain for benzodiazepines were only vaguely described in one study (Fountain *et al*, 1999).

Having explored these issues initially we then undertook a broader literature review. This was done as a preamble to the design of the interview brief, and the review continued through the course of the research as new topics emerged from the data that was coming in.

### 1.1 Benzodiazepines

Benzodiazepines, prescription sedatives first synthesised in 1955, were seen as safer and as having substantially less side effects than their predecessors, the barbiturates. By the mid-1970s Valium was the most frequently prescribed drug in the world (Robertson and Treasure, 1996), and between 1970 and 2000 benzodiazepines became a key part of medical practice.

Benzodiazepines can be divided into Hypnotics (sleep-inducing) and Anxiolytics (anti-anxiety), but some benzodiazepines can have both effects. Recently a new group of non-benzodiazepine hypnotics have been developed, which have similar effects to benzodiazepines.

Since the 1980s concerns have been expressed about the use of benzodiazepines. Some of the concerns were in relation to their potential for dependence in long term use, an issue identified in studies as early as 1961<sup>9</sup>. Another series of concerns relates to the side effects of benzodiazepine use, including cognitive impairment and risk of accident (Larson *et al.*, 1987). A third area of concern was the growing awareness of benzodiazepine abuse, particularly among drug users (Robertson, Treasure, 1996).

Alongside the more general features of benzodiazepine use, there were other issues that emerged from the literature review which were particularly relevant to topics that came up in the focus groups. One of these was the reality of “paradoxical” response to benzodiazepines, where the effects of the drug are the opposite to what is normally expected (Robertson and Treasure, 1996).

### 1.2 Misuse of benzodiazepines

According to the literature, there is clear evidence that benzodiazepines are part of the favoured drug repertoire of opiate users (Fountain *et al*, 1999; Robertson and Treasure, 1996; Best *et al*, 2002.), although they are seldom the primary drug of misuse. The EMCDDA 2002 Report<sup>10</sup>, which looks at the wider European context, notes that the most common patterns of problematic polydrug use include heroin combined with other opiates, such as diverted methadone, or with benzodiazepines (p41). Some misusers can attain a very high tolerance level to benzodiazepines. One study found that the average daily dose consumed by drug users was the equivalent of 210 mg of diazepam (Seivewright,1993).

9 Clare, A. (1991). The Benzodiazepine controversy: a psychiatrist’s reaction. In Gabe, J. *Understanding Tranquilliser Use. The Role of the Social Sciences*. Tavistock/ Routledge. London. 180-189.

10 European Monitoring Centre for Drugs and Drug Addiction [EMCDDA] (2002). *Annual Report on the State of the Drugs Problem in the European Union and Norway*.

In the Irish context, the most recent data from the National Drug Treatment Reporting System<sup>11</sup> found that in 1996 benzodiazepines were reported as the main problem drug reported by 1.2% of cases attending treatment in the Republic of Ireland and recorded in the NDTRS (p4). This figure increased to 1.4% in 2000. Between 1996 and 2000 the figure for benzodiazepines as “second problem drug” increased from 16.2% to 18%. More significantly, in 1999 and 2000 there was a shift from opiates to benzodiazepines as the most common secondary drug (p6). In addition, in 2000, while 18% reported benzodiazepines as the second problem drug, 15% reported cannabis and 8.1% reported Ecstasy (p6).

The EMCDDA (2002) Report suggests that there is general consensus that polydrug use has four main functions: “It maximises effects, balances or controls negative effects and substitutes sought after effects” (p39). The report adds that the particular substances used depend on local availability, and local prescribing practices, particularly where they include medical drugs prescribed to drug users in treatment (p39).

The report also identifies the risks associated with certain drug combinations. While recognising that it is difficult to overdose on benzodiazepines alone, the report notes that their use in large dosages, combined with high dosages of other substances such as alcohol or opiates, may be fatal (p39). Unpublished research by Ray Byrne<sup>12</sup>, which examined the Dublin City Coroner reports on drug related deaths during 1998, noted that the majority of the cases recorded tested positive for a number of drugs at the time of death. Benzodiazepines showed up in 67.5% of these cases, the highest incidence of any of the drugs recorded, although this does not indicate their relative contribution to the cause of death in each case.

### 1.3 The prescribing of benzodiazepines

There is a considerable volume of medical and sociological literature on the topic of benzodiazepine prescribing. Koumjian (1981) argues that benzodiazepines have been used as a form of social control which effectively reduces conflict between the individual and the social system. Cooperstock and Lennard (1979) suggest that continued benzodiazepine use is frequently related to role conflict and social stress.

Others have a far more benign view of benzodiazepines. Marks (1983) concludes that the benefits from the use of benzodiazepines within good medical practice far outweigh their problems. Taylor (1989) goes even further, arguing that the original valid reservations around benzodiazepine prescribing had been overwhelmed by an irrational “damnation of benzodiazepines” which, according to Taylor, is unwarranted and not evidence based.

Clare (1991) argues that the prescribing of benzodiazepines is “a complex cultural and social process with political, economic, moral as well as medico-social implications” (p187). Elsewhere, Gossop (2000) notes that the prescription itself can already play a multitude of different social functions, before even looking at the actual drug involved. From the literature review there are a number of issues that emerge around prescribing practices that do suggest a need for further exploration.

One of these is the evidence of gender difference in the prescribing of benzodiazepines. Marks (1983) identifies some possible explanations for this phenomenon, such as the fact that women tend to utilise practitioner and hospital services at higher rates than men, or that women are more willing than men to talk about their emotional issues (p123). However the pattern still raises questions. The recent report of the NACD Drug Prevalence Survey (2003) found that lifetime prevalence for Sedatives, Tranquillisers and Anti-depressants was 15.1% for Females as compared with 9.3% for Males. The same report also confirmed what other international research has consistently indicated, that the prescribing of this category of drug increases with age. In the 45-64 age groups more than one respondent in six reported using sedatives, tranquillisers or anti-depressants in the last month (p6).

A second issue is the relationship between the prescribing of benzodiazepines and the socio-economic situation of the patient. A recent Irish based study of the “Influence of material deprivation on prescribing patterns within a deprived population” by Williams *et al* (2003) concluded that prescribing rates for a number of symptomatic medications, including benzodiazepines, increased with increasing deprivation.

A third issue which has a bearing on the prescribing of benzodiazepines is the perspective of the prescriber, and the factors that influence that perspective. In a study undertaken to examine the physicians perspective on prescribing

11 O'Brien, M. et al (2003). *Trends in Treated Drug Misuse in the Republic of Ireland 1996-2000*. Drug Misuse Research Division, Health Research Board. Occasional Paper No.9.

12 Byrne, R. (1999). *The Relative Mortality Risks of Methadone and Other Drugs Implicated in Drug Related Deaths Investigated by the Dublin City Coroner in 1998*. Unpublished. School of Social Sciences, Dublin Institute of Technology.

benzodiazepines (Bendtsen *et al*, 1999) the authors concluded that an improvement in the rational prescribing of benzodiazepines is not achieved by the making of new rules, but by developing the communication and negotiation skills of the physicians, as well as the addressing of the logistical difficulties faced by doctors. In particular they considered that more time needs to be spent with patients requesting benzodiazepines, and valid non-pharmacological alternatives need to be made available.

#### 1.4 The supply of benzodiazepines

The literature provides a number of perspectives on the supply of benzodiazepines for illicit or non-therapeutic use. Practically all benzodiazepines that are used originate as a prescription. Fountain *et al* (1998), drawing on the findings of a London based study, detail some of the ways in which diverted prescription benzodiazepines are obtained from prescribers. Edmunds *et al* (1996) noted the practice among some alcoholics who are being treated with benzodiazepines of selling them to drug users in order to buy alcohol.

There is also evidence in the literature that some benzodiazepine users take their prescribed benzodiazepines on a self-determined “on demand” or prophylactic schedule (Ayd, 1981). This practice leaves non-used benzodiazepines available for distribution or sale. Fountain *et al* (1996), however, suggest that although this practice has been reported it does not appear to be widespread. At the same time, in the US, it was an issue of concern identified during a NIDA Conference (1993) looking at the issue of Prescription Drug Diversion.

#### 1.5 Conclusion

In this literature review we have identified a lack of information in relation to the role played by benzodiazepines in the development of substance misuse problems at the level of a local community. Our literature review sought to identify particular themes that might potentially throw light on such a pattern of development. In particular the review focused on the areas of the misuse of benzodiazepines, the prescribing of benzodiazepines, and the supply of benzodiazepines. Some other literature in relation to benzodiazepines and the specific Ballymun context are presented in Chapter 6.

#### 1.6 Key findings

- By the mid-1970's Valium was the most frequently prescribed drug in the world, and between 1970 and 2000 benzodiazepines have become a key part of medical practice.
- Since the 1980s concerns have been expressed about the use of benzodiazepines. Some of the concerns were in relation to the potential for dependence in long-term use, others relate to the side effects, including cognitive impairment and risk of accident, and a third emerging area of concern was their abuse potential.
- There is clear evidence in the literature that benzodiazepines are part of the favoured drug repertoire of opiate users.
- While it is difficult to overdose on benzodiazepines alone, their use in large dosages, combined with high dosages of other substances such as alcohol or opiates, may be fatal.
- The prescribing of benzodiazepines is a complex cultural and social process with political, economic, and moral implications as well as medico-social ones.
- There is evidence indicating that prescribing of benzodiazepines is significantly higher among females than males, and that the level of prescribing of benzodiazepines increases with the age of patients.
- Recent research in the Irish context indicated that the prescribing of benzodiazepines increased with increasing level of material deprivation.
- It is suggested that an improvement in the rational prescribing of benzodiazepines is not achieved by the making of new rules, but rather by developing the communication and negotiation skills of doctors, addressing the logistical difficulties created by patient load and time constraints, and by increasing the availability of valid non-pharmacological alternatives to benzodiazepine use.

## Chapter 2 – Methodology

### 2.1 Community based research

Methodology in social research refers to both the techniques used and the presuppositions that underlie the use of the techniques. The presuppositions include things such as the understanding of the human person, of the way society is constructed, and of what is “truth”. Normally the researchers work from a particular perspective without too much presentation of the values involved. However, in looking at the issue of community research it is necessary to say a little more about where we are “coming from” in the development of our methodological approach.

The Ballymun Youth Action Project is a “community response” to drug and alcohol addiction in the Ballymun Area. The “community” in question is the geographical one, but it is very clear that the identity of this community is also strongly influenced by a history of shared experiences, such as periods of very high local unemployment; of shared perceptions, such as the hope that the current regeneration will be a positive development; and of shared understandings, such as belief that change only comes about if people work together to make it happen.

One of the first tasks facing this research project was to develop a research methodology that would genuinely be community based. To that end it was decided that the project would seek the active participation of people living and working in the community of Ballymun, not just as research participants, but also as researchers and stakeholders. This approach, we believe, not only contributes to the quality of the information gathered, but also generates the capacity to undertake further research, and to follow up on the issues that are highlighted within this research project. The research project also had a component of Action Research in that it allowed a variety of stakeholders to engage with and explore the research topic, to gather information, and to identify possible interventions. The overall approach of the research, as the title suggests, was an exploratory one. The methodology adopted was primarily a qualitative approach, though the pharmacy survey provided a quantitative backdrop to this qualitative work. One further methodological element was the decision to adopt methodological triangulation<sup>13</sup>, where the information sought was gathered through a variety of different methods rather than the reliance on one technique.

In practical terms our approach included:

- The creation of a research team to oversee the project. Membership of the Research Advisory Group was designed to ensure the involvement of the various local stakeholders.
- The design of the research question, and the development of the interview schedules, through a consultative process with interested members of the local resident and healthcare community.
- The selection of focus group moderators and individual interviewers who were part of the Ballymun Community, and who would have a particular “access” to the various target groups who were to be interviewed. Training was provided in the particular skills of interviewing and focus group moderation.
- The selection of the focus group participants and individual interviews involved a clear presentation of the role of the research in the context of the Ballymun Community.
- In preparing for the discussion of the findings, the local perspective on the material was again fed into the process.
- It is envisaged that the final report of the research will feed back into the community as a source of information, questions, and positive change.

From the outset the team recognised that the problem of benzodiazepine use and misuse was long-standing and was deeply entrenched in the attitudes and practices of individuals, groups and institutions. It was necessary to investigate the varying social circumstances and the corresponding social and psychological ties which enmesh people in the prescribing, consumption, diversion and misuse of benzodiazepines. It was necessary also to examine the formal and informal constraints which influence the behaviour of individuals involved.

<sup>13</sup> See Denzin, N.K. (1970). *The Research Act in Sociology*. London. Butterworths.

## 2.2 Target groups

The project involved the gathering of data from people living and/or working in Ballymun. In the light of the research question a number of “target groups” were identified as appropriate and potentially useful sources. These were:

- Local healthcare professionals including doctors and pharmacists.
- Legitimately prescribed benzodiazepine consumers.
- Opiate and multisubstance misusers.
- Young People who are likely to include benzodiazepines in their drug repertoire.
- Community and Voluntary Organisations who interface with benzodiazepine use.

For each of these target groups an appropriate data gathering method was adopted. These included focus groups, individual interviews, and key informant approaches. The data was supplemented by a survey of benzodiazepine dispensing records in Ballymun Community Pharmacies.

## 2.3 Gathering the data

Focus groups are seen in the literature as playing a distinct role to individual interviews within the research context.<sup>14</sup> While we did envisage the focus groups as being generative of ideas, discussion, and challenge to the participants, we also hoped that they would prove to be a source of information relevant to the topic. The design of a specific interview schedule, which was the template for all of the groups, alongside some very specific training, did result in the focus groups providing the type of data required. Individual interviews were undertaken when additional information, or information from a particular perspective, was sought. Six focus groups took place, with an average of six participants. Two individual interviews were also recorded.

A second feature that proved very helpful was the attendance in all focus groups of one of the members of the Research Advisory Group, who was known as the “link person”. The focus group moderator posed the questions and facilitated the group process in coming up with discussion and answers. The “link person” was available to listen to what was coming up in all of the groups, and was also able to provide a useful second opinion on the perceptions and understandings of the moderator. The “link person” ensured a consistency in the research questioning, and in the later processing of the data.

## 2.4 Processing the data

While the data from the local pharmacy survey and the key informant report both follow standard procedures in the gathering, processing and presentation of the data, the methodology used for processing the data from the focus groups does require further elaboration.

There were six focus groups.

- Adult community members who are likely to have used benzodiazepines in a therapeutic/legitimate way.
- Two groups of problematic drug users who may or may not include benzodiazepines in their drug repertoire.
- Those in recovery from problematic drug use and no longer misusing benzodiazepines.
- Young people who are likely to include benzodiazepines in their drug repertoire, but who are not considered to be engaged in problematic drug use.
- Members of community and voluntary organisations who interface with problems of benzodiazepine use.

While the membership of the groups was determined by these particular characteristics, the participants also included other perspectives such as “parent” or “resident”.

We opted to have different moderators working with each focus group. It was considered that this was a more appropriate way to work with the different target groups. It was also felt that using various moderators would allow a wider range of people have direct access to, and experience of, the research process.

14 See. Gilbert, N. (Ed). (2003). *Researching Social Life. 2nd Ed.* London: Sage. Ch 10. Also. Litoselliti, L. (2003). *Using Focus Groups in Research.* London: Continuum.

However it was also recognised that this option could create difficulties at the level of the consistency of the material gathered. To deal with that situation we nominated a person who would attend all of the focus groups, and who would allow for a consistency of approach. The role of this linkage person, who was a member of the research team, also allowed the recognition of emergent themes.

The data gathered from the focus group interviews was processed as follows:

1. Directly after the interview the Moderator and the Link Researcher went through the questions on the interview guide, noting down what they considered were the answers to the questions, and if they remember particular points during the focus group where these answers were given. They also noted any other related information that they saw coming up, any particular points of agreement or disagreement that emerged, and finally they noted down anything else about the group that might have a bearing on what came up.
2. As this data was coming in from the various groups, some issues emerged that it was felt could be explored further with some of the groups, and additional questions were added to the interview guide. The emerging data also provided the context for the additional individual interviews.
3. With this initial list of points the Link Researcher and one external researcher, who has not attended the focus group, went through the recording, fitting the data with these points, as well as keeping an eye out for anything else that might have been missed. Transcripts of relevant sections were made at this stage, and the material from the groups was tabulated.
4. The material that emerged was gathered thematically, and using the tabulated responses, the various themes were explored to see how frequently they emerged within the groups, how the themes related to each other within the data, and how the themes related to the research question. The underlying methodology for this part of the process was the inductive approach of category coding which essentially envisages the three stages of “open coding”, where the data was gone through to identify themes; “axial coding”, where the themes are then organised; and finally, “selective coding”, where the organised themes are used as the selection criteria for gathering answers into groups (Strauss, 1987).
5. The draft findings that emerged from this process were then presented to a number of groups, including the research team and the full staff team of the Ballymun Youth Action Project. The subsequent discussion of the findings in these contexts provided further input into the discussion stage of the report.

## 2.5 Researching a sensitive topic

From the outset it was recognised that our research question was addressing a sensitive topic. Anecdotally it was known that benzodiazepine use impacts on a large number of people in Ballymun, and that this situation has existed for more than 25 years. At the same time there was a clear awareness that within the healthcare field there exists substantial divergence in understandings of the role and use of benzodiazepines.

Accordingly, from the start of this research project there was an awareness that drug use is an issue that intimately affects people's lives, and one that needs to be researched in a very respectful way. In formulating our own ethical guidelines we were guided by the “Research Ethics – Guidelines on Good Research Practice (2002)” of the National Advisory Committee on Drugs (NACD), the “Statement of Ethical Practice” (1991) of the British Sociological Association (BSA), and by the Code of Practice of the Ballymun Youth Action Project. Consequently we have erred on the side of caution when providing the information from focus groups and interviews. Given the community setting of the research, and the fact that many of the respondents belong to identifiable sub-groups within the community, we have consistently sought to prevent the identification of participants. While our intention is not to be general in our presentation, at times we have opted to present particular pieces of information in a more general manner. A consent form was completed by everyone who participated in the study, and in the process of presenting this to each participant sensitive issues that might result for people were addressed by the moderators or interviewers. Support structures were also put in place to allow participants the opportunity to deal with any issues that might have emerged as a consequence of the interview process.

## 2.6 Limitations

As a research team we opted to use Focus Groups as a central part of our research approach. We recognise the potential limitations associated with this research tool, but considered that the use of additional interviews where necessary, and the input from the other data sources, would help to identify distortions generated by the Focus Group process.

We recognised from the outset that access to “legitimate” long-term benzodiazepine users was going to be difficult, and in the data gathering only one focus group represented this perspective. Further investigation of this perspective is something that we consider is warranted in the long term.

## 2.7 Conclusion

In this chapter we have given a presentation of the methodology used in this research. We sought an approach that would be genuinely community based and would seek the active participation of people living and working in the local community. The overall approach was exploratory, and there was both a qualitative and quantitative dimension to the gathering of information. The chapter also indicates the various stages of the process, from the gathering to the processing of the information, and indicates the various ways in which we endeavoured to recognise and respond to the sensitive nature of the research topic.

## Chapter 3 – Core Themes from Findings

Note: In the presentation of the Core Themes the numbers in brackets, e.g. [3,5], are the identifying numbers of the actual focus groups where a particular discussion occurred. The numbers 7 and 8 refer to individual interviews.

Before examining the role of benzodiazepines in the development of substance misuse problems, it is first necessary to identify what emerged from the data in relation to the actual understandings, practices, and attitudes that are connected with benzodiazepine use. Essentially the first step is to see what is actually happening in Ballymun, and then, on the basis of that information, to examine the different elements that are linked, or might contribute to the development of substance misuse problems in Ballymun.

### 3.1 Benzos in Ballymun

The findings from the focus groups indicate that benzo use is seen to have a history within the Ballymun community. In the 1970s Ballymun was seen as “*Roche soaked*” [5,6], and from then on benzos seem to have been consistently used. Their continued availability is indicated in the observation by one of the additional interviewees that in the 1980s benzos were used as currency on the street drug scene [7]. Four of the groups consider that at present benzos constitute a normal part of life in Ballymun [1,4,5,6].

A wide variety of benzodiazepines were mentioned during the research by those interviewed. People used both the “approved” names and the “brand” names. The references included Valium, Dalmane, Rohypnol, Xanax, Librium, Halcion, Temazepam, and Mogadon. However, all six groups included Valium as being a commonly used benzo in Ballymun, with two of the groups indicating that Valium was the preferred benzo [1,2]. In one group it was suggested that there was a preference for Valium because people know the brand name [2] and thus people think it is safer using Valium than other benzos.

The prevalence of benzos in Ballymun has been increased, according to three of the groups, by the opening up of the Treatment Centre at Domville House. [1,2,4]

Another feature of benzo use in Ballymun is its public nature. People are seen to come to Ballymun to sell benzos [1]. Tablets are counted publicly in the Shopping Centre [7]. Drug users are seen selling them in the vicinity of the “*Red Brick*” (Treatment Centre) [3].

While benzo use may be quite public in Ballymun, five out of six focus groups indicated that family member use of benzos was a significant first point of contact with benzos for people, the first place where they actually saw benzos [1,2,3,4,6]. Apart from being a point of contact, some groups also noted that the family itself was an actual source of benzos, whether intentionally - where the mother gives a benzo to the child, “*if she felt that you were down she’d give you a Valium*” [1], or unwittingly - where benzos are stolen or taken at home [1,3,4]. Two groups also note that, at times, benzos are shared by couples [1,2]. One of the additional interviewees mentioned that much learning about the effects of benzos comes from watching family members taking them and seeing what happens [8].

When groups were asked what was the youngest age they had heard of people using benzos, two groups said 11, one said 12, and one said 13. It was clear from the groups that the taking of benzos is not particular to any one age group. Specific age categories mentioned included young people, young women, parents in their 40’s and 50’s, and elderly people. In one group it was noted that benzo use can be spread across generations of women within one family. “*Every woman in the family, from the granny to the mother, to the daughter, who is probably a mother now, and every one of them would be using benzos*” [5].

### 3.2 Benzos and gender

In the findings, benzos are seen to play a particular role in the lives of women. Five out of six groups clearly identify women as one of the groups/categories involved in benzo use. [1,2,4,5,6]. Men, as a group or category, are not indicated in this way by any of the groups.

There are various perceptions expressed in the groups as to why benzo use seems to be more associated with women. One factor, expressed in several groups, is the impact of children on women's lives. One group noted that benzos are given to *"Girls with young kids, who find it hard to cope with the babies"* [4]. It was further commented that, *"Kids and all, do be in the ma's faces a lot, and so I think women can feel more trapped in the home. Fathers can just walk out, but mothers can't. So I think that's why there's a lot more women on Valium"* [4]. Elsewhere it was noted that mothers were given benzos when their children were *"acting up"* [6], or just to help them *"cope with the kids"* [2,4,6]. Another area indicated by the groups is the level of pressure faced by women. Two groups considered that there are more pressures on women [4,6]. As it was put in one group, *"The women have more of the pressure, young girls with their young children"* [6]. Interestingly, three of the groups identify *"housewives"* specifically as using benzos, rather than the more generic term *"women"* [1,2,4], and it could be suggested that the element of staying at home and dealing with the pressures in the home is highlighted in this.

In relation to women's use of benzos two groups indicate that benzos have had a special role, as *"wonderdrug"* [2] or as *"mother's little helper"* [6].

It was noted in the groups that doctors were seen to tend to prescribe to mothers presenting with particular issues. For example, as mentioned earlier, mothers are seen to be prescribed benzos to cope with kids, [2,4,6], to cope with separation [4], or to cope with pressure [4].

While men are not identified as a category using benzos, there are observations in the data concerning men's use of benzos. In one group it was suggested that men may use benzos less than women because men are able to go to the pub more easily and deal with stress in that way [4]. The same group also suggested that a possible reason why fewer men are prescribed benzos was the fact that men are slower to go to the doctor with problems [4]. However, another group did see benzo use linking with the change of the *"father role"* in society [5]. In relation to how men use benzos, two groups did suggest that men use benzos to get *"stoned"* rather than to cope [2,4].

### 3.3 Benzos and young people

When asked to identify who is involved in using benzos all of the groups mentioned young people.

The findings suggest that some young people take benzos when they are in their social groupings for the *"buzz"* [1,2,4], or as one person put it, *"sometimes we take them to have a laugh an' all"* [3]. One group linked this occasional style of benzo use with cannabis use [3]. The same group also suggested benzo use being linked with the use of ecstasy [3]. However, in one group it was noted that younger people themselves, while recognising and accepting the occasional use of benzos for these *"recreational purposes"*, were quite negative around more regular benzo use, and benzo users. There was a frequent linking of benzo use to problematic drug use, to *"junkies"* [3], and a belief that if young people took more than occasional benzos they would be *"slagged"* by their peers because benzos are seen as *"gear tablets"* [3]. This negative perception of benzo use was also seen to exist among parents of young people using benzos. In one group tablet use by sons or daughters was described as a *"nightmare"* [6], with one person saying that if it came to benzos, *"I'd rather a needle in their arm any day"* [6].

While two groups did suggest that regular benzo use was not significant among young people in Ballymun [3,4], one of the additional interviewees stated that young people liked to take benzos to feel good about themselves and to forget what people think, and that some young people take benzos to escape reality and to get away from problems [8].

### 3.4 Reasons for benzo use

The reported reasons for the use of benzos can be divided into two main types. There are reasons that are linked to the therapeutic/legitimate use of benzos, and there are reasons more closely associated with the non-therapeutic/non-legitimate use of benzos.

All of the groups identified reasons for the therapeutic/legitimate use of benzos, and there was a general acceptance that they did have a role in this context. *“If you went in and you genuinely needed them and you took them the way you’re supposed to, they will do the job for you.”* [1].

Four of the groups said that benzos are sometimes used by those suffering from depression [1,2,3,5] to allow them *“get on with life”* [2]. One of these groups saw a role for benzos in general for helping with mental health problems [5].

All of the groups said that many people are prescribed benzos to help them sleep, with three of the groups naming the elderly as a particular group who are prescribed a lot of sleeping tablets [2,4,5].

Three groups mentioned the use of benzos for those suffering from “anxiety” or “from their nerves” [1,2,3], with one additional source commenting that, *“if used properly they do more good. If you’ve nerve problems you’re better off on tablets”* [8].

Two groups said that benzos had a legitimate purpose to help people who had suffered a bereavement [2,5], and one additional source said clearly that *“If there is a death people are prescribed benzos”* [7].

In a more general way five of the six groups saw benzos as useful in helping people cope in a variety of different situations. Helping cope with the kids [2,4,6]. Helping to cope with death [2,3,5], or stress [5], or simply just helping to cope [4]. One group sees women in particular using benzos *“to keep them a bit sane”* [4].

Three groups saw benzos being used when people are trying to come off alcohol [1,4,5].

Other reasons given for benzo use were; to help when something goes wrong [1], dealing with anxiety and panic attacks [2], when going through a separation [4], or when trying to forget what’s going on at home [4].

There is evidence in the data to suggest that the benzos can be used in an appropriate therapeutic way by problematic drug users, usually as part of a particular treatment regime. All groups were aware of benzo prescribing linked with the clinics and treatment centres, and three of the six groups said that drug users on methadone treatment programmes are prescribed benzos as part of their treatment [2,3,4].

Other groups noted that for problematic drug users the use of benzos to help deal with depression, to *“calm people’s nerves”*, and to *“help cope”*, is similar to any other group within the population [1,4].

All of the groups also indicated reasons for use that are more closely linked to the non-therapeutic/non-legitimate use of benzos. However it is also evident from the groups that the non-therapeutic use of benzos is not restricted to problematic drug users.

All groups acknowledge that benzos are sometimes taken by drug users for a desired chemical effect, frequently referred to as the *“stone”* or the *“buzz”*. This effect can be obtained from the use of the benzo on its own, or it can be created through mixing benzos with other drugs such as heroin or alcohol in order to increase the intoxicating effect. Three groups specifically mention that benzos are used to *“top up”* the effects of heroin or methadone [1,2,4]. The use of benzos with other substances is explored in section 3.5.

Four out of six groups note that benzos can be used to come down off stimulants, particularly ecstasy and cocaine [1,2,3,4]. From a harm-reduction perspective one group made the observation that it is probably better to use Valium than take heroin in order to come down from ecstasy [4].

When discussing detox, one group suggested that when drug users have struggled to come off other drugs, when it comes to benzos they are sometimes reluctant to let go because the benzos are seen as the *“last little thing left”* [4].

Benzos are seen by three of the six groups as useful in dealing with emotional problems [1,2,4]. As it was put in one group, *“if you’ve anything you don’t want to handle or that’s getting you down, you just swallow a handful of Valium and get a handle on it”* [8].

Two of the groups mentioned the “invisible” effect that benzos can induce [1,4]. People stated that at times this was positive and helped them gain a false sense of confidence, and at times allowed them to do things they otherwise wouldn’t even think of doing, such as shoplifting. *“It’s like as if they’re invisible depending on how many they’ve taken”* [4]. *“When I’d be in and I’d be on Valium I’d be filling me jacket with everything”* [1].

When looking at the reasons for use of benzos, there were some other factors that were brought up in the groups that were seen to have a bearing on the reasons for use, and the patterns of use.

Information about the drug was one such factor. Four groups indicate that there is a general lack of accurate information about the make up and effects of benzos [1,2,5,6]. In the actual groups themselves there was also evidence of a certain amount of confusion between benzos and tricyclics or SSRI anti-depressants.

A second factor was the profile of different drugs, and the differing perceptions held. These different perceptions were also seen to have an effect on the use pattern.

In one group, Xanax, especially for young mothers, was seen as *“posher”* than other benzos [4]. In the same group, Xanax was referred to as being the *“Roche of today”* and taking over from Valium among the population of housewives who were traditionally prescribed benzos - *“Xanax is the relaxer of the housewife of today”* [4]. In the same group it was also noted that *“Valium has more of a stigma attached to it”* [4]. Another group considered that Xanax, Stilnoct and Zimovane were seen as “lighter relaxants” [2] than the previously prescribed benzos.

Another group opened up the topic of the perceived difference between generic benzos and branded ones. The group considered that there is a real difference between Valium and generic diazepam [2]. As mentioned earlier, it was considered that there was a preference for Valium because people know the brand name and thus see it as safer [2]. It was also stated that, when obtaining benzos, people *“won’t buy them if they’re after been taken out of the carton”* [2] because it could be mixed with something else, or not what the person thought it was.

### 3.5 Benzos and other substances

A particular feature of non-therapeutic use of benzos is the frequent use of benzos with other substances. All of the groups interviewed stated that people in Ballymun mixed benzos with other drugs. There was a wealth of information provided on this topic from the groups.

Four groups mentioned the use of benzos to increase the effect of heroin [1,2,4,6]. This mixing of benzos with heroin can include intravenous use [2,4]. *“Some people actually mix them in with the heroin and they get a better buzz”* [2]. It was also mentioned that this “topping up” was linked to methadone use [2].

Two groups mentioned Dalmane (flurazepam) as the preferred benzo [2,4]. When discussing with those groups why Dalmane was so popular it became evident that it was popular amongst opiate users because of the ability to mix Dalmane with heroin to make the effect of heroin stronger. Also, intravenous drug users liked Dalmane in tablet form because it doesn’t clot when mixed with heroin and injected [2,4].

Four of the six groups mentioned those dependant on alcohol as a group of people who use benzos. The four groups referred to alcoholics being prescribed benzos, usually Librium, in the context of alcohol problems, whether to deal with the aftermath of “bingeing”, or as part of a process of coming off alcohol [1,2,4,5]. Three groups also noted the use of Valium with alcohol for the effect produced [1,2,6].

One practice frequently mentioned was the use of benzos to “deal with” the effects of the use of another substance. Four groups mentioned benzos being used to “come down”, to lessen the negative effects that followed the use of other drugs. As it was put in one group *“Say you take E or anything, it’ll take you down off ‘em”* [1]. Ecstasy was named by the four

groups [1,2,3,4]. Cocaine was mentioned by three of the groups [1,2,3], and coming down off “speed” was mentioned by one group [3].

Three groups indicated that benzos were used with Cannabis [2,3,6], with one group suggesting that benzos with “joints” was the most frequent way in which young people in Ballymun would mix benzos [3].

One group noted the use of benzos with ecstasy to increase the effect of the ecstasy [3].

One final addition that was mentioned by two groups was the “cup of tea”, whether “*taking hash with benzos and a cup of tea to mellow*” [6] or to help “*bring up the stone*” from Methadone and benzos [2].

### 3.6 Benzo use as “normal”

A number of the groups consider that benzos are considered a normal part of life in Ballymun. [1,4,5,6]. It was expressed in one group; “*It just becomes part of the normal thing. For people who are prescribed them, and take them in the right doses, it’s just part of your life, it’s not seen as any harm. That’s how people are, probably ‘til they die. It’s part of who they are. It gets them through the day*” [4]. The picture given in these groups is that people consider using benzos as normal [5], and that a lot of people are taking them [4]. Benzos seem part of the culture, and nobody seems to question this situation [6]. The level of access to medication is a significant part of the social context and this is seen to be linked to the practice, particularly in the 1970s, of widespread prescribing of benzos in Ballymun [5]. The very availability of benzos in turn makes their presence seem more normal. The impact of benzo prescribing practice has also clearly contributed to the sense that benzos are quite different to heroin. As one person put it, “*They’re prescribed, so they’re not looked upon as a filthy drug*” [4].

The apparent normality of benzo use is highlighted in the observation by all groups that regular script holders are consistently presented as a source of benzos for others. It would seem that there are so many benzos in use that they are in effect treated the same as other “household” medications despite the fact that they are significantly more complex than painkillers or antibiotics.

In terms of the attitudes held specifically around benzos, two of the groups [1,4] note that the very fact of being prescribed by doctors contributes to the perception of benzos as being more acceptable. “*People don’t see them as bad because the doctor prescribes them*” [1]. Several groups considered that there exists a strong implicit trust in doctors, particularly given the fact that, in many cases, it is perceived that doctors give very little information about why they are prescribing a particular drug, or about the effects of the medication [1,2,4,5,6].

It was expressed in one group that there is no sense of concern evident in Ballymun that benzos are a problem [5]. It was considered that “*people don’t put the gravity on them that’s put on other hard drugs*”, partly because the “visual effect” of benzo use in Ballymun [5] in contrast to the impact of heroin use, is perhaps less obvious.

Five of the six groups felt that there is a general perception that coming off benzos is very difficult [1,2,4,5,6]. While indicating a level of awareness about the negative effects of withdrawal, it is also quite likely that this general perception around the difficulty of benzo detox does in some way foster a continuance of benzo use among people in Ballymun.

Another illustration of how benzos are embedded in the culture is the amount of stories told about benzos in the interviews. Many of these stories are based on what people have heard from others. There are stories about things people have done while “stoned” on benzos. There are stories about the multiple ways in which people obtained benzos. There are also stories about the negative impact of certain types of benzo use, including of people dying, or of becoming “*fucked up, all thick and all*” [3]. There are stories of what it is like for parents living with their children who misuse benzos. “*You don’t know where they’re going, what they’re at, or what they’re doing. It depends what they’re taking*” [6].

### 3.7 Benzos and the specific Ballymun context

Within the groups a number of issues were identified as contributing to the benzo use situation specifically in Ballymun. These include unemployment, poverty, marginalisation, lack of amenities, and lack of education [5]. It was also seen that

benzos, in turn, contribute further to the problems. *“I feel it’s [Ballymun] a marginalised area, and I do feel that the problem is made worse because of easy access to benzos”* [5]. Literacy was also identified as an issue in Ballymun [5]. In one group the view was expressed that in order to get off benzos you would need to leave Ballymun altogether [1].

Another factor which was considered to have a bearing on the benzo use situation in Ballymun is the level of health care provision for the size of the population. One group noted that there are too many patients per doctor [5], while one of the additional sources clearly indicated that the limited number of GP’s in the area means they are effectively overloaded, so they end up prescribing a lot [7].

Another environmental factor, which was seen to increasingly have an effect on benzo use, is the impact of the current regeneration process in Ballymun.

Stress caused by the regeneration was mentioned by one of the groups [5] and by one of the additional interviewees [7]. People mentioned that moving home is very stressful for people at the best of times and in Ballymun some have to move more than once [5]. The extra stress is placed on mothers in particular who are struggling to keep children off roads that have only recently become dangerous [7]. One of the groups mentioned a case whereby a woman asked the doctor to increase her benzo script due to her not being able to cope with the regeneration, *“I won’t be able for this for 12 years. I’ll end up killing myself. I had to go back to the doctor. I had to get more medication”* [5].

This level of stress was seen to be increased by people’s frequent inability to sleep as a result of the increase in noise levels. *“If I’m not out me head basically goin’ to sleep well then I can’t get to sleep”* [5]. One further contributory factor mentioned was the fear associated with the changing environment of Ballymun. One group noted that people are too frightened to venture out on their own and need to have someone with them at all times [5].

### 3.8 Benzos and doctors

When asked where do most people get the benzos they use, all groups include prescribing of Benzos by doctors as one of the sources.

In exploring the topic “why does the use of benzos develop?” all groups considered that doctors’ prescribing of benzos had a role to play. As one group put it, *“the doctors’ response to someone with a problem is give them a few Roche and send them home”* [6]. In one group it was specifically considered that doctors’ prescribing practice has made some people into addicts [2].

Five out of the six groups indicated an awareness of doctors in Ballymun that prescribe benzos. [1,2,4,5,6]. These include GPs, as well as doctors in the Methadone Treatment Centre, and in the Health Centre. One group suggested that prescribing in the case of the Health Centre is “tight” [4]. No group specifically indicated the psychiatric services as a source of benzodiazepine prescriptions.

Some groups express the belief that doctors will prescribe benzos as *“an easy way out”* [5], or to get the patient *“out of their face”* [2]. *“They just give them tablets, anything to get rid of them”* [6]. One group commented, *“People only have to tell doctors they can’t sleep and they’re prescribed sleepers”* [6]. However, as mentioned previously, it was also suggested that a factor contributing to this situation is the fact that there are too many patients per doctor in the Ballymun area [5], with one additional interviewee further suggested that a few of the doctors in the Ballymun area are clearly overloaded with patients [7].

Four groups note that, in general, doctors are not prescribing for a specific short term [1,2,4,6], and that people can be on a script for years. *“You’d be talking about years because she didn’t even realise she was on them that long”* [6]. One additional interviewee considered that once people enter the medical system there is often no questioning of why they continue there, and why there is need for a repeat prescription [7].

In one group it was noted that doctors do give private scripts to GMS patients [4], while another group suggested that medical card patients are seen as being “less” than paying patients [5].

Four out of six groups noted that the level of information people have about benzos is limited [1,2,5,6]. Three groups specifically identify the doctors as failing to provide this information [4,5,6], and one of these groups identified literacy issues as a contributory factor [5].

It emerged from a number of the groups that people see the prescribing of benzos by doctors as also serving the needs of the doctor and not just the patient. Three groups considered that doctors would prescribe benzos to get people out of the premises [2,5,6]. Another interviewee considered that when people go to the doctor they want to receive something from them, and benzos are one way available to the doctor to respond to this need [7]. Another group perceived that while counselling was more easily available in middle class areas, with referrals being made by doctors, benzos were more freely prescribed to people in Ballymun [4].

### 3.9 Impact of policy and practice on benzo use

A number of groups mention the impact of prescribing practices within the context of methadone treatment. All groups are under the clear impression that benzos are given out to many clients on methadone maintenance. Two of these groups indicate that tolerance of benzo use, let alone prescribing within the clinics, was not a feature of the original, centrally located, methadone maintenance programmes, but was something that developed with the emergence of the satellite clinics and new treatment centres [1,2]. One additional source noted, however, that the prescribing of benzos meant that benzos came within the treatment regime and were less likely to be used for “binges” [7]. It was noted in another group that “*Nowadays you don’t need to rob a chemist ‘cos it’s given out, prescribed to you*” [4].

Another policy change that has impacted on benzo use is seen to be the emergence of more regulation of benzo prescribing. Two groups clearly state that benzo prescribing has reduced because of pressure being put on doctors. The source of the pressure to reduce prescribing is seen as the “Health Board” [1] and the “new protocol” [2]. As it was put, “*The Eastern Health Board now are noticing. So what they’re doing now with doctors, they’re really cracking down hard on them*” [1]. This is linked, by one of the groups, to a current shortage of benzos available on the street [1]. The same two groups [1,2] also note that benzos are “like gold dust” at the moment, or, as one group put it, “*now benzo scripts are not like butter vouchers*” [2]. A third group also noted that getting benzos, or being prescribed benzos, has become more difficult in the last three years [4]. However three of the six groups indicate that, apart from the restriction of new prescribing, people’s scripts for benzos may continue for years [1,2,5], and one group clearly states that doctors do not monitor the scripts they are handing out [5].

The shift toward daily/weekly rather than monthly scripts means that the information leaflet is not given to the benzo user, with the resultant impact on the provision of information about the product [2].

While the focus in this section is the impact of policy on practice, there was an awareness among some groups that people’s practice can itself have an influence on policy. In one group it was mentioned that due to people bingeing on their month’s prescription of benzos, some doctors arranged for them to get a daily dose of benzos at the chemist/treatment centre [1]. Another group mentioned that chemists brought in a new procedure whereby people had to sign for their benzo script in the chemist, to prevent people taking the scripts of others [5].

### 3.10 Identifying the nature of the benzodiazepine problem

Alongside the clear recognition that the prescribing of benzodiazepines does have a valid role in certain situations, the findings from the focus groups also highlight what are considered to be the “problematic” aspects of benzodiazepine use.

Four groups mentioned the addictive and dependence creating nature of benzos [1,2,4,6]. As it was put in one group, “*I’ve got now that I’m dependent on them. I’ve been taking them that long I need them*” [1].

Four of the six groups said that people do things they normally wouldn’t as a result of the effect of the benzos [1,3,4,6]. In one group it was commented, “*One of my lads jumped through windows on tablets*” [6]. In the same group, it was felt that a number of the deaths from people jumping off the balconies in Ballymun were a direct result of people being on benzos and unaware of what they were doing. “*I think that all these people that are jumping off these balconies, I think the majority of them would be on tablets*” [6].

Four of the groups mentioned that when a certain amount of benzos are taken people can actually start speeding, and people's heads start racing. People described this as a negative effect [1,2,4,6]. *"If you take enough of them, they turn the opposite way and make you speed"* [1]. One group described the impact of this "speeding effect" at home, *"you fear of being in your home when they're out of it. You'd have to stay awake all night long 'til they go asleep"* [6].

Two of the six groups highlighted the negative effect of mixing alcohol with benzos [3,4], noting how the mix can *"send you on a mad one"* [4].

Another two groups identified aggression as an effect associated with people suddenly coming off benzos [5,6].

Three groups mentioned that some benzos can affect your mental functioning [3,5,6]. One group expressed this very strongly; *"benzos make you fucked up, all thick 'en all"* [3]. The other groups identified the way benzos can cause the speech to be slurred and the thinking muddled, and the belief that *"benzos effect their brain cells"* [6].

Concern was noted within one group in relation to the prescribing of benzos with methadone, *"how in the name of good God any doctor prescribes sleeping tablets to someone who's on methadone I can't understand. The methadone and the tablets to me,.. like are they not afraid they'll have a heart attack or something?"* [6].

Another understanding of the "problematic" aspect of benzodiazepines focussed on the prescribing practice in some cases. Four out of six groups highlighted the length of time people can be on a script [1,2,4,6]. Four groups also noted that the level of information people have about benzos is limited [1,2,5,6], a problem compounded by the fact that some people in Ballymun have literacy problems and have difficulty in reading instructions or an information leaflet. The prescribing of benzos in response to chronic social issues or to assist with the coping problems of women was also of concern among the groups.

### 3.11 The complexity of the distribution

Throughout the data there is evidence that there does appear to be a large supply of benzos available to the Ballymun community. There does not seem to be evidence that there are "benzo dealers" as such within the community, but rather the indications are that benzos are obtained by people in Ballymun through a wide variety of sources and approaches.

All of the groups said that many people's way of obtaining benzos is through a prescription from their doctor. In some cases it was noted that this prescription was given after the patient used some "strategy" to convince the doctor to prescribe [1,2,4]. As one group put it, *"If you know what the tablet is supposed to be prescribed for, all you have to do is think of a little sob story and explain that, you know, I'm feeling this, I'm feeling that"* [4].

All groups listed buying benzos on the street as a common means of obtaining benzos. All of the six groups said that normally there were a lot of benzos available on the 'street', and each group suggested that the sellers of these benzos on the street are normally seen to be drug users, *"All the junkies get them off their doctors and just sell them"* [3], and occasionally alcoholics [2,4]. As noted in one group, *"an awful lot of alcoholics get them off their doctors to sell for drink"* [2].

Three groups specifically mentioned people selling benzos in the vicinity of the Methadone Treatment Centre in Ballymun, sometimes along with Methadone, from their "take-aways" [2,3,4].

Three groups identified the home as another place where benzos can be obtained [1,3,4], whether given by someone, or, as it was put in one group, stolen from where *"they're lying there on the unit or whatever"* [4].

Five of the groups suggested that people shared and swapped their benzos [1,2,3,5,6], and it would appear that this is very common and is seen as "helping out" someone. As one person commented, *"You'd look after someone, then when they'd get theirs they'd look after you"* [4]. Alternatively, *"Someone might just give it as a favour"* [6]. These practices have led to the development of an understanding of benzos as a form of currency. While this notion was primarily linked to drug users who used benzos as currency to buy/obtain other drugs, there is a clear indication from the groups that others in the community also see benzos as currency.

No group speaks explicitly of “dealers” selling benzos. Instead they talk of “people” selling them. When examined more closely it emerges that all six groups note that the majority of scripts being sold on the street, or privately, are in fact people’s own scripts.

All of the groups except one give indications as to why people sell their benzo scripts [1,2,3,4,6]. Some sell the benzos to buy alcohol [1,4], some to buy messages [2], some to buy other drugs [3], and some just to make a few bob [4,6].

As with any currency there is seen to be a relationship between the availability of benzos and their value. In the 1970s a “Roche 10” Valium was worth 25p [5]. Currently the same tablet is sold for €2. When there is scarcity of benzos their exchange value increases, and, as mentioned earlier, two groups specifically note that, in the current climate of restricted benzodiazepine prescribing, benzos are seen to be like “gold dust” [1,2].

It is clear from the data that the availability of “surplus” benzos is one of the pre-conditions for their use as currency. Two groups specifically asks why this “surplus” is there in the first place, and *“how do they get them so freely to sell?”* [3,6].

### 3.12 Changing the situation

Among five of the six groups it was felt that there is a general perception that coming off benzos is very difficult [1,2,4,5,6].

Four of the six groups said benzos are seen as harder to come off than heroin [1,2,4,6], with one group adding, *“They say tablets are the worst thing to come off”* [6].

Four groups suggested that there is a general fear amongst benzo users in relation to coming off benzos [1,2,4,5]. *“Even if you’ve never tried to come off them, you could be nervous because you’re told you could take fits, you know, and all these different kind of things. So there’d be a lot of fear around coming off them”* [2]. This in many cases was linked to a fear of the withdrawal effects, which were seen to include *“shakes, jumps, can’t sleep, you’re sweating, panic attacks, everything, where you’d say I’m not going through fuckin’ this”* [1] and which led to people *“dreading the thought of coming off them”* [2]. The fear was increased where people had actually seen detoxes and found it frightening to witness [4].

Other reasons why people found it difficult to come off benzos included the belief that some people were reluctant to give up benzos because it made people *“feel good”*, and people were scared of changing [5]. It was also suggested that it is even more difficult to get off benzos if the whole social context is involved in regularly accessing medication [5], and the view was proposed that to get off benzos you need to leave the area [1].

When asked about people’s experience of benzo detox, four of the six groups considered that the general perception was that few people successfully completed detoxes [1,2,4,5]. Two of the groups suggested that a possible reason for poor success rates on detoxes may be that benzo use is part of the norm for people and a coping mechanism so they had no reason to stop using them [4,5]. One of the groups mentioned that for many drug users who detox from other drugs, their benzo use is their last bit of “support” left and as a result are slow to discontinue their use. This, the group suggests, may be another reason why benzo detoxes appear to be a rarity [4]. As one person commented, *“I gave up everything else, it’s the last little thing”* [4].

Three of the six groups mentioned the need for support for people to detox and the need for appropriate systems to be put into place for those wishing to detox [1,4,5]. One additional interviewee expressed the need for *“a proper plan in place on how you’re going to withdraw”* [7].

In two of the groups it was said that their experience of doctors detoxing them was not a positive one [2,4], with people citing examples of doctors just cutting off prescriptions after years of prescribing benzos [4], or the use of very rapid detoxes [2]. In the early days of methadone maintenance, one motivation for detoxing was seen to be the necessity to do so in order to *“to keep a place on the clinic”* [2].

One of the additional interviewees considered that doctors are generally not making connections in the area that might facilitate the provision of alternatives to benzos [7]. As it was put in one group, the doctor gave tablets *“Instead of sitting and having a proper chat, or getting someone to have a chat”* [6]. At the same time another group did note a situation where a local doctor linked in with a community group in order to facilitate the effective administration of benzos for one particular patient [5].

In relation to alternatives to benzo prescribing, it was noted that counselling has been traditionally seen as a resource for better off people, whereas benzos were prescribed more freely in Ballymun [4]. Another group also felt that the doctors’ first response to someone presenting with a problem was tablets [6].

### 3.13 Key findings

- The family is the first point of contact with benzodiazepines for many people.
- Benzodiazepine use is not specific to any one age group.
- Benzodiazepines are seen to play a particular role in the lives of women.
- Reasons that are given for the therapeutic/legitimate use of benzodiazepines include: to deal with depression, to help sleep, to help with anxiety, to help at a time of bereavement, and to help “cope” in a wide variety of situations.
- Reasons for the non-therapeutic use include: to get a desired chemical effect and to help deal with the effects of other substances, particularly stimulants.
- There does seem to be a general lack of information “out there” about the make up and effect of benzodiazepines.
- A particular feature of non-therapeutic use of benzodiazepines is their frequent use with other substances.
- The use of benzodiazepines is seen as very normalised within the Ballymun context, and the prescribing practice of doctors is seen to have contributed to this situation.
- In general it is perceived that doctors have not prescribed benzodiazepines for a specific short term, and that people can be on a script for years.
- The general perception is that “coming off” benzodiazepines is very difficult, and that few people successfully complete detoxes. At the same time it is noted that appropriate systems need to be put in place to support those wishing to detox.
- The current regeneration process in Ballymun is seen as having an effect on the level of benzodiazepine use.
- There is seen to be a clear link between methadone maintenance treatment and the prescribing of benzodiazepines.
- The problematic aspects of benzodiazepine use which were identified include: the addictive and dependence creating nature of benzodiazepines, the changed behaviour of individuals when larger amounts are taken, the fact that benzodiazepines can produce effects which are the opposite to those expected, the negative effect of mixing alcohol with benzodiazepines, and the impact of benzodiazepine use on mental functioning.
- There does appear to be a large supply of benzodiazepines available to the Ballymun community.
- It is considered that the majority of the benzodiazepines being sold on the street are in fact repeat GMS private prescriptions.
- It is considered that swapping and sharing of benzodiazepines between people is a frequent occurrence.

## Chapter 4 – Findings from an Investigation of Benzodiazepine Dispensing Patterns in Ballymun using Community Pharmacy-based Dispensing Records

As part of our research methodology it was decided to gather information that would provide indications in relation to the actual nature and level of prescriptions for benzodiazepines in the Ballymun area. The following are the findings from a retrospective study of the prescriptions for benzodiazepines that were dispensed in a limited number of community pharmacies in Ballymun over four separate one week periods between December 2000 and July 2002.

### 4.1 Method

Community pharmacists are required by law to retain records regarding all prescriptions dispensed for a period of two years. These records were held using McLernon's pharmacy dispensing system in the community pharmacies included in this study. The data held in this system provided the material for the study.

Four sample one-week periods were chosen at random from the preceding two years. Dispensing data on diazepam, flurazepam and temazepam were collected for these weeks and subsequently analysed using SPSS [Statistical Package for the Social Sciences]. These three benzodiazepines in particular were studied because they are the most frequently prescribed benzodiazepines under the General Medical Services scheme<sup>15</sup>. Although some of these drugs were formulated as capsules, all unit doses were categorised as "tablets" for the purposes of this study.

### 4.2 Findings on prescription characteristics

#### 4.2.1 Frequency

A total of 751 instances of tablet dispensing were included in this study, which spanned the 4 one-week periods outlined in Table 1 below. As indicated by the numbers in Table 1, no statistically significant change in the incidence of dispensing was seen in the course of the study period ( $p = 0.95$ )

**Table 1: Dispensing Frequency**

	<i>1-7 Dec 2000</i>	<i>1-7 July 2001</i>	<i>1-7 Dec 2001</i>	<i>1-7 July 2002</i>	<i>Total no. instances of prescribing</i>	<i>% of prescription items studied</i>
Diazepam	109	121	122	120	472	62.9
Flurazepam	41	42	44	42	169	22.5
Temazepam	27	24	34	25	110	14.6
<b>Total</b>	<b>177</b>	<b>187</b>	<b>200</b>	<b>187</b>	<b>751</b>	

#### 4.2.2 Prescription sources

Prescriptions studied had come from a variety of sources, but most were issued free-of-charge under the General Medical Services Scheme (GMS).

GMS Prescription	89.5% (n=672)
Private Prescription	6.9% (n=52)
Mental Health Service Prescription	3.6% (n=27)

<sup>15</sup> See Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. p.11.

### 4.2.3 Prescriber information

More than 40 doctors had prescribed tablets but 77% of all prescription items studied came from prescriptions written by four doctors.

### 4.2.4 Drugs

Table 2 lists the incidence of dispensing of the drugs studied, differentiating each drug into the various unit dosage forms available. Note that this information is based on data from the prescriptions dispensed, and not on the patients from whom these drugs were prescribed, so that a number of the drugs dispensed may relate to the same individual patients.

**Table 2: Incidence of dispensing by drug and unit dose dispensed**  
(as a total for the 4 one-week periods studied)

	<i>No. dispensings</i>	<i>(%)</i>
Diazepam 2mg	69	(9.2)
Diazepam 5mg	381	(50.7)
Diazepam 10mg	22	(2.9)
Flurazepam 15mg	43	(5.7)
Flurazepam 30mg	126	(16.8)
Temazepam 10mg	10	(1.3)
Temazepam 20mg	100	(13.3)

## 4.3 Findings on patient characteristics

### 4.3.1 Patient sex

The investigation recorded the sex of the patients to whom the drugs studied were dispensed and found that almost two-thirds (65.9%, 495/751) were dispensed to females, one third to males (34.1%, 256/751)

### 4.3.2 Patient sex and drug dispensed

The data were examined to look for a relationship between the patient's gender and the incidence of dispensing of each drug. They suggested that the benzodiazepine dispensed was significantly related to the patient's sex ( $\chi^2=13.51$ ,  $df=2$ ,  $p<0.01$ ). Male patients appeared more likely to be dispensed flurazepam while temazepam dispensing seemed more common among females. Details are given in Table 3.

**Table 3: Drug dispensed as related to patient sex**

	<i>No. Male</i>	<i>(%)</i>	<i>No. Female</i>	<i>(%)</i>
Diazepam	149	(58.2)	323	(65.2)
Flurazepam	77	(30.1)	92	(18.6)
Temazepam	30	(11.7)	80	(16.2)

### 4.3.3 Time since drug first prescribed

Patient files for those involved in the study of data from the period 1-7 July 2002 were examined to investigate the length of time since these tablets were initially dispensed to them (N=188). Details are given in Table 4.

**Table 4: Time since first record of benzodiazepine dispensing**  
(for patients dispensed prescriptions in July 2002, N=188)

	<i>No. patients</i>	<i>(%)</i>
1 - 12 Months	41	(21.8)
13 - 24 Months	23	(12.2)
25 - 60 Months	50	(26.6)
> 60 Months	74	(39.4)

When these data were related to patient sex, they suggested that significantly more female patients had first been dispensed benzodiazepines over two years earlier, while male patients were more likely to have been dispensed benzodiazepines for the first time during the preceding 24 month period ( $\chi^2=9.99$ ,  $df=1$ ,  $p<0.01$ ). See Table 5 for details.

**Table 5: Time since initial record of benzodiazepine dispensing by patient sex** (for patients dispensed prescriptions in July 2002, N=188)

	<i>No. Male</i>	<i>(%)</i>	<i>No. Female</i>	<i>(%)</i>
1-24 months	30	(50)	34	(26.6)
> 24 months	30	(50)	94	(73.4)

#### 4.4 Discussion

These data do not purport to be representative of all dispensing practice in the Ballymun area or in Irish community pharmacies as a whole during the study period. Neither do they include all the prescriptions for benzodiazepines written by doctors in Ballymun, since patients may have attended doctors and/or community pharmacies outside this area. They do, however, provide useful qualitative information on the local situation at that time, and have value as such, in gaining some insight into benzodiazepine dispensing in the Ballymun area when this study was carried out.

This study found no significant changes in the incidence of dispensing of diazepam, flurazepam or temazepam in a limited number of Ballymun community pharmacies over the course of the time period studied, and its findings suggest that the use of these medicines continued to be equally commonplace. Of the drugs studied, diazepam was the most commonly dispensed, followed by flurazepam. Diazepam 5mg, flurazepam 30mg, and temazepam 20mg were the most popular unit dosage forms, each being dispensed to more than 10% of the population studied.

General Medical Service (GMS) prescriptions were most likely to be used by doctors prescribing benzodiazepines, which may reflect the local economic situation (i.e. most people had medical cards). The study suggests that the GMS carries a considerable financial burden relating to the on-going use of benzodiazepines, as, although the drugs themselves are not expensive, related prescribing and dispensing costs cannot be ignored.

The concentration of benzodiazepine prescribing amongst a small cohort of doctors may relate directly to the size of their practices as a whole. In addition, it should be noted that as the McLernon computer system allows for the nomination of only one prescriber per patient, this information may not have been updated for every prescription dispensed, so that the data regarding benzodiazepine prescribers may not have been accurate in all instances. Nevertheless the findings of this study suggest that further research could be useful in clarifying this situation.

The study found that females represented almost two-thirds of the patient sample studied, which may indicate that females were more likely to be dispensed these medicines. The figures for the 2002 census report that 52.4% of Ballymun residents are female and 47.6% are male<sup>16</sup>. In this context the ratio indicated by the study is not reflective of the wider demographic situation in Ballymun. The study also found evidence of gender-related trends in benzodiazepine dispensing in the

<sup>16</sup> Cited in: Ballymun Partnership. (2003). *Ballymun Fact File 2003. A socio-economic profile of Ballymun for people living, working, investing, researching and delivering services in the Area*. Dublin.

population studied, and further investigation could be useful in exploring the clinical rationale behind these trends. In particular, the apparent increase in the incidence of dispensing of benzodiazepines among male patients that was highlighted by this study should be explored in greater detail.

When examining the duration of tablet dispensing, the data did not indicate whether dispensing was continuous following the initial supply to the patient. In addition, patients may have attended another community pharmacy for earlier prescriptions. These limitations reduce the value of data relating to the duration of dispensing for the medicines studied. However, notwithstanding these limitations, this study indicated that a considerable proportion of patients who are initiated on benzodiazepines continue to take them for many years, despite guidelines to the contrary. This is a clinical issue that should be addressed in a broader context, to ensure that all patients receive sound and appropriate treatment, which is in accordance with best practice guidelines for the healthcare professionals involved, and which respects the rights of patients.

#### 4.5 Key findings

- 90% of the prescriptions studied were issued under the GMS scheme.
- 77% of all prescription items studied came from prescriptions written by four doctors, while the overall number of doctors who prescribed benzodiazepines in the material covered by the study amounted to more than 40 in total.
- Females represented almost two thirds (65.9%) of the patient sample studied, which may indicate that females were more likely to be dispensed these medicines.
- The study also found evidence of gender-related trends in benzodiazepine dispensing in the population studied. In the study males were more likely to be dispensed flurazepam while temazepam dispensing seemed more common among females.
- Of the drugs studied, diazepam was the most commonly dispensed, amounting to 62.9% of prescription items studied, followed by flurazepam. Diazepam 5mg, flurazepam 30mg, and temazepam 20mg were the most popular unit dosage forms, each being dispensed to more than 10% of the population studied.
- Examination of the time since the first record of benzodiazepine dispensing for patients dispensed prescriptions in July 2002 indicated that for 21.8% of the sample studied the first record of a benzodiazepine prescription was within a time period of one to 12 months beforehand. However for 39.4% of the sample, this time period amounted to more than five years.

## Chapter 5 – Medical Perspectives on Benzodiazepines – Key Informant Report

Doctors are generally reluctant to discuss their prescribing outside the profession of medicine, and benzodiazepines are a sensitive topic, where professional opinion is deeply divided. Accordingly it was deemed appropriate to identify medical perspectives on benzodiazepines through the research approach known as the key informant approach<sup>17</sup>, where the informant is currently involved in the field being researched. Ballymun is an area of high socio-economic disadvantage, where the pressures on medical services are severe and healthcare resources are recognised as inadequate. In an attempt to outline the dynamics of benzodiazepine prescribing, some medical perspectives were gleaned through informal one to one discussion with doctors in general practice, psychiatry, and addiction services in Ballymun and other similar environments on the northside of Dublin. Interviewing was semi-structured and opportunistic, and was conducted in person and by phone by the key informant. The following presentation is grounded in the information gathered through this process. The observations reported below are based on the key informant's perceptions of medical attitudes and practices, and the description should not be considered definitive.

### 5.1 Patterns of prescribing

The local pharmacy survey data confirmed the national pattern that most benzodiazepine scripts originated in general practice, and that the vast majority were of the monthly repeat variety. GMS scripts were commonly dispensed, while private prescribing and psychiatric clinics seemed to make a much smaller contribution. The report of the National Benzodiazepines Committee demonstrates considerable interprescriber variation in practice prescribing rates across the ERHA area. This suggests that there are differing attitudes and practices among doctors in relation to benzodiazepine prescribing. Any brief description of a professional activity always runs the risk of oversimplification, and the Ballymun environment is certainly a challenging one from the orthodox medical perspective. It is important to bear in mind that the categories below are not always mutually exclusive and serve only to illustrate the kinds of tacit or explicit logic which may be at work among a diverse group of practitioners. The various strands of medical opinion might be represented broadly as follows:

#### 5.1.1 Abstinence orientation

Some doctors take the view that there are very few good reasons for prescribing benzodiazepines at all, outside the small number of indications in neurological disease. Practitioners in the statutory treatment centres are also likely to be conscious of the opinions and practices at the National Drug Treatment Centre, where benzodiazepine positive urinalysis was often considered a reason for sanction. They consider that the drugs discourage counselling engagement and prevent life issues from being addressed. They tend to feel that existing recipients should be obliged to “face up to reality” and should be weaned off their supplies. They regard benzos primarily as drugs of misuse and are sometimes critical of colleagues who prescribe routinely, particularly private prescribers. They usually treat problems of anxiety and depression with SSRI-type antidepressants (such as Prozac) or by referral to psychiatric services in the orthodox manner. Some doctors of this persuasion provide methadone treatment within or external to the clinics, and may attempt to prevent their patients from using benzodiazepines by withdrawing methadone take-away rights if the urinalysis is consistently benzo positive. Others simply tell the patient that they will not prescribe them personally, but may turn a blind eye to the fact that the client continues to obtain them. In some cases, both the methadone and benzodiazepine prescribers are aware of each other's prescription, but the case is seldom discussed jointly and practitioner disagreement is not usually acknowledged openly.

#### 5.1.2 Short-term prescribing orientation

Some doctors are prepared to prescribe benzodiazepines on a licensed short-term basis, to treat panic attacks, to deal with a bereavement or other crisis, or to relieve anxiety while anti-depressant medication takes effect. They may also be prepared to offer a short detox to any of their own patients who have got into trouble with benzo misuse, but discourage applications to join their practice list from other persons who are seen to be actively drug seeking.

17 See. Neuman, W.L. (2000). *Social Research Methods. Qualitative and Quantitative Approaches. 4th Ed.* Boston. Allyn and Bacon. Ch.13. on “Field Research”.

These doctors may have some insight into the many reasons why repeat benzo prescribing became widespread in socially disadvantaged areas, but are determined to prevent this happening in their own practices. They use SSRI antidepressants, and psychiatric or counselling referral to address problems of mood and coping, although they have a sense that local psychological services are “pathology oriented”, rather than health promoting, and that there is a lack of psychological services for disturbed teenagers. They acknowledge that some long-term benzodiazepine scripts can be difficult to stop, but feel that, with a supportive approach, the vast majority of patients can be persuaded to accept that the hazards of dependence outweigh the benefits of the medication. In the case of these long term-scripts review is carried out at least yearly, but they feel that the time available does not permit much enquiry into the way in which the prescription is consumed. These doctors consider that their patients would avail of appropriate psychological supports and cognitive methods if these were easily available in the practice setting.

### 5.1.3 Long-term prescribing orientation

Repeat scripting of benzodiazepines is done in most practices, although the volume and the approach vary. Doctors who tend towards repeat prescriptions may have a very low expectation of assistance from psychiatric services, as well as a feeling that patients are not at all likely to engage with psychological approaches or other non-benzodiazepine alternatives. These doctors tend to take the view that benzo dependence is widespread and entrenched, and that the problem is a legacy of earlier years when the hazards of long-term use were not well recognised. The monthly repeat benzo script is usually not seen as problematic in itself, but simply a traditional means of coping with the ongoing difficult circumstances of life in Ballymun, including the current disruption associated with the regeneration process. Review may tend to be limited to those cases where the arrangement is tending to become troublesome, with escalating demands for benzodiazepines or early request for the monthly script.

Some doctors in the community and in the Treatment Centre offer explicit benzodiazepine maintenance to methadone maintained patients, perhaps recognising that such persons are also dependent on benzodiazepines and that it is neither realistic nor humane to expect them to detox. The rationale is based on the principle of regulation (Seivewright, 1993), so that chaotic benzodiazepine misuse can be converted into a more orderly state of dependence. These doctors are highly aware of the problems of multisubstance addiction and diversion and tend to prescribe limited volumes with weekly dispensing. The monitoring of this prescribing is not simple, as there is no way of ascertaining from urinalysis, blood samples, or any other test whether the patient is actually consuming all or most of the tablets personally, except in the unusual case where the patient is diverting the entire supply. Prescribers of this kind are, like the vast majority of their colleagues, reluctant to prescribe benzodiazepines to persons not currently dependent, and tend to use SSRI-type compounds, as well as referral to psychiatric or counselling services for problems of mood.

### 5.1.4 Private scripting

Private scripting can occur in various circumstances. An additional private script may be written by a GMS prescriber for a patient who has run out of the usual GMS month's supply. There are a huge range of reasons which may be offered for the shortfall, including theft of drugs from the home, seizure by Gardaí, loss during hospital visit, etc. GMS patients may also approach another practitioner in search of a private prescription without informing their GMS doctor. Patients not eligible for the GMS may obtain a private script for benzodiazepines or other drugs on an occasional or a repeat basis. In any case, a fee is payable to the doctor.

## 5.2 The issue of social support

Most repeat benzodiazepine scripts originate in general practice. GPs are independent professionals who are contracted to provide services under the General Medical Services scheme, which provides free primary care to persons who are means tested or are otherwise deemed entitled to benefit. Many persons in the Ballymun area have a Medical Card where prescriptions are written under the scheme, but GP's also prescribe on a private basis.

General practitioners are in direct competition with each other for patients, since all patients are entitled to choice of doctor. However, some practice lists may be limited or are considered from time to time to be “full”, and some doctors may operate informal quotas for certain categories such as homeless persons, who may be considered likely to impose a heavy and complex burden of medical care. Individuals may also be refused admission to a medical list on a range of issues which are considered likely to cause disruption to the smooth running of the practice.

Patients approach practices with a very wide range of expectations and demands, often related to the social and economic aspects of medical diagnosis and treatment. Ballymun is acknowledged as an area of socio-economic disadvantage, where many persons have traditionally relied on the state for income support and housing, and there are many categories of social benefit for which the GP acts as the designated “gatekeeper”.

It is likely that doctors are categorised by word-of-mouth as more or less helpful in respect of their willingness to provide general social assistance along the lines described above. There has traditionally been a high turnover of population in certain parts of Ballymun and this has impacted on the patient flows in and out of practices. It seems likely that patients with many social needs would tend to flow towards practices which were not “full” and where the gate-keeping function was known to be defined in a relatively open way. Information about “good doctors” would be likely to be transmitted within extended families and neighbourhood groups, so that some practices would become more “demand-led”, at times developing close associations with very needy intergenerational networks.

### 5.3 Review of repeat scripting

Repeat benzodiazepine prescribing in the Ballymun area probably developed, as elsewhere, against a background of this type, where problems of coping were very prominent, especially for women and chronically ill persons. Pressure to prescribe benzodiazepines is felt to be greater in disadvantaged areas than in better-off parts of the city, where the conditions of life are more secure. Problems of long-term dependence and misuse were probably not recognised by either patients or doctors until repeat prescribing patterns had become well established. Review and reduction may have been achieved in some cases but is likely to have been problematic in many cases for a variety of reasons which include the following.

#### 5.3.1 Patient demand

Some experienced prescribers state that the local demand for such prescriptions has been consistent and unremitting, and that there has been little willingness on the part of patients to consider alternatives, even if these were thought to be effective.

#### 5.3.2 Volume of potential reviews

Where a substantial repeat benzodiazepine scripting pattern has evolved, involving high numbers of patients, the servicing of this demand is time consuming in itself. The absence of computer-generated scripting or systems and other barriers to efficiency can also deter or delay a review process.

#### 5.3.3 Time demand of review process

Benzodiazepines are a sedative drug, where detoxification carries psychological and biological risks. Recurrence of the original symptoms is often difficult to distinguish from withdrawal symptoms and many patients may balk at the prospect of change in the prescription. Any attempt to reduce the script is likely to oblige the practitioner to enter into a lengthy discussion of the problems which generated the initial scripting as well as the likely effects of reduction.

#### 5.3.4 Professional hazards of involuntary detox

An attempt to reduce or stop the repeat script can be problematic, and it may not be at all obvious to the patient why any change should be imposed. The longevity of the prescription may well be seen by the patient as providing ironclad justification for continuance, and it may be argued that “you do not have the right to stop my tablets”. Reference may be made to other individuals who are in receipt of similar medication and the matter may be presented in terms of entitlements, or the contrary opinion of other practitioners who may have prescribed originally. Persistence with the involuntary detox may well trigger a threat of complaint that the practitioner has created a situation of dependence which

is now being callously disregarded. Litigation may well be mentioned or physical assault may be threatened. In any case, the practitioner is likely to become embroiled in a tricky process of negotiation where other acceptable and equivalent benefits have to be offered in exchange, a process which may be difficult to reconcile with the orthodox medical role.

Psychiatric clinics may also find it extremely difficult to stop a benzo script once it has become established. Many patients are co-addicted to alcohol or the common codeine-based painkillers. Services are further handicapped by the rapid turnover of medical staff and the consequent difficulties in maintaining continuity and consistency of care.

### 5.3.5 The most difficult cases

Every general practice has its very difficult cases, and practices in areas of social disadvantage have more than most. Such individuals or families take up a disproportionate amount of professional time, present very serious dilemmas in treatment and referral, and can bring huge stresses to the practice. When a practice is inclusive in its orientation and supportive in its style of care, it will inevitably attract the difficult cases which other less tolerant practices avoid, and as an agency of last resort, may persist with their care in almost impossible circumstances. In these situations the demand for sedative prescribing may be highly intensive and escalating, with a huge variety of complex and traumatic psychosocial events offered as justification, and in these circumstances it is not easy to separate the various presenting issues. If there is associated aggressive “acting-out” behaviour or verbal abuse in the surgery this can result in loss of staff or patients, especially private patients, who are unlikely to be dependent on the practice for general social support. In this context, the simple demands for a repeat benzodiazepine prescription may appear normal, reasonable, and appropriate by comparison.

## 5.4 Issues of benzodiazepine detox

Detoxification from benzodiazepines is a complex concept. In straightforward biological terms, it refers to the reduction and cessation of consumption. Verification of this process is impossible without urinalysis or other testing, and this sort of control is not usually seen as part of ordinary medical care.

### 5.4.1 Opiate addicts

Most medical experience with benzo detox has been gained in the statutory addiction services, where, in general, the experience has not been a happy one. Many methadone treatment applicants do seek a benzodiazepine script at some point, and very few are genuinely open to reducing subsequently. Treatment attenders often claim that they have been prescribed much bigger amounts from some other doctor in the past, and these accounts are sometimes based on fact.

As described above, the medical approach varies among clinic methadone prescribers and community GPs. Some doctors prescribe benzodiazepines with methadone maintenance treatment, while others simply refuse or offer non-benzodiazepine alternatives. Some GPs refuse to prescribe methadone, but are prepared, at times, to issue addicts with a benzo script, perhaps to help them to get off or to stay off heroin. This script may perhaps continue on while heroin use does not change, but the doctor may be told that the script is keeping the client “off drugs”. A benzodiazepine script can help in managing and concealing the primary drug habit, and this may continue to be the wish of the patient.

Some opiate addicts get their methadone from one doctor and benzodiazepines from another. They may not reveal the existence of either doctor to each other if they are fearful of sanction for “double scripting”. When clients already have a repeat script from a community GP it is unlikely that they they will seek a “benzo detox” at the Treatment Centre. Clients requesting “benzo detox” frequently indicate that they are seeking the benzo script on the strength of a promise that they intend to stop taking tablets in the future. Experience at the methadone clinics has been that benzo detox is no more successful than opiate detox, and that the client continues to consume benzos after the end of the 4-6 week period of detox prescribing. Clients usually say that they need a continuing script as they need more time to “come off”, and often say that they had really been taking far more than they told the doctor when the benzo detox was agreed, but they were “afraid to tell the truth at the time”. It is impossible to verify the amount of benzos actually consumed either before or during the detox, and most clinic doctors seem to have stopped offering “benzo detox” as a result.

### 5.4.2 Alcoholics

Alcoholism is a common disorder in Ireland and is particularly common in areas of social disadvantage. Many alcoholics attend for medical attention as a result of the physical, psychological and social complications of the alcohol use, which is sometimes obvious in terms of appearance and behaviour, and may be confirmed by blood tests showing disturbed liver function. Requests for assistance with the “DTs”, or alcohol detox are not unusual in general practice, especially where the pattern is one of “binge” drinking and where the family has had to become involved in the care of the alcoholic. Further assistance is available from AA or from the Substance Misuse Programme of the Psychiatric Services. It would seem, however, that many alcohol dependent persons are reluctant to inform their doctor about their addiction or to allow their drinking pattern to be investigated.

In these circumstances alcohol-related problems may present as chronic insomnia, depression or anxiety and a repeat benzodiazepine prescribing pattern may have resulted. It is not easy for a doctor to address addiction issues where the patient is in denial about the problem, and it may be impossible in these circumstances to ascertain the drinking habit which underlies the psychological symptoms. While an accurate alcohol history is often obtained when concerned relatives contact the doctor, some patients who are in receipt of a repeat benzodiazepine script on the basis of a diagnosis of “stress” or “anxiety” are probably reluctant to reveal the extent of their alcohol addiction because of a fear that doctors will cease to prescribe.

It is generally true that doctors are much more comfortable prescribing for the relief of anxiety than for the maintenance of sedative dependence. It is also likely that experienced doctors often correctly intuit the presence of alcoholism, but may be discouraged from discussing it by a fear of damaging the doctor-patient relationship. Where alcoholism is present in both partners or drinking problems are widespread within the extended family, the problems of denial are liable to be exacerbated, and it may be impossible to discuss the matter openly. In these fraught circumstances, several family members may be in receipt of repeat benzo scripts and such prescribing may be very uncomfortable for the doctor.

## 5.5 Key findings

- Various strands of medical opinion exist in relation to the prescribing of benzodiazepines. These positions may be described as the abstinence orientation, the short-term prescribing orientation, and the long-term prescribing orientation.
- The issues of social support, and of dealing with particular difficult cases, are considered to be factors involved in understanding the prescribing orientation of doctors.
- The review of repeat benzodiazepine prescribing is seen to be influenced by the level of patient demand for benzodiazepines, the volume of potential reviews, the time demands of such reviews, and the professional hazards of detox.
- There is considerable variation within the benzodiazepine prescribing practices associated with methadone maintenance treatment.
- The relationship between alcoholism and benzodiazepine prescribing is seen to be a complex one.

## Chapter 6 – Discussion of Findings

### 6.1 The level of benzodiazepine prescribing in Ballymun

While this research does not intend to make quantitative estimates of benzodiazepine consumption in the Ballymun area, the information gathered does allow some potentially useful observations to be made regarding this issue. At the national level the General Medical Services [GMS] scheme covers approximately 31% of the population, and the analysis of the figures indicates that in 2000, 11.6% of the adult GMS population were prescribed benzodiazepines<sup>18</sup>. The most frequently used benzodiazepines prescribed under this scheme in 2000, according to the Report of the Benzodiazepine Committee (2002), were Diazepam, Temazepam, and Flurazepam, and they accounted for almost 50% of the benzodiazepines prescribed under the GMS scheme in that year<sup>19</sup>. The same report also indicates that a one-month supply has “virtually become the standard practice for the prescribing of benzodiazepines in that scheme” (p13).

At the Ballymun level, the data from the Pharmacy Survey indicates that almost 90% of all prescriptions examined were GMS prescriptions. In the first week of July 2000 there were 177 instances of the prescribing of Diazepam, Temazepam and Flurazepam in the pharmacies studied. Following the national trend for the same year these three benzodiazepines should account for 50% of the total GMS benzodiazepine prescribing. Accordingly the figure of 177 should then be half of the total benzodiazepines prescribed per week, giving a weekly figure of 354. In the month of July 2000 it is to be expected that each of the other weeks recorded the same level of benzodiazepine prescribing in these pharmacies, given that monthly scripts are effectively standard practice<sup>20</sup>. Thus, the weekly total of 354 needs to be multiplied by four to get the monthly total of 1416 prescriptions. As mentioned in the Pharmacy Survey data, only 90% of scripts examined were GMS scripts. 90% of the monthly figure bringing the total of GMS scripts for benzodiazepines, as presented in these pharmacies, to 1274.

The most recent figures<sup>21</sup> indicate that the population of Ballymun is 15,160 people, and that 58.6%, or 8,884 individuals, are on the GMS scheme. Of this figure, 70.9%, or 6,299, are aged 15 or over. The 1274 prescriptions for benzodiazepines estimated to have been dispensed in July 2000 amounts to 20.22% of all GMS scheme users, over 15, in Ballymun. This is almost double the national figure of 11.6% for the adult GMS population. As noted earlier this is only a notional figure, but given the fact that not all pharmacies used by people from Ballymun were examined by this research it is possible that the actual level of benzodiazepine prescribing is in fact higher than 20.22%. On the other hand however, the fact that an unknown number of the scripts examined may have been dispensed to persons never resident in Ballymun, or former residents, means that the estimate is of heuristic value only. This problem illustrates the difficulty of ascertaining the levels of benzodiazepine consumption in the community.

One further piece of data in relation to the level of benzodiazepine use, and which might be considered as supportive of the suggested high rate of prescribing for Ballymun, is provided by the 2002/2003 Drug Prevalence Survey (NACD/DAIRU, 2004). According to the data, the lifetime prevalence for the category “Sedatives, Tranquillisers, Anti-depressants” is 17.2% for the Northern Area Health Board (which includes Ballymun), which stands in contrast with the figure of 12.2% for all Health Board areas (p23).

### 6.2 Benzodiazepines and gender

With Valium marketed at one stage as “mother’s little helper” it comes as no surprise that higher usage of benzodiazepines tends to be found among females. A recent study of GMS data for the Eastern Regional Health Authority found higher usage among females of all age groups<sup>22</sup>. Details from the NACD Drugs Prevalence Survey also indicate higher level of benzodiazepine prescribing among females<sup>23</sup>. The data from the local Pharmacy Survey found that, of the prescribing

18 Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. pp10-11.

19 Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. p11. Figure of 50% based on the non inclusion of the non-benzodiazepine hypnotics in the final figure.

20 Some sources suggest that the number of ‘continuing monthly prescriptions’ presented tends to be higher at the start any given month rather than be a constant figure throughout the monthly period. This may have a bearing on these tentative calculations.

21 Ballymun Partnership. (2003). *Ballymun Fact File 2003. A socio-economic profile of Ballymun for people living, working, investing, researching and delivering services in the Area*. Dublin. Part 5, p8.

22 Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. p15.

23 NACD. (2003) *Drug Use in Ireland and Northern Ireland*. First Results from the 2002/2003 Drug Prevalence Survey. Bulletin 1. p7.

instances studied, almost two thirds (65.9%) were dispensed to females, with one third to males. This strong trend towards higher benzodiazepine use among females is also expressed frequently within the responses from the focus groups. While this gender ratio pattern might be applicable to various socio-economic contexts, there are some aspects of the data provided by the focus groups that suggest that this high level of benzodiazepine prescribing to women is particularly linked to the socio-economic situation in Ballymun.

Research, which examined the economic status of lone parents in Ballymun, found that 18.2% of adults in Ballymun are lone parents<sup>24</sup>. 92.4% of these are women. 47.8% of lone parents are in the 25-34 year age range, and 9.9% are under the age of 25. The research also suggests that almost all lone parents are social welfare recipients. What is indicated in these findings is the existence of a large group of relatively young women, on their own, with one or more children, who are receiving social welfare payments. Several of the focus groups refer to the “pressure” experienced by women, especially young women, in “coping with the kids”. If benzodiazepines are prescribed to this group of people to help them “cope”, then it can reasonably be suggested that it is linked to the person’s socio-economic situation. The Key Informant report supports this understanding, noting that the level of benzodiazepine prescribing in Ballymun emerged in a context where problems of coping were very prominent, especially for women and chronically ill persons.

These findings must be a source of concern. The reality of young lone parents is primarily a social and cultural one. The “medicalisation” of this reality does not seem appropriate. Other interventions, whether individual or structural, designed to address the levels of experienced stress need to be fostered and used.

### 6.3 Benzodiazepines in medical practice

There is no questioning the fact that the benzodiazepines which are used or misused in Ballymun, originate in prescriptions, or that doctors in the GMS, Private Practice, the Addiction Service or the Psychiatric Service write almost all of the prescriptions. The Report of the Benzodiazepine Committee (2002), when looking at Benzodiazepine prescribing rates within the ERHA area, noted that, in 2000, 17% of GPs participating in the GMS scheme had higher than expected prescribing ratios for benzodiazepines, with 5% prescribing at least 50% more than the average<sup>25</sup>. The Pharmacy Survey undertaken for this piece of research, where 89.5% of prescriptions were GMS prescriptions, found that 77% of all prescription items studied came from prescriptions written by four doctors.

It has been noted in the presentation of the Pharmacy Survey data that this phenomenon may be related to the impact of practice size. If there are more patients attending a practice this is likely to be reflected in the number of prescriptions presented to pharmacies. However a number of other potential contributing factors need also to be considered. The Key Informant report indicated that, among some doctors, the view is taken that benzodiazepine use is simply a traditional means of coping with the ongoing difficult circumstances in life, particularly in areas of socio-economic disadvantage, and that prescribing needs to take that into account. This perspective would seem to find support in the recent research by Williams *et al.* (2003). From another perspective, the focus groups suggested that many people in Ballymun do tend to use benzos as a way of “coping”, and that this practice has become very “normalised”, further generating expectations of the doctor patient relationship. If doctors become categorised, in the eyes of the community, as sympathetic to social support needs, then it also likely that a higher level of benzodiazepine prescriptions will be sought from these sources.

It does seem evident that the phenomenon is not simply reducible to unilateral doctor decisions about benzodiazepine prescribing. Accordingly this research would support the view that focussing attention primarily on doctors’ clinical decisions is only a partial response to the situation.

It is suggested in the focus group data that there are too many patients per doctor in the Ballymun area, and that some general practices seem to be quite overloaded, so that time pressures are likely to have an impact on prescribing practices. The review of prescribing is essentially a review of whether or not the “indications” which prompted the initial prescribing are still evident in the patient, and whether or not the prescription is still appropriate. The key informant report suggests that the time demanded, and the volume of patient load, are in fact the key determinants in deciding whether or not reviews happen regularly.

24 Ronayne, T. [WRC Social and Economic Consultants in association with Ballymun Partnership] (2001). *Ballymun Employment Report 2K*. Dublin. p20.

25 Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. p16.

The data from the focus groups very clearly suggests that the review of benzo scripts is not a normal occurrence, and that people can often be on benzos for years without review. The data from the pharmacy survey, while not making any observations on the practice of review, does clearly indicate that the time period since the first record of benzodiazepine dispensing in 78.2% of the scripts studied was greater than one year, and that in 39.4% of the scripts the time since the first record of a benzodiazepine being prescribed was greater than five years.

With benzodiazepines this review process is complicated by the fact that the withdrawal of the drug can lead to symptoms which are very difficult to distinguish from the original problem.<sup>26</sup> It is acknowledged that benzodiazepines can cause dependence when taken on a long term basis, even in prescribed therapeutic doses<sup>27</sup>. Thus stopping or reducing these scripts is in effect a detox process. Given the high level of repeat long term scripts for benzodiazepines indicated by the Pharmacy Survey it becomes clear that a major reduction in the level of repeat benzodiazepine prescribing will require a high level of detox support for the patients involved, if their rights are to be protected at all in the process. The Key Informant report shows that there are a number of other considerations which may influence the medical thinking around detox. These include the professional hazards of involuntary detox and the difficulty of addressing informal sharing and redistribution networks which are independent of the medical system.

The issue of detox is further complicated by the general perception among the community, indicated strongly in the focus groups, that coming off benzos is very difficult. A second perception indicated in the focus groups, and supported by the key informant report, is that for many people these drugs have become a normalised way of “coping” and consequently the perceived need for detox, or for reducing use, is not seen as a pressing one. Another issue indicated by the focus groups was the fact that many people seem to have only limited information about benzodiazepines, their precise function and their appropriate use. For the most part this lack of information was attributed to the fact that doctors did not generally provide the information.

The research also makes it quite clear that medical activity is not the only variable impacting on the overall pattern of benzodiazepine use in Ballymun, and it is evident that placing the focus on doctors alone is not adequate. The structural issues obviously play a role, as do the socio-cultural perspectives which have emerged within Ballymun. These need to be addressed as part of any process of changing patterns of prescribing. The provision of adequate and accurate information about benzodiazepines must form a part of this process of change. The need for this information provision has not always been accepted, and in the literature review we were struck by the observation by Taylor (1989) who commented that “Unfortunately, the increasingly strident and threatening clamour against the therapeutic use of benzodiazepines compels doctors today to be unusually circumspect, and to temper their medicinal advice with a (recorded) caution of the side-effects patients might experience... and of the possibility of a traumatic morbid dependence on prolonged medication” (p703).

## 6.4 Benzodiazepines and methadone treatment

There was a clear perception among all of the focus groups that benzodiazepines are prescribed to many persons on methadone maintenance. This is confirmed by the key informant, who suggests that clients coming onto methadone treatment often do seek a benzodiazepine script. Three of the focus groups also indicated that they considered that the problem of benzodiazepine misuse in Ballymun has become more prominent with the development of treatment services. The Report of the Benzodiazepine Committee (2002) indicates that in the larger Addiction Centres in the ERHA area up to 30% of clients are prescribed benzodiazepines, with the figure rising to almost 60% in some of the satellite clinics (pp17-18). The same report also notes that there is a wide discrepancy between the percentage of clients testing positive for benzodiazepines in the various centres and clinics and the percentage actually prescribed in those centres and clinics (p17). This would seem to indicate a significant degree of diversion or multiple scripting, along the lines described in the work of Fountain and her colleagues.

The rationale for the prescribing of benzodiazepines to opiate users is addressed in some of the literature (Seivewright, 1993), though concerns have been expressed in some quarters<sup>28</sup>. The Good Practice Guidelines issued in conjunction with the Report of the Benzodiazepine Committee (2002) recognised the issue of dependence on benzodiazepines and appeared

26 Quigley, P. (2001). Public Health Dimensions of Benzodiazepine Regulation. *Critical Public Health*, Vol 11 (4).

27 Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. p6.

28 See. Best, D. et al. (2002) Factors surrounding long-term benzodiazepine prescribing in methadone maintenance clients. *Journal of Substance Use*, 7. pp175-179.

to accept that maintenance benzodiazepine prescribing may be a valid prescribing response in certain circumstances (p65). The Guidelines also noted that substance misusers often have very severe psychosocial problems which may have preceded their substance misuse, or co-exist with the addiction.

Analysis of the Ballymun Treatment Centre case mix (Quigley, 2002) has demonstrated the presence of severe biomedical and psychosocial problems among those attending for treatment. Many clients have attended a range of doctors in the past, and some of the dependence may have arisen in the context of poorly monitored or even unethical prescribing. In any case, the issue of dependence needs to be addressed in a humane and rational manner. It is possible that the clinical policies of the treatment centres may have exacerbated the problem of benzodiazepine misuse by “pushing” clients away from heroin use by means of sanctions, and so induced clients to move towards substitution with the less contentious but equally potent mixture of methadone, cannabis and benzodiazepines.

It is very clear from the literature and the focus group data that benzodiazepines are a very real part of opiate users’ drug repertoire. In the Irish Context a review of Drug Services for the Eastern Health Board in 2000 commented that, “the high rates of benzodiazepine positivity indicate a major problem of poly drug misuse which requires urgent and concerted attention”<sup>29</sup>. The need for attention to this issue is further highlighted by the data which emerges from the reports of the Dublin City Coroner for 1998 and 1999 in relation to opiate related deaths, and which indicates that benzodiazepines are the most common drug group implicated in opiate related deaths during that period<sup>30</sup>.

In order to understand why the level of benzodiazepine use may be rising it is necessary to look at the issue from the drug user’s perspective. The literature does give clear insights into factors which underlie the choice to use benzodiazepines. The EMCDDA Annual Report (2002), as mentioned in the Literature Review, suggests that there is a general consensus that polydrug use has four main functions: “it maximises effects, balances or controls negative effects and substitutes sought after effects” (p39). The findings from the focus groups would support that basic position. In particular it was frequently noted that benzodiazepines were used to increase or “top up” the effect of heroin or methadone. This practice, in itself, is not remarkable among poly drug users. However research among opiate users does suggest that this practice also particularly occurs where the quality of the heroin or the impact of the methadone is experienced as less than expected<sup>31</sup>.

## 6.5 Benzodiazepines and the development of substance misuse problems in Ballymun

Our research question sought to explore the role of benzodiazepines in the development of substance misuse problems in Ballymun. As mentioned in the literature review, we found no studies which looked at the specific role that benzodiazepines might play in the development of such problems. The following considerations, however, may throw some light on the question.

The international evidence supports the position that broad cultural factors play a significant part in substance use and misuse<sup>32</sup>. Our study suggests that within Ballymun there is a generalised acceptance of benzodiazepines. This “normalisation” of benzodiazepine use has emerged through a complex interplay of doctor practice, patient expectation, and inadequate information flow. If the use of one specific drug type, which is also a drug of misuse, becomes acceptable or normalised, then it is not unreasonable to suggest that this process does have a contributory effect when it comes to considering the misuse of other drugs. When this “normalisation” process begins for people at a very early age, as suggested in the focus groups, then it is likely that the impact on community members is even greater.

A more practical consideration is the fact that the evidence emerging in this research suggests that there is a significant supply of benzodiazepines coming into the community through GMS prescribing, and, to a lesser degree, through the statutory Addiction Services where monthly supplies are not issued and doses are generally restricted. A substantial number of the prescriptions are repeat prescriptions, and there may be a good number which have not been reviewed on a regular basis. If these benzodiazepines are not used by the person owning the prescription then it appears that the surplus benzodiazepines can and do enter into the illicit market, and the evidence suggests that this occurs normally through informal and closed networks. This informal benzodiazepine economy does not seem to be linked to larger drug distribution

29 Farrell, M., Gerada, C., Marsden, J., (2000) *External Review of Drug Services for “The Eastern Health Board”*. London. National Addiction Centre, Institute of Psychiatry. p8.

30 Dept of Health and Children (2002). *Report of the Benzodiazepine Committee*. p19.

31 Fountain, J., Griffiths, P., Farrell, M., Gossop, M., Strang, J.(1999) Benzodiazepines in Polydrug-using Repertoires: the impact of the decreased availability of temazepam gel-filled capsules. *Drugs: education, prevention and policy*, 6(1). p63.

32 Morgan, M. (2001). *Drug Use Prevention. An Overview of Research*. Dublin. NACD. p22

channels, but seems to be a more commonplace and culturally acceptable practice. This conclusion finds support in the broader perception among many members of the Ballymun community that the use of benzodiazepines is seen as a very normal and socially acceptable activity.

The nature of benzodiazepines themselves also appears to play some role in the development of substance misuse problems. They are a versatile and malleable drug in terms of the effects they can produce. The focus groups identified a wide range of usage patterns that included the use among problematic drug users and among the general population. Such a versatile drug does have the potential to generate new patterns of use which potentially have an impact on the use of other substances.

## 6.6 Ways forward

In the study by Bendtsen *et al* (1999) the authors concluded that an improvement in the rational prescribing of benzodiazepines would be assisted primarily by developing the communication and negotiation skills of the physicians. In particular they considered that more time needs to be spent with patients requesting benzodiazepines, and valid non-pharmacological alternatives need to be made available. The study by Catalan *et al* (1984) supports this position, finding that very brief counselling for patients with low to moderate levels of anxiety was as effective as benzodiazepine therapy. Clare (1991) suggests that “non-specific curative factors, such as supportive contact with a doctor, patient expectation, and the passage of time, may have become undervalued with the headlong rush to pharmacotherapy” (p187). The lack of time available to the patient does seem to be an issue in the Ballymun context, and a higher doctor patient ratio might impact on this situation. The disposition of the doctor, and the willingness to engage in appropriate brief non-pharmacological interventions is another issue. If doctors are not disposed to engage in this process, then an effective referral process, or the use of multi-disciplinary primary care teams, would certainly provide alternatives for patients.

It is clear from our research that any change to the current pattern of benzodiazepine prescribing or use will need to take account of the complex interplay of factors that are involved. The restriction of prescribing practice alone will not address the psychosocial issues, and is likely to create additional patient trauma. It may also undermine existing doctor patient relationships, and possibly lead to a purposeless or wasteful migration of prescription items to the non-benzodiazepine hypnotics. Such outcomes are not necessarily in the interest of the medical practitioners, the patients, or the community in general.

Regulatory controls need to be in the context of a holistic response to the issues and a much more thoughtful professional response is required. The findings clearly suggest that structural issues such as patient load, and the lack of support services, particularly counselling and stress management services, need to be addressed at a structural level. Resources need to be put in place to prevent the situation emerging where the doctor is expected to “gate-keep” a range of services which are not a sensible part of the medical remit.

Patient expectations also need to be taken into account, particularly the situation where many individuals have been effectively on a benzodiazepine maintenance for years. The process of changing that situation needs to be carried out in consultation with the patient. However the findings of this research do indicate that there is a widespread anxiety about the problem of detoxing from benzodiazepines, and that this is likely to impact on efforts to change prescribing patterns.

Part of the concern in Ballymun is linked to the level of information available to people in the community, and a change in this regard does seem to constitute a key element in any way forward.

In the early days Valium was marketed as “mother’s little helper”. With hindsight, and drawing on the data provided through this research, perhaps the question around benzodiazepines at this stage is “whose little helper are they?” To what degree do benzodiazepines allow a wide variety of individuals and structures to “cope” with realities that are unfavourable or inadequate. Exploring this issue is crucial in dealing realistically with the current situation. Undoubtedly changing the pattern of benzodiazepine use in Ballymun constitutes a significant challenge. The process of dialogue, research, and information sharing does appear to be the way in which the required professional and political will for necessary reform can be generated.

## Chapter 7 – Conclusions and Recommendations

### 7.1 Conclusions

This research set out to explore the role of benzodiazepines in the development of substance misuse problems in Ballymun. The findings that emerged from that exploration throw light on a wide range of issues linked to the use of benzodiazepines within the Ballymun context.

The findings suggest that the level of benzodiazepine prescribing in Ballymun may be notably higher than the national level. They also indicate that a considerable proportion of patients who are initiated on benzodiazepines continue to take them for many years. The data from the Pharmacy Survey indicates that the first record of benzodiazepine dispensing in almost 80% of the scripts studied was greater than one year, and for almost 40% it was greater than five years. The findings also indicate that the conditions that would foster the review of benzodiazepine scripts, such as available time and an adequate patient load, are not normally present in the Ballymun context.

The findings suggest that there is a clear gender bias in the prescribing of benzodiazepines in Ballymun, with women being prescribed almost two thirds of the benzodiazepines covered in the Pharmacy Survey. The findings also suggest that this bias is related, in certain aspects, to the socio-economic situation of people in Ballymun.

The findings also support the view that benzodiazepine use has become “normalised” for many people within Ballymun, including both consumers and providers.

The findings also indicated that the issue of benzodiazepine detox is a complicated one. To have any significant impact on the current high level of “long-term” benzodiazepine scripts would require a lot of people to undergo detox, with all the associated resources required. At the same time the findings have suggested that many people consider benzodiazepine use as quite normal, and consequently would be resistant to detox. Added to that is the commonly held perception that benzodiazepine detox is actually a difficult process for the individual.

Another finding coming through clearly from the research is the recognition that the prescribing of benzodiazepines in the context of methadone maintenance does raise issues. These include health concerns around such polydrug use, but also an underlying question around the adoption of a maintenance approach parallelling the methadone maintenance process.

The findings throw light on the processes whereby the use of benzodiazepines within the Ballymun community can be seen to contribute to the development of substance misuse problems in the area. These include the impact of the “normalisation” of benzo use, the availability of benzos for illicit use, and the versatility of benzos as a substance of misuse.

One final conclusion that emerged from the data is the belief that benzodiazepines serve all kinds of needs within the community, both for patients and doctors. The evidence suggests that the use of benzodiazepines is not the appropriate response in all of the contexts indicated.

### 7.2 Recommendations:

- That the patterns of benzodiazepine prescribing in Ballymun and elsewhere in Ireland be examined. This entails a closer examination of prescribing practice, including duration, review procedures, dosage and drug.
- That the emphasis on responding to these findings, and the findings of further examination, is not directed solely at individual doctors. It is clear that the problematic aspects of benzodiazepine prescribing are linked to a complex set of interrelated factors which include doctors, patients, socio-cultural contexts, and available resources. While the work of confidential medical audit and self-regulation is primarily one for the profession, it should be recognised that there are considerations of public health and welfare which demand an urgent approach to the problem.

- That there is a need for adequate provision of information about benzodiazepines to all members of the community. The provision needs to address the current shortfalls in provision, particularly those created by literacy difficulty and the non-provision of the “information sheet” with less than monthly scripts.
- That there is investment in the development of services to complement medical practitioners. In particular there is a need to develop non-pharmaceutical alternatives to benzodiazepine therapy.
- That there is a review of the current practice of benzodiazepine prescribing to all persons on methadone treatment, both within and outside of the statutory treatment centres, and that such review should include the issues of providing motivation for change, detox approaches, multi-disciplinary responses, and the question of statutory-community shared responsibility.
- That the experience of other similar communities be examined in the light of the findings of this research. In particular that efforts be made to make up for the shortfall of information about the situation of “legitimate” long-term users of benzodiazepines, and that the related issues of community mental health be examined locally.
- Finally, it is hoped that the findings of this research will contribute to a clearer understanding of the role that benzodiazepines play in Ballymun. It is also hoped that, in the spirit of the community based research approach, it will enable all stakeholders to gain insight and identify strategies which will contribute to effective change.

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