MAT standards informed response for benzodiazepine harm reduction

Call to action

The unprecedented harm associated with street benzodiazepines in Scotland is a public health emergency that demands a different approach. The false notion that postponing change in prescribing practice is the safest position and the current status quo, is unacceptable. The current rate of high levels of benzodiazepine related harm seen in Scotland qualify in the **Orange Guidelines** as 'exceptional circumstances'. We all have a responsibility to listen to, assess and understand a person's unique story of benzodiazepine use to identify appropriate treatment and care. Initial conversations should address immediate risk of harm, particularly overdose and death. Conversations should be underpinned by principles of psychological and trauma informed care including safety, empowerment, choice, collaboration and trust, in line with the MAT standards (see summary in **Appendix A**).

There is no straightforward, one-size-fits-all approach to reduce harm from street benzodiazepines. Existing literature has limited applicability in the current Scottish context and national evaluation of current practice and research into future prescribing interventions are both at an early stage. This guidance, developed by the Benzodiazepine Working Group, places the person at the centre of their care and treatment, taking a holistic and integrated approach in line with Realistic Medicine*. It represents a national consensus of expert opinion to specifically respond to rising harms, incorporating available evidence of effectiveness from practice. This work is intended to generate learning as part of the ongoing review of evidence.

* **www.realisticmedicine.scot**

This guidance aims to set out key principles which align with the MAT standards and is designed for all staff supporting those who present with high risks of drug-related harms.

Be prepared to talk about benzodiazepine harm reduction

Empathic listening – seek to understand

Needs-based assessment

Zone of accepted risk – collaborative risk assessment

Offer benzodiazepine harm reduction

Shared goals – review progress

In recognition of the levels of harm within this cohort this guidance encourages flexible and individualised higher intensity care; in particular to support staff working in specialist treatment services who are regularly engaging with people using street benzodiazepines as well as opioids. Included is information on immediate changes you can make and action you can take to actively reduce harms by forming therapeutic relationships which consider the prescribing of benzodiazepines and the safe and effective delivery of appropriate psychosocial interventions.

Be prepared to talk about benzodiazepine harm reduction (MAT 1, 3, 4)

Wherever people are accessing support we all have a responsibility to have conversations about street benzodiazepines, placing the person at the front and centre of their care. While it is important to highlight that assessment of the impact of street benzodiazepine use is complex; benzodiazepine conversations should happen from the first day of presentation to any service as part of harm reduction support to individuals. The ethos of same day treatment for most people will be gaining an understanding of their benzodiazepine use and harms to develop a benzodiazepine care plan and to offer immediate harm reduction advice. All people presenting with benzodiazepine use and/or following a near-fatal overdose where benzodiazepines may have been implicated, should be proactively assessed for appropriate prescription and psychological support within specialist services.

Empathic listening – seek to understand (MAT 5, 6, 10)

Establishing and maintaining a therapeutic relationship through active listening should underpin all the work we do. Anyone accessing support should be seen regularly and encouraged to discuss their benzodiazepine use. Changing their benzodiazepine use will be a priority for some people while others may not consider their use to be a problem. Listening to and understanding the reasons for 'change' and 'no change' are therefore crucial. Does the person want to make any changes to their use, if yes why? What are their reasons for change? What are their goals – support to reduce harm/rationalise use, support to self-detox, prescribing to support stabilisation, prescribing with a view to support detox? Exploring any previous attempts at making a change or periods of abstinence is important: what worked well, what challenges did the person face? What was different then to now? If change is not a priority, explore the reasons why; how does the person's use help them in their life and what would be their concerns if they were they unable to access benzodiazepines? What would need to be different in order for them to make a change to their use? A person may feel making a change to their use is important but lack confidence in their ability to make that change, explore steps already taken and existing skills. If a person cannot identify any reasons for change and is at a pre-contemplative/contemplative stage then a period of motivational enhancement may be appropriate to support the success of any intervention.

Needs-based assessment (MAT 6, 10)

Responding to people in a way that fosters acceptance, trust and collaboration is critical for a person to feel listened to and able to discuss their use openly without fear of an invalidating and rejecting response. A person's benzodiazepine use should not define them. Benzodiazepine use occurs for a reason and understanding the context in which it occurs is important. A holistic bio-psycho-social assessment (see **Appendix B**) will inform a unique and shared understanding of the person's benzodiazepine use. This psychological formulation will identify the following factors to directly inform the care and treatment plan:

- **Presenting issues:** What are the immediate concerns – i.e. benzodiazepine use placing person at risk of harm?
- **Predisposing factors:** Why this person? What has happened in this person's life that has made them vulnerable to developing these problems?

- **Precipitating factors:** Why now? – What are the triggers for use?
- **Perpetuating factors:** How are the presenting problems being maintained?
- **Protective factors:** What strengths, skills and resources does the person have? What existing supports are in place?

Zone of accepted risk– collaborative risk assessment (MAT 1, 2, 3)

The risks associated with street benzodiazepine use are extensive and well documented, relating to both direct and indirect harms that include but are not limited to seizures, risk- taking behaviours, cognitive impairment, homelessness, contact with the criminal justice system, overdose and death. These risks are acknowledged within The Medicines and Healthcare Regulatory Authority (MHRA) Competition and Markets Authority (CMA) advice for benzodiazepines* and opioids, March 2020: 'The MHRA reminds health care professionals that benzodiazepines and benzodiazepine –like drugs co-prescribed with opioids can produce additive CNS depressant effects, thereby increasing the risk of sedation, respiratory depression, coma and death. Healthcare professionals are advised only to co-prescribe if there is no alternative and, if necessary the lowest possible doses should be given for the shortest duration' which is often referenced in situations when decisions not to prescribe are being made. The MHRA guidance does not consider that people using street benzodiazepines are already experiencing many of these harms from their street drug use and that a prescribing intervention is acknowledging these harms and aiming to reduce them by reducing the use of street benzos, neither does it state that co-prescribing is contraindicated. What the guidance does promote is the ethos of a zone of accepted risk between the prescriber and the person.

This MAT informed guidance for benzodiazepines embraces the ethos of shared decision-making within Realistic Medicine. 'Realistic Medicine is not about failing to offer treatment it is about supporting people using healthcare services, and their families to feel empowered to discuss their treatment. That's why changing our style to sharing decisions with our patients is one of our priorities. A move away from the 'doctor knows best' approach to

* **www.gov.uk/drug-safety-update/benzodiazepines-and-opioids-reminder-of-risk-of-potentially-fatal-respiratory-depression**

shared decision making between the professional and patient will require more meaningful discussions about the treatment options available as well as their risks and benefits'.[*]

A summary of risk associated with street benzodiazepine use should be weighed and documented against a summary of the risks of treatment options, including the risks associated with decisions not to offer interventions, and each explored for the individual and the service. While not all risks can be mitigated by prescribing interventions (in particular increased sedation and cognitive impairment) and there lacks a strong evidence base for community benzodiazepine detoxification or substitution, making a decision not to prescribe may perpetuate identified harm. The rationale therefore not to prescribe should be considered alongside the person considering Benefits, Risks, Alternatives, Nothing (BRAN)[†] and clearly documented.

Where risk is extremely high due to previous nonfatal overdose or physical or mental comorbidities, a period of inpatient or residential stabilisation, if available, should be considered. The Benzodiazepine Working Group has already made an early recommendation to the Drug Death Task Force to support access to residential beds to provide a place of safety for those who are at highest risk of benzodiazepine harms.

[*] **www.realisticmedicine.scot**

[†] **www.nhsggc.org.uk/patients-and-visitors/realistic-medicine/info-resources-for-staff/cmo-advocates-bran-questions/#**

Offer benzodiazepine harm reduction (MAT 1, 2, 6, 9, 10)

The assessment, psychological formulation and risk analysis described above will support the identification of shared goals which may include:

- an immediate response to support **harm reduction***
- offer of appropriate psychosocial/logical interventions
- supported self-reduction of street benzodiazepines
- medication assisted detox for abstinence
- medication assisted stabilisation (maintenance prescribing).

Prescribing

The principles of benzodiazepine prescribing in the context of benzodiazepine dependence are not new to specialist treatment services although practices differed when the magnitude of harm from street benzodiazepines was less. Prescribing can enable individuals to move away from street benzodiazepine use and associated harms, in order to stabilise and improve their mental and physical health and to enable them to look at other underlying social difficulties, such as housing, welfare, and relationships.

When assessment, formulation and exploration of risk concludes that prescribing is likely to bring benefit, there should be informed consent which explicitly acknowledges the potential harms from prescribing (drowsiness, falls, respiratory depression etc.) and if the prescribing is off label. Clear and realistic harm reduction goals need to be set before starting any prescription. This will include a clear understanding of under what circumstances a prescription will be stopped if it is not seen to be helping the individual in reducing harms.

* See: **Crew (2020) Benzos**. Information guide on use, effects, safety and help.

Established prescribing principles include:

- Use of a single benzodiazepine is considered safer than prescribing multiple benzodiazepines.
- Diazepam is an effective choice due to its relatively long half-life and as it comes in a range of tablet strengths (2mg, 5mg, 10mg).
- The maximum licenced daily dose of 30mg is preferred in most cases as it is associated with less likelihood of adverse effects.
- Where risks are particularly high, a lower starting dose of 10 or 20mg daily and titration upwards may be safer than starting at a higher daily dose.
- People with concomitant opioid dependence should be offered same day opioid substitution therapy as per MAT standards.
- The additional risk associated with concomitant alcohol dependence or regular excessive drinking should be acknowledged.
- Daily or frequent instalment dispensing at community pharmacy should be used until harms are stabilised.
- New benzodiazepine prescribing should have the immediate/short term goal of stabilisation of street benzodiazepine use which can then be reviewed.
- Where benzodiazepine prescribing demonstrates harm reduction, it may on balance be considered safest to continue for a period of time to enable stabilisation.
- Medication assisted detox should be tapered at an individually titrated rate.
- Prescribing interventions should not sit in isolation and should be under regular review.

Psychosocial/psychological interventions

Psychosocial and psychological interventions within these guidelines are not unique to benzodiazepines but would be considered best practice in the management of all substances in accordance with the MAT standards and **LPASS** report (2018).* A matched care approach is advocated where at lower tiers, emphasis is on safety and stabilisation, providing a foundation on which higher intensity interventions requiring greater competences, delivered by applied psychologists can be safely and effectively delivered. All interventions should be delivered as part of a recovery care plan, integrating the most appropriate psychological, social, medical and other non-medical interventions for an individual in recovery. Interventions should be based on a comprehensive assessment of need. The assessment and psychological formulation will identify which interventions are appropriate. For more information on the different tiered interventions, see **Appendix C**.

The terms psychosocial and psychological are often used interchangeably but there are important distinctions. Psychosocial interventions can be delivered by a range of care providers 'Frontline practitioners are likely to use psychological and social techniques and tools (such as motivational techniques, relaxation training, alcohol/drug diaries and self-help materials) as part of their practice within a psychologically minded approach. These techniques do not constitute a psychological intervention, but are invaluable components of routine care' (p19 LPASS report). Psychological interventions are delivered often to protocol by practitioners with additional competences who have protected time to both deliver and regularly attend supervision.

Shared goals – review progress (MAT 2, 3, 5, 10)

Interventions under this guidance should be regularly monitored, reviewed and agreed with the person, to consider:

- Progress towards achieving goals.

* **www.gov.scot/publications/delivery-psychological-interventions-substance-misuse-services-scotland-report/**

- Any concerns (raised by person or by others) should be explored routinely. This might include any lapses, presenting intoxicated, or nonfatal overdose. Lapses (temporary return to street use) are common when a person is making a change and should be responded to compassionately. Seek to understand circumstances and context in which the lapse occurred and how to support the person to get back on track. A lapse will not automatically mean an intervention will cease prematurely.

- If person has relapsed (returned to previous pattern of street use, routinely topping up and seeking intoxication) revisit assessment, formulation and any benzodiazepine prescription.

- Is the initial goal(s) still relevant? If not identify new goal(s).

Any changes to the treatment plan should be discussed with the person, ideally in advance and a further review date agreed. As part of the collaborative goal setting process there should be an agreed plan for regular reviews and a response should the person struggle to attend. This should include informed consent to contact identified people who could support the person to reviews (assertive outreach) whether this is a service provider or named person (i.e. family member).

Appendix A: Medication Assisted Treatment (MAT) standards*

The MAT standards are evidence-based standards to enable the consistent delivery of safe, accessible, acceptable, high-quality drug treatment across Scotland. These are relevant to people and families accessing or in need of services, and health and social care staff responsible for delivery of recovery-oriented systems of care.

Standard 1: All people accessing services have the option to start MAT from the same day of presentation.

Standard 2: All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.

Standard 3: All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.

Standard 4: All people are offered evidence-based harm reduction at the point of MAT delivery.

Standard 5: All people will receive support to remain in treatment for as long as requested.

Standard 6: The system that provides MAT is psychologically informed (Tier 1); routinely delivers evidence based low intensity psychosocial interventions (Tier 2); and supports the development of social networks.

Standard 7: All people have the option of MAT shared with primary care.

Standard 8: All people have access to independent advocacy and support for housing, welfare and income needs.

Standard 9: All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.

Standard 10: All people receive trauma-informed care.

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* **www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/**

Appendix B: Bio-psycho-social assessment

The following bio-psycho-social assessment provides a comprehensive understanding of a person's need to determine appropriate interventions and support. Like pieces of a jigsaw, the information gathered at assessment will help to develop a clear picture of the person's presenting issue (formulation).

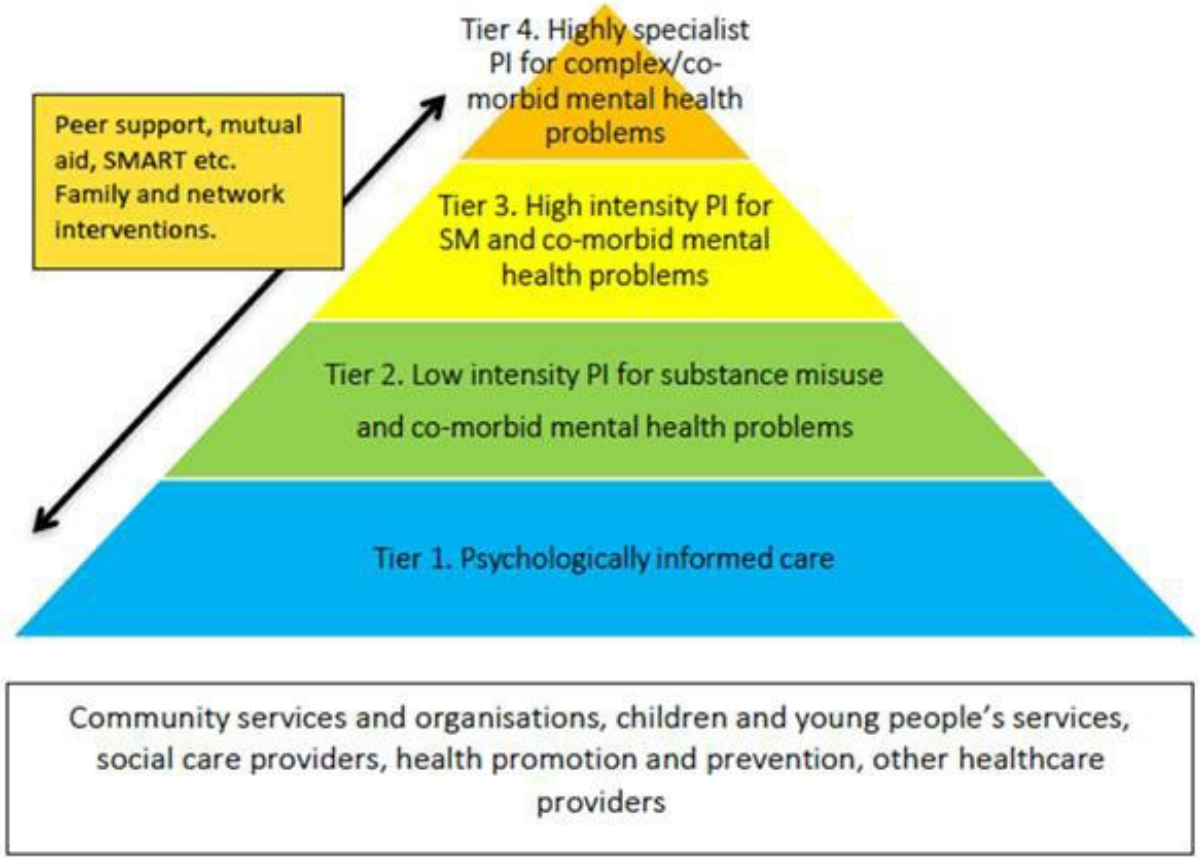
Biological	
Current substance use: Assessing the person's current use of benzodiazepines and other non-prescribed and prescribed substances.	• Coming alongside and understanding the person's relationship with benzodiazepines and how this fits into their typical day is essential. • Talk the person through a typical day and how their substance use fits into that as best they can. How does their use help them in their life and what would be their concerns if they were unable to access benzodiazepines. • Quantities and frequency, route of administration, pattern of use over 24 hours and over the week. • Assessment of tolerance/withdrawals. • Substance use history (timeline) including any non- fatal overdoses (NFOD) and treatment, periods of abstinence.
Physical health: Current physical health status	• BBV status, sexual health, and pain. • Current management, engagement with services and any treatments offered. • Relationship between substance use and attempts to manage physical health should be explored.

Psychological	
Motivation and readiness to change	• Listen to and identify the person's priorities. • Understand the person's desire and reasons for 'change' and 'no change'. • Explore previous change attempts what worked well, what challenges did they face?
Functional analysis	• Exploring the most recent time when the person used drugs and making links between thoughts, physical sensations, emotions, and behaviours including consequences of use.
Cognitive impairment	• Ask about problems with memory, can person keep track of appointments etc. • Key messages/information from appointments should be written down (depending on literacy). • Prompts to remind people of appointments should be offered. • Where there are more specific concerns regarding cognitive impairment then consideration should be given as to whether a more formalised assessment is required.
Co-occurring mental health	• Identify co-occurring mental health problems (including complex PTSD) and any treatments (Prescribing/Psychological) including person's view on how helpful this is and their engagement with any services.

Social	
Relationships	• Identify significant relationships and quality of these relationships. • Understand social network.
Housing	• Does the person have secure accommodation? • Risks of homelessness. • Rent arrears.
Finances	• Understand any financial stressors either related to substance use or otherwise.
Child and family	• Does the person have any dependants? • Contact arrangements. • Identify any child protection concerns.
Education/employment	• Is the person studying/in work? • Does drug use impact on work performance/safety?
Daily routines	• How does the person spend their time? • Engagement in meaningful activities.
Legal	• Any legal issues? • Are they under a treatment order? • Forensic history. • Current/pending charges.
Goals and aspirations	• Understanding of person's goals, short, medium and longer term. • What do they want to achieve, what are their hopes?

Appendix C: Psychological matched care model

Figure 1. Matched care model



Examples of Tier 1 psychological informed care would include (but not be limited to) establishing and maintaining a therapeutic relationship, trauma informed key working, comprehensive assessment (including risk), assessment of motivation and readiness to change, skilful goal setting, harm reduction interventions and psychoeducation regarding impact and effects of benzodiazepines, awareness of cognitive impairment, support to increase social networks and signposting to appropriate guided self-help for relaxation, sleep and pain management as informed by the assessment and formulation.

Examples of Tier 2 low-intensity interventions for benzodiazepine use and co-occurring mild to moderate mental health problems would include (but not be limited to) motivational interviewing, NES core skills, CBT-informed relapse prevention to support recovery management, emotional regulation skills, guided self-help and trauma-informed psychoeducation.

To respond to immediate harm, psychologically informed care (Tier 1) and lower intensity interventions (Tier 2) will be most appropriate. For those with complex benzodiazepine and co-occurring complex mental health problems, access to higher intensity interventions (Tiers 3 and 4) may be appropriate and should be accessed via psychologists working in drug and alcohol services.

Tier 3 high intensity interventions are aimed at moderate-to severe difficulties with significant complexity. The person's level of motivation and drug use will already be identified via Tier 1 and/or Tier 2 interventions. Interventions are standardised/evidence-based psychological therapies, typically delivered to protocol. Protocols can be adapted for benzodiazepine use.

Tier 4 highly specialist psychological interventions are typically reserved for highly complex clinical presentations, which are beyond the scope of standardised treatment. These presentations typically result from a history of complex trauma and can include personality disorders. Significant cognitive impairment is a further typical difficulty seen at this level.

Interventions at this level are frequently delivered in collaboration within a multidisciplinary team.

All delivery should be carried out within a clear structure of managerial and clinical supervision to ensure effective delivery and governance. Psychological interventions are delivered via a complex interpersonal interaction. Coaching and/or supervision specifically designed to support delivery is essential at each tier to ensure the safety and integrity of interventions for both service users and practitioners.

Appendix D: Acknowledgements

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