

# Wobbled Up

## The illicit use of diazepam in Redcar

(initial research designed to inform an awareness campaign)

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*Lifeline***Project**

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## Executive Summary

Benzodiazepines belong to the hypnotosedative group of drugs, which are one of the main three families of CNS depressant. They are divided into hypnotics (which induce sleep) and anxiolytics (which reduce anxiety), though also have other medical uses. Their main effects include sedation and muscular relaxation. Benzodiazepines have become the fifth most popular type of controlled drug in England & Wales (after cannabis, cocaine, ecstasy and amphetamines). In 2009, there were an estimated quarter of a million illicit benzodiazepine users in Britain, and annual police seizures peaked at over 4,000. Benzodiazepines are now involved in about 10,000 overdoses and almost 600 deaths per year, which, along with opiates, makes them the most dangerous controlled drugs in Britain. The most commonly prescribed benzodiazepine is diazepam (once called Valium). Excluding opiates, it is also the most commonly prescribed controlled drug in Britain, followed by zopiclone and temazepam.

Redcar & Cleveland police authority area (PFA) had the highest rate of benzodiazepine seizures of all 40 PFAs in 2008/09, accounting for one in six of all tablets seized in England & Wales. Furthermore, a needs assessment study in Redcar & Cleveland in 2009 identified benzodiazepine use as a previously unrecognised and growing problem among local drug users. In July 2010, focus groups were conducted at a local drug agency with 13 drug users to assess the nature and extent of diazepam use in Redcar. It was reported that illicit use of benzodiazepines in Redcar had begun around five years ago, and had now reached record levels. Diazepam was by far the most popular benzodiazepine, and was mainly available in the form of 10 mg tablets known as *blues*, *vallies* or *wobbles* (typically costing £1 each). The main reasons for its use among problem drug users was the poor quality of heroin and other drugs in Redcar, while younger drug users were taking it for recreational purposes (eg. at weekends). Both groups were typically mixing it with alcohol and drugs to enhance its effects.

It was reported that diazepam was mostly taken orally, though some users were injecting it. New and occasional users took up to

five tablets per session, while regular users usually took between 20 and 100 tablets per day. Several batches of diazepam tablets were being sold at any given time, and their quality was very variable, with some batches being totally fake. It was believed that most dealers obtained their supplies from the Internet or abroad, while some batches were illegally produced. The main desired effects of diazepam (especially when combined with alcohol) were increased happiness, sedation and relaxation. However, it also had many other 'side-effects'. These included physical effects like loss of coordination and incoherent speech; and psychological effects such as emotional blunting, cognitive deficits (particularly amnesia), aggression, and delusions (notably of invisibility). Participants reported that the main harmful consequences included dependence and withdrawals; overdose; injuries arising from accidents; criminal behaviour (notably acquisitive and violent offences); and deterioration in social relationships. The report concludes by discussing the kinds of information and advice which could help to reduce the harmful consequences of diazepam use.

# 1. Introduction

In July 2010, Lifeline Publications embarked on an awareness campaign on the illicit use of benzodiazepines in Redcar and Cleveland. This research was conducted in order to inform the initial stages of the planning and implementation of the campaign. This document reports the methods and findings of this research, and begins with a brief overview of this group of drugs (slang terms are in *italics*, while trade names start with a capital letter).

## 1.1 Benzodiazepine use in Britain

**Hypnotosedatives.** Benzodiazepines (*benzoes*) are a sub-group of the hypnotosedative family of drugs (*downers*). Along with alcohol (*booze*) and opioids (*gear*), hypnotosedatives belong to the class of drugs known as CNS depressants (the other two classes are stimulants and hallucinogens). Hypnotosedatives are prescribed by doctors for various purposes, though are generally distinguished by their two main functions: hypnotics/soporifics (sleeping pills and potions) and sedatives/anxiolytics (which reduce anxiety, relax muscles, and induce relaxation). In short, two of their most well-known medical uses are the treatment of insomnia and the treatment of neurotic disorders like anxiety – though other medical uses include anaesthesia during medical procedures, and the control of epilepsy. Hypnotosedatives are often described by the umbrella term ‘tranquillisers’, though some sources use this term for anxiolytics only. It should be noted that they are unrelated to the ‘major tranquilliser’ group of drugs (eg. chlorpromazine), which are prescribed to control symptoms of psychosis. In addition to benzodiazepines, the other main hypnotosedative groups of drugs include barbiturates (eg. phenobarbital), anti-histamines (eg. diphenhydramine) and z-drugs (eg. zopiclone/ Zimovane).

**Benzodiazepines.** Benzodiazepines were first synthesised in 1955 as a safer alternative to barbiturates, based on the belief that they were not addictive (false) and far less toxic (true). In addition to being divided into hypnotics (*sleepers*) and anxiolytics (*tranx*),

benzodiazepines are also classified by the duration of their effects, that is, as longer-acting or intermediate-acting (see ‘McDermott’s Guide to the Depressant Drugs’, Lifeline Publications, 2010). The most well-known longer-acting benzodiazepine is diazepam, an anxiolytic once dispensed as Valium. The most well-known shorter-acting benzodiazepine is probably temazepam (*temazzies*, *eggs*), a hypnotic once dispensed as Normison. Other common anxiolytic benzodiazepines include lorazepam (Ativan), alprazolam (Xanax) and chlordiazepoxide (Librium); while other common hypnotic benzodiazepines include nitrazepam (Mogadon/*moggies*) and flunitrazepam (Rohypnol/ *roofies*).

**Diazepam** is both the most commonly prescribed benzodiazepine and the most popular illicit benzodiazepine in Britain. Its full chemical name (hyphenated here) is chlorodihydro-methyl-phenyl-benzodiazepinone (C<sub>16</sub>H<sub>13</sub>ClN<sub>2</sub>O). It was the second benzodiazepine to be licensed for medical use after chlordiazepoxide (Librium) in 1960, and was released by Hoffman-LaRoche in 1963 under the trade name Valium. It causes sedation and muscular relaxation by enhancing the brain neurotransmitter GABA.

As regards their **legal status**, benzodiazepines were classified as Class C controlled drugs in Britain from 1986, following an amendment to the 1971 Misuse of Drugs Act. Class C drug offences are dealt with by maximum prison sentences of two years for possession (without a prescription), and 14 years for trafficking (notably supply and production). They are also mostly classified as Schedule 4i drugs, though three of the stronger types are in Schedule 3 (which has stricter controls on medical prescribing and dispensing) - namely temazepam, flunitrazepam and midazolam.

**Prescribing** of benzodiazepines has clearly declined since the peak in their medical usage around 30-40 years ago. There were around 30 million prescriptions of benzodiazepines dispensed in Britain in 1979 (Daly 2008). By contrast, the annual number of prescriptions of benzodiazepines dispensed from community pharmacies in England from 2007 to 2009 was around 11.5 million, though the total figure for ‘tranquillisers’ is between 16 and 17 million if we incorporate the more recently available z-drugs

Table 1: The number of prescriptions of benzodiazepines and z-drugs dispensed from community pharmacies in England in 2007 and 2009

	Benzodiazepines			Z-drugs	
	diazepam	temazepam	All	zopiclone	All
2007	4.7 m	3.3 m	<b>11.5 m</b>	4.4 m	<b>5.1 m</b>
2008	4.9 m	3.1 m	<b>11.4 m</b>	4.7 m	<b>5.4 m</b>
2009	5.0 m	3.0 m	<b>11.4 m</b>	4.9 m	<b>5.7 m</b>

(it should also be noted that these figures exclude hospital pharmacy prescriptions) (NHS Information Centre 2009).

Of the 13 types of benzodiazepine dispensed from community pharmacies, two were clearly the most prevalent - diazepam and temazepam - which comprised more than two-thirds of all benzodiazepine prescriptions dispensed in each year between 2007 and 2009 (Table 1; see Appendix 2 for details). In addition, the number of zopiclone prescriptions dispensed from community pharmacies in England also climbed to a record 4.9 million in 2009 – making it the next most commonly prescribed hypnotic drug after diazepam since 2007. Indeed, excluding certain opiate drugs (notably codeine and tramadol), these three hypnotics - diazepam, zopiclone and temazepam - are now the most commonly prescribed controlled drugs in England.

Furthermore, recent government reports which have reviewed the available evidence have estimated that there were about 1.5 million people dependent on benzodiazepines in 2008, with an additional 0.5 million dependent on z-drugs; and concluded that the total cost to the NHS of problems arising from prescribed benzodiazepines has reached about £8 billion a year (APPDMG 2008; APPGITA 2009).

The precise **prevalence** of illicit use of benzodiazepines in England & Wales is not known, because the two main annual surveys of drug use (one among adults, and one among secondary schoolchildren) focus on ‘tranquillisers’ rather than key sub-groups like benzodiazepines. However, the vast majority of people indicating illicit tranquilliser use in surveys are likely to be referring to benzodiazepines, with most of the remainder probably referring to z-drugs (it should also be noted that official statistics on levels of self-reported drug use are widely regarded to be

under-estimates). Annual surveys of drug use among adults (16-59s) in England & Wales by the British Crime Survey reported that lifetime use of tranquillisers peaked at 3.7% in 2000, after which it dropped down to 2.6% in 2004/05, before rising steadily again to 3.2% in 2008/09 – just over one in 30 adults (Home Office 2009b). Past-year use of tranquillisers among adults peaked at 0.7% in 2000, before falling to 0.4% in 2005/06, and then rising steadily again to 0.7% in 2008/09. Based on the latest figures, it was estimated that over a million (1,023,000) adults had tried tranquillisers without a prescription, and that over a fifth of a million (211,000) had done so in the past year – making it the fifth most popular controlled drug. Breakdowns for young adults (16-24s) showed that lifetime use of tranquillisers peaked at 4.5% in 2000, before falling to 2.0% in 2007/08, and then rising again to 2.6% in 2008/09; while past-year use among young adults peaked at 1.5% in 2000, before falling steadily to 0.6% in 2006/07, then climbing again to 1.0% in 2008/09. Lastly, annual surveys of drug use among English secondary schoolchildren (11-15s) in 2008 reported that lifetime use of tranquillisers stood at 0.7%, while past-year use was 0.5% (with annual levels remaining around 0.4%-0.5% since 2001) (NHS Information Centre 2009).

According to the 2009 annual report on the ‘UK Drug Situation’, 2,512 people who received **treatment** for problem drug use in the UK in 2007/08 reported that their primary drug was a benzodiazepine (up from 1,929 in 2003/04) - of which 1,285 were new drug treatment demands (Davies et al. 2010). Additional evidence has been provided by the Drug Treatment Outcomes Research Study (DTORS), a longitudinal study designed to follow drug users in England seeking treatment over a period of up to 12 months. The first stage of research found that 25% of clients entering treatment in England had used unprescribed benzodiazepines in the

four weeks prior to entry. The NTA 2006 user survey provided information about the continued use of illicit drugs by those in treatment (NTA 2007). Of the respondents who reported using on top of prescriptions (just over half), 43% indicated illicit use of benzodiazepines. A higher level of use on top of prescriptions was reported in the survey of clients using pharmacy based syringe exchange schemes – including 58% who indicated illicit use of benzodiazepines (see Eaton et al., 2008).

In addition, annual research conducted by Drugscope covering 20 British cities and towns in 2008 found evidence of a rise in illicit use of benzodiazepines in 15 of the locations (Daly 2008). The report concluded that importation of benzodiazepines from other countries was probably the major source of illicit supplies in Britain, followed by production by criminal gangs within the country. The 2009 Drugscope survey of street drug trends in Britain reported that “while authentic 10mg [diazepam] pills diverted into the black market are being sold in most areas for £1, fake versions from labs in China and south east Asia are available at half the price” (Daly 2009: 4). However, there is also recent evidence that their “attractiveness as a street drug has sparked a thriving online trade” (‘Ministers declare war on Britain’s tranquilliser crisis’, *The Independent on Sunday*, 4 July 2010).

**Seizures** of illicit benzodiazepines in England & Wales have also climbed dramatically over the past decade (Home Office 2009a). The number of seizures quadrupled from 950 in 2000 to a record 4,029 in 2008/09 (which excludes an additional 609 seizures of temazepam, which are recorded separately). Compared with other groups of drugs in 2008/09, this was the sixth highest number of seizures after cannabis, cocaine, heroin, amphetamines and ecstasy. The quantity of benzodiazepines seized nationally also soared from around 100,000 doses in 2000 to 1,760,000 doses in 2008/09.

As regards **overdoses**, annual statistics on in-patient cases of drug-related poisoning dealt with in English hospitals show that over the last decade around 7,000 to 10,000 people a year were treated for overdose/poisoning involving benzodiazepines, peaking at 9,841 in 2008/09 – a higher number than for any other category of controlled drug (DOH 2009). Though some

of these were suicide attempts, the available evidence indicates that most were accidental overdoses. Indeed, overdose is much more likely when diazepam is mixed with alcohol or other drugs (particularly heroin or methadone) – a hypothesis supported by the statistics on drug-related deaths below.

Turning to fatal overdoses, the LD50 (lethal dose for the average person) for diazepam is greater than 10 grams - compared with an ED50 (effective dose for the average person) of 10 mg. As regards toxicity and potential for overdose, this theoretically makes it one of the safest psychoactive drugs, with a safety index (LD-ED ratio) of over 1,000 to 1 (Gable 2004). Yet, Professor Heather Ashton, one of the UK’s leading experts on benzodiazepine use and addiction, has estimated that there have been about 17,000 **deaths** linked to tranquilliser use in the UK in the last 50 years (APPGITA 2009). Although the overall number of fatalities involving benzodiazepines has declined somewhat over the past two decades, the number of deaths involving diazepam has increased. For instance, in England & Wales, the total number of deaths involving benzodiazepines fell from 277 in 1993 to 230 in 2008 (ONS 2009). However, this is largely due to a steady drop in the annual numbers of temazepam-related deaths – while the number of deaths involving diazepam have climbed from 52 in 1993 to a record 133 in 2008. Trends in Scotland mirror those in England & Wales – that is, while the number of temazepam-related deaths has also dropped off significantly, the number of diazepam-related deaths climbed from 84 in 1996 to a record 317 in 2008. In short, the total number of benzodiazepine-related deaths in the UK (excluding Northern Ireland) in 2008 reached a record 594, of which 450 (76%) involved diazepam (z-drug deaths in England & Wales also climbed from zero in 1993 to 51 in 2007). In short, benzodiazepine fatalities now constitute the highest number of deaths associated with controlled drugs other than those linked to heroin/morphine. Lastly, annual statistics also indicate that only five to ten per cent of deaths related to diazepam involved no other drugs – in short, over nine in ten diazepam-related deaths are multi-drug deaths, typically involving alcohol and/or opiates, and sometimes other drugs.

## 1.2 Benzodiazepine use in Redcar & Cleveland

Redcar & Cleveland is one of 12 DAT areas in the North-East region of England. At mid-2007, it had a population of 139,400, of which 10% were 16-24s, 99% were white, and 12% were in poor health. When the seizure statistics for 2008/09 are broken down by the 40 police force areas (PFAs) of England, Cleveland PFA ranked second (after Northumbria PFA) for the number of benzodiazepines seized – 154, which amounted to 10% of all the benzodiazepines seized nationally (Home Office 2009).. When these seizure figures are converted to rates per million population, Cleveland PFA ranked first – 275 benzodiazepine seizures per million population, compared with a national rate of just 29 per million. Lastly, Cleveland PFA also ranked third (after Northumbria and Devon & Cornwall) on the quantities of benzodiazepines seized across the 40 PFAs of England – namely 23,800 doses (which amounted to 16% of all benzodiazepines seized in England in 2008/09). In short, official statistics indicate that Cleveland PFA had one of the largest illicit benzodiazepine markets in England in 2008/09, with about one in six of all the tablets seized in England being seized by police in Cleveland.

This official picture of high levels of benzodiazepine use in Cleveland is further supported by a needs assessment study of problem drug use in Redcar & Cleveland in 2009 (Redcar & Cleveland Drug Action Team, 2009). A snowball sample of 80 local people who had used drugs was interviewed, of whom 66 (83%) were current users, and 30 (38%) were presently in drug treatment. The sample included 45 people resident in Redcar, and 35 resident in East Cleveland and Eston Corridor. Among current users, benzodiazepines (*sleepers/wobblies*) were the second most commonly used drug (59%) after heroin (68%) - with the next two most prevalent drugs being methadone and alcohol (about four in ten users each). When asked about the number of days on which they had used each drug in the previous week, benzodiazepine users indicated an average of six out of seven days (compared with five days for heroin). The report concluded that “benzodiazepines and alcohol ... featured highly in reported daily use ... [and] are playing larger roles in people’s habits than people recognise” (2.7.2). Trends in the annual

prevalence of problem drug use and drug treatment cases in Redcar & Cleveland are presented in Appendix 1.

The number of drug-related deaths in Redcar & Cleveland DAT area in 2008 was reported to be nine – a rate of eight per 100,000 population (Goodman 2009). Even so, the number of fatal overdoses involving benzodiazepines in Redcar & Cleveland was relatively low (compared with opiate-related overdoses) – a total of six between 2006 and 2009, averaging 1.5 per year. More precisely, according to the Confidential Deaths Inquiry Coordinator for Redcar & Cleveland PCT (28th June 2010), the number of deaths involving benzodiazepines was three in 2006, zero in 2007, two in 2008, and one in 2009 . The two deaths in 2008 were poly-drug deaths: one involving prescribed diazepam, non-prescribed temazepam, and heroin; and the other involving non-prescribed diazepam and methadone. The death in 2009 was also a poly-drug death, involving non-prescribed diazepam and other unspecified drugs. Local newspapers have also presented articles about several local poly-drugs deaths since 2004 involving combinations of alcohol, benzodiazepines (notably diazepam or temazepam) and/or opiates (notably methadone, heroin or tramadol) (*eg, Evening Gazette, 11/12/08; Northern Echo, 11/12/08*).

## 1.3 Research methods

**Data-collection procedure.** In June 2010, the Team Leader of Lifeline Redcar, contacted Lifeline Publications to make arrangements for research into illicit use of benzodiazepines to be conducted. Staff at the agency then began asking service users who used benzodiazepines if they or any of their associates would be willing to participate in a focus group. In July 2010, Lifeline’s Director of Communications (ML), assisted by the director of independent drugs research agency 3D Research (RN), visited the premises of Lifeline Redcar to conduct focus groups with illicit users of benzodiazepines, along with short unstructured interviews with two members of staff. Three focus groups were conducted: one with five participants, and two with four participants each – making a total of 13 people. Each focus group was conducted in a private room on the premises of Lifeline Redcar, and began with an introduction from ML, who explained the purpose of the research

(to produce a publication for benzodiazepine users); and that participation was voluntary, confidential and anonymous. Focus group participants were asked about their personal experience of benzodiazepines, and their knowledge of benzodiazepine use among their friends and associates in the Redcar area. Using a pre-structured list of topics, ML prompted participants to give information about benzodiazepine use, and RN kept a written record of their responses (as well as making some verbal prompts). At the end of each session, participants were asked if they had any questions, thanked for their help, and given £10 each for their assistance. Each focus group lasted between 40 and 60 minutes.

**Participants.** All 13 participants were white adults living in the Redcar area. Their ages ranged from 18 years to around 50 years. The first focus group comprised four participants (P1 to P4) - three men and one (P4) woman. The second focus group comprised five young men (P5 to P9). The third focus group comprised four participants (P10 to P13) – three men and one woman (P13). Initial discussions with staff and service users confirmed that most participants and their drug-using associates were poly-drug users, with the most popular drugs - other than benzodiazepines and alcohol - being cannabis (notably *skunk*), amphetamine sulphate (*speed/wiz*), and/or heroin (*gear/smack*). Some participants also mentioned current or past use of cocaine (*sniff/coke*) and ecstasy (*Es/pills*) – as well as ‘legal highs’ such as mephedrone (*m-cat/meow*).

**Recording and reporting.** Participants’ responses were prompted using a pre-structured list of topics, designed to exhaustively cover the relevant information. The verbal responses were recorded by writing rather than tape-recorder (which could have inhibited honest responding and compromised our guarantees of confidentiality). As in any group discussion, there was a degree of mumbling and meshing which meant that some responses were not recorded. Similarly, the strong accents and local slang of some participants also led to the loss of a small amount of information – though clarification was usually sought in such circumstances. The two most talkative participants in the three focus groups were the two women (P4 and P13). In the Findings section, no distinctions are

made between the individual focus groups, and the 13 participants are referred to as P1 to P13. To indicate the extent of agreement on particular issues, the following quantifiers are used: all (13), most (7 to 9), around half (4 to 6), some (1 to 3), and no-one (zero). ‘All or most’ will also be referred to as ‘general agreement’ or ‘consensus’. The best and most useful responses of participants are quoted verbatim, including any slang or expletives. Lastly, the findings are organised under a series of headings derived from a conceptual model of harm reduction (Newcombe 1992, 2010).

## 2. Findings

The responses of focus group participants are presented and summarised under five broad sub-sections: social and historical context, consumption, effects, harmful consequences, and interventions. Several sub-headings are also used within each of the five main sub-sections to present information about particular topics.

### 2.1 Social and historical context

This section covers the local illicit market for benzodiazepines, the type of products available, and the history and extent of use of these drugs in the Redcar area.

**Illicit markets and products.** Asked about their own use of benzodiazepines and what they knew about use of these drugs among their associates in Redcar, participants of each focus group quickly made it clear that use of these drugs was almost entirely restricted to diazepam. Only two other benzodiazepines were mentioned - temazepam and nitrazepam - which were only rarely available (usually ‘diverted’ from older people being prescribed them). Some participants also reported local illicit use of the z-drug zopiclone (*Zimovane/zimmies*), which previous research has found to be the most popular hypnotic drug in Middlesbrough after the three benzodiazepines mentioned above (Newcombe 2008). One participant also stated that some local drug users had recently been taking dipipanone (*Diconal/pinkies*), a prescribed opiate drug with similar sedative and analgesic effects to heroin.

Lastly, some participants were also using methadone, either on prescription or illicitly.

There was general agreement that several different **types of diazepam** had been available over the last two or three years, and that *“five or six types are available at the moment”* (P11). The typical product was a 10 mg blue tablet, with either ‘Roche’ or ‘Mano’ printed on it, though there were different types of each brand available. Occasionally, standard 2 mg (white) and 5 mg (yellow) tablets were also available. Some participants, notably P2 and P4, also reported that a type of white diazepam tablet was sometimes available which dealers claimed contained 20 or 30 mg of diazepam. Though all diazepam tablets were invariably round and of fairly small size, the colour of 10 mg blues was reported to vary from light blue to dark blue, while the tablet material of blues and whites varied from crumbly and dusty to hard and gritty. The main slang names for diazepam tablets were *vallies*, *diazies* or *wobblies* - or *blues*, *whites* and *yellows* to indicate tablets by their specific colour - while vaguer terms included *tabs* and *pills*. In addition, specific batches of tablets were sometimes given their own slang names – notably the current dark blue tablets known as *‘charge sheets’*. Lastly, although blue 10 mg diazepam pills marked ‘MSJ’ were commonly available in the North-West during 2010, none of the Redcar participants mentioned MSJs in the focus group discussions.

Some participants (including P1, P7, P9 and P10) were currently receiving prescriptions of diazepam. Since most of these prescriptions were for relatively small daily doses (about 5 mg to 25 mg per day), the typical participant with a diazepam *script* misused them by taking several days’ doses at the same time. However, there was general agreement that doctors were now very reluctant to prescribe benzodiazepines – particularly to suspected drug users/dealers – and so the main **source of diazepam** in Redcar was local drug dealers. Dealers were believed to mostly obtain their stock by ordering them from ‘online pharmacies’ (websites), though some were thought to travel abroad to countries where they could be bought from pharmacies without a prescription – such as Thailand, India and Turkey. Some participants claimed that some local dealers operated by ordering small amounts of diazepam tablets from several

websites, and once they had established which website companies were providing ‘genuine’ tablets (i.e. having a tranquilliser-like effect), they then *“stuck to that site and ordered much larger amounts”* (P11). There was also general agreement that diverted prescribed diazepam tablets (i.e. buying them off people getting them on prescription) was only a rare source for most users.

There was also general agreement among participants that many if not most batches of diazepam being sold in Redcar were **fakes** (‘duds’), containing no or very little diazepam: *“you can take 20 of them, and get no effect at all”* (P4). Some participants believed that counterfeit tablets were much more likely to have been made by local or at least British people – *“by dodgy dealers in their kitchens or bathrooms”* (P1) - rather than imported from abroad or purchased online. There were many different views as to which kinds of tablet were of the highest and poorest quality, with distinctions made on the basis of their visual/physical characteristics – notably colour, size, texture and markings. For instance: *“the white ones are OK, but the blues are usually shit”* (P2); *“my mate got busted for a load of dark blue tablets, but when the police analysed them there was no diazepam in them”* (P1); *“the dusty blues work best – people will buy just the dust from the bottom of the dealer’s bag”* (P3); *“the Roche ones don’t work, the Manoes are the best”* (P4); *“the Manoes are the dodgiest ones”* (P6); *“the small ones are more likely to give you a decent hit than the bigger ones”* (P11). However, the view of one participant may have best reflected the true situation: *“it just depends on the particular batch – who made them, or where they are from”* (P5).

Participants also expressed a variety of opinions about the type and toxicity of the **adulterants** added to weak or fake diazepam tablets: *“duds are cut with rat poison and animal shit”* (P1); *“a lot of the vallies going round at the moment are just chalk dyed blue”* (P10); *“some dealers will sell you any blue tablets they can get their hands on”* (P2).

Following periods in which only fake or weak tablets were available, ‘word soon got round’ when a good batch of diazepam tablets had become available: *“fights break out on the street among kids eager to get hold of them*

and get off their heads” (P4); “thanks to mobiles [phones], when a boss batch of blues turns up, it’s common knowledge within an hour” (P8).

The **typical price** of one 10 mg diazepam tablet (*blue*) was generally reported to be about £1, though costs were also affected by their quality, and bulk purchases resulted in a cheaper unit cost. For instance: “you can get 50 blues for £25 to £50” (P4); “you can pay £250 for 1,000” (P11). Overall, participants’ comments on the price of diazepam tablets indicated a unit cost of about 25p to 50p for bulk purchases.

**History and prevalence of use.** There was broad agreement that the illicit use of diazepam in Redcar was now at an all-time high, and that levels of use had begun rising about five years ago (2005), reaching a peak over the last three years (2007 to 2010): “everyone round here is doing vallies now” (P6); “they are used across the board now, even by young teens” (P11). However, most adult users had moral scruples about selling diazepam to anyone younger than teenagers: “one guy was selling them to 11 and 12 year olds, and people grassed him up ‘cause it’s wrong to sell them to kids” (P4). Most participants agreed that diazepam tablets were now very easy to get hold of in Redcar: “tabs are easier to get than gear” (P9); “I picked some up on the way here” (P8). Among participants who commented on the popularity of diazepam (about half), there was general agreement that it had become the most popular drug in Redcar after cannabis and amphetamine (speed), and was more popular than cocaine and ecstasy. This seemed to be at least partly because it was used across a variety of drug scenes: “it has different uses for different people or places – helps you get a gouch off gear, smooths the come-down off wiz, and loads of people get a buzz by mixing it with booze, and going partying or grafting” (P12). The different reasons for using diazepam are discussed more in the next section.

## 2.2 Consumption

**Reasons for use.** Reasons for using drugs can be divided into three chronological types: reasons for starting, reasons for continuing, and reasons for ceasing (or reducing) use. The reasons given for starting to use benzodiazepines were similar to those given by users of recreational drugs in other research

- including curiosity, liking the effects of drugs, and having nothing else to do – though specific reasons given by those prescribed diazepam included controlling anxiety and depression. Also, the poor quality of other illicit drugs in Redcar – notably heroin, cocaine and ecstasy – had led many local drug users into taking ‘legal highs’ and/or illicit hypnotosedatives instead. For instance, one heroin-using participant stated that “the gear around here is shit - I tested positive for Valium when I was just using gear – because it had no heroin in it, just diazepam” (P4). Similarly, several participants pointed out that local heroin users often took diazepam at the same time as heroin “because the gear is so weak, and the only way of getting a mong off it is to top up with a load of vallies” (P1). Though participants indicated various ages for when they first tried diazepam, the typical age was probably around 14-15 years.

The main reasons given for continuing to use benzodiazepines included pleasure (wanting to repeat a desirable/fun experience) and developing a habit (craving and avoiding withdrawals). There was general agreement that younger drug users in Redcar regarded diazepam tablets as recreational drugs like ecstasy and speed, and either used them for a ‘buzz’ when having fun or partying, or as a way of reducing the come-down from use of stimulants: “I used to take them at school to help me come down off wiz” (P5); “clubbers use them to come down off Es and sniff” (P6). One heroin-using participant commented that young drug users “shout ‘smackhead’ at you on the street while they are off it on blues – they reckon that blues are totally different from smack and don’t give you a habit” (P4). The reasons for ceasing or reducing use were not explored in depth (mostly because the typical participant had not yet reached this stage), though some participants mentioned that many local users were being ‘put off’ by the high levels of fake tablets being sold, and/or because of increasing tolerance to the effects.

**Settings of use.** The settings in which diazepam was taken were very varied - notably people’s homes, but also many public places, from pubs to parks. In short, diazepam was often used as a ‘backdrop’ buzz to everyday life - though see ‘Reasons for use’ (above) and ‘Mixing with other drugs’ (below). Also, the settings of use often change as diazepam

use develops into a habit: *“it starts off as a social thing with your mates, but can end up as isolation as the habit takes hold, either because they want all the vallies for themselves, or because no-one can stand being with them any more”* (P11).

**Methods of use.** Diazepam tablets were nearly always consumed by swallowing them, though one participant (P7) mentioned that he sometimes “sucked” them to get a quicker effect. Many participants indicated that they knew people who had tried injecting diazepam, but only two admitted having injected diazepam themselves: *“I was injecting eggs and wobblies at first, but stopped because it was messing up my arms and my head”* (P5). However, the general view was that most injectors only tried ‘shooting up’ diazepam for a short while, because *“it’s too hard to cook them up - they jellify and block the pin”* (P2) – and because the insoluble materials in the tablets *“wrecks your veins”* (P8). There were no reports of people smoking or sniffing diazepam.

**Amounts used.** Many participants stated that when people first tried diazepam they were effective in fairly small doses: *“new users can get off on around two to five blues”* (P8); *“I’ve been off them for a while, so now I only have to take four or five blues to get wrecked”* (P6). However, there was general agreement that regular and habitual users usually ‘necked’ anywhere between 10 and 100 tablets to get the desired effect – partly due to tolerance, and partly because so many batches were weak or fake: *“I took 120 mg this morning before cycling here”* (P7); *“I can take 20 blues and get nothing at all”* (P4); *“I usually take about six for a buzz, but two or three times as many if I’m going grafting”* (P5); *“when I get my script off my doctor, I can take all 28 tablets in the same day, but when I take the street blues I can do up to 80 and get less effect”* (P9); *“I once took 600 blues in one week”* (P4); *“most daily users on a binge have to double the dose every two or three days”* (P8).

**Frequency of use.** All participants began as experimental/occasional users of benzo-diazepines, but at least half had quickly progressed to regular recreational use of diazepam. Some participants reported that they were now daily users, while most of the others had either been daily users in the past, or had

friends or associates who were daily users (see: Dependence). Most participants stated that they usually took all the tablets they had purchased in one ‘go’, though some preferred ‘stacking’: *“I take half a dozen to start, then every hour or two I take five to ten more”* (P5); *“I usually take about 25 to 50 blues in one go, then I eventually fall asleep, and when I wake up I take more straight away – you think that just 10 minutes has passed, but it could be five or six hours”* (P4).

**Mixing with other drugs.** As noted earlier, participants and their associates were mostly poly-drug users – meaning that they had a repertoire of recreational drugs which they used for different purposes and in different settings (and depending on availability). But it also became clear that most participants were multi-drug users – meaning that they used two or more drugs during the same session (evening/night/day) of drug use. There was almost total agreement among participants that the drug most commonly ‘mixed’ with diazepam by themselves and other local users was alcohol, *“because it gets you totally off your head”* (P4); *“you get a much better hit when you use vallies with alcohol”* (P3); *“I always take blues and booze together, because it gives you the best buzz - it wipes you out”* (P8); *“if you’ve got a habit on vallies, you have to drink on top of them to get any effect”* (P10).

Many participants stated that another drug often taken at the same time as diazepam was heroin, mainly because *“taking blues on top of the shit gear you get round here helps you get a decent mong off it”* (P9) – but also because *“gear is often cut with crushed-up diazepam anyway”* (P4). Although diazepam was regarded as a good drug to reduce the come-down (after-effects) of stimulant drugs, participants disagreed about the effects of using amphetamine and diazepam at the same time: *“lots of people like taking wiz with vallies, because you are more in control that way”* (P10); *“wobblies and wiz together ain’t a good idea, your head is all over the place”* (P7). Diazepam was also taken at the same time as cannabis, mainly because cannabis was the most popular drug and was smoked throughout the day by many local drug users, and so it *“just happened by chance”* (P10).

## 2.3 Effects

Almost all of the effects and consequences of diazepam use reported by participants mirrored those described by users of zopiclone in Middlesbrough in earlier research (Newcombe 2008): *“the only real difference is that zimmies are less likely than vallies to be duds, and they taste terrible”* (P8). Some participants also believed that the effects experienced were heavily influenced by the setting and context of use: *“it’s all down to the situation and the people you are with”* (P10).

**Physical effects.** The main physical effects of diazepam intoxication included:

(a) the face: constricted pupils, shiny eye-whites, narrowed eye-lids, staring blank expression, and dry mouth and lips;

(b) the body: muscular relaxation (slouched posture), lack of coordination (staggering gait, clumsiness), and slower movements.

Most participants agreed that they could recognise someone high on diazepam by their **appearance** as well as their behaviour: *“their eyes look glazed and shiny, like glass”* (P3); *“your eyes go pinned too, and bright blue like a Husky dog”* (P2); *“they get blue flecks at the corners of their lips”* (P1); *“the blue dye comes off on your hands, and you can end up with blue lips too”* (P13).

‘Wobbly’ and ‘wobbling’ were the most commonly used terms to describe the effects of diazepam on bodily **coordination** – followed by phrases like ‘crashing around’ and ‘bouncing off the walls’: *“you know when the vallies have kicked in because when you stand up you start wobbling about everywhere”* (P3); *“you might knock someone over and bounce off the walls, without realizing it”* (P4); *“my sense of balance goes completely, and I start crashing around”* (P10); *“I get real clumsy, and keep letting ciggies drop from my hand”* (P13). Some participants also referred to the **slowed-down movements** of people on high doses of diazepam, and observed that even simple activities took longer to complete than normal (eg. unpacking a bag, rolling a cigarette). In the worst cases, heavily intoxicated diazepam users assumed strange frozen postures, or just stared blankly ahead or at the floor - *“like you are in a*

*trance”* (P12); *“like a zombie”* (P8); *“they go into their own slow-mo world”* (P11).

Most participants also agreed that their **appetite** was usually boosted when using diazepam: *“you get bad munchies on them, especially for sweet things”* (P2); *“I’m always snacking on them”* (P4); *“they reduce your sense of taste, so you can eat just about anything”* (P12). Around half of participants also mentioned that they felt thirstier than usual after taking diazepam – though this could also be attributed to the dehydrating effects of the alcohol they usually consumed with diazepam.

**Psychological and behavioural effects.** The three stages of drug effects are: onset stage (as the drug comes on), main stage, and residual stage (as the drug wears off) – with the after-effects (typically coming on the next day, after sleeping) usually referred to as the ‘come-down’. After swallowing, the onset of the effects of diazepam usually took about 10 to 20 minutes to come on, and then lasted anything from two to 12 hours - depending on the dose, their potency, what drugs they were mixed with, and individual factors (tolerance etc.). The mental effects were reported by most participants to start with a noticeable lift in mood, and *“a sudden desire to rattle on, like with speed”* (P12). As regards the main effects, diazepam almost invariably made people feel less anxious or depressed, with intensified feelings of happiness, relaxation, disinhibition and/or sedation: *“you get some momentary bliss in a life of worries and boredom”* (P1); *“it’s like being drunk, but weirder”* (P5); *“you start to feel monged out, like with gear”* (P13).

However, diazepam can lead to other **emotional responses** becoming stunted - particularly negative moral feelings such as shame and guilt. The notable exception to this emotional blunting are spontaneous outbursts of aggression - especially when large doses of diazepam were taken or used together with alcohol: *“when you drink on top of vallies it can make you really violent ... once I tried to stab my friend with some scissors, just because he laughed at me”* (P4); *“it’s easy to flick over to aggressive if someone winds you up when you’re on blues and drink”* (P5); *“arguments can start easily in the wrong company – one moment things are OK, the next moment it’s chaos”* (P10); *“nice quiet people can turn really*

*nasty, like Jekyll and Hyde*" (P12) [see Harmful Consequences].

Significant reductions in perceptual, thinking and memory skills were mentioned by almost all participants as hallmark effects of diazepam intoxication. These **cognitive deficits** included fuzzy vision, lack of concentration, distractability, confusion, failing to complete plans, forgetting what was being said or done, and having difficulty with everyday tasks such as operating electronic devices like telephones and computers. But the cognitive deficit which produced the most animated discussion, and which generated the most striking anecdotal tales, was **amnesia**: "*when you take enough vallies, you can easily lose a whole week*" (P3); "*I give my kids their pocket money, but they clock on that I'll forget about it when they see that I'm on blues, and they'll ask for it again*" (P4); "*you could kill someone and not even know that you had done it*" (P8); "*you can put your wallet down and then spend half an hour looking for it*" (P12); "*my mates say they saw me in Tesco arguing on and on about chicken nuggets with some poor till-woman, but I can't remember it at all*" (P11).

However, participants' were in general agreement that there were two 'classic' signs of diazepam intoxication apparent in users' behaviour: an increase but deterioration in the content and production of speech (talking nonsense), and acting under the influence of delusions (crazy behaviour). As regards the first sign – **incoherent speech** (*babbling*) – participants provided many illuminating comments, of which the most notable included: "*we know that we talk a lot of crap on vallies, but though it just sounds like doped-up babbling and total shit to other people, we know what we are saying to each other because we are used to talking like that*" (P4); "*people on blues think they are talking normally, but they're all talking over each other, and it's the biggest pile of waffle you've ever heard*" (P12).

The second most salient sign of serious diazepam intoxication, particularly when it was used with alcohol, is the **delusion** – a false belief which would seem very strange to an unintoxicated person. For instance: "*a few weeks back, I took a load of blues after smoking gear, and I just kept thinking that I was back in my jail cell – I lost track completely*" (P9).

The most common 'diazepam delusion' was the delusion of **invisibility**, which combined with 'false confidence' manifested itself in various ways: "*you go shoplifting and think that you are being really clever and that the security guys can't see you, but you really stand out*" (P1); "*you move round in your own private bubble, all your problems gone, and thinking no-one can see you*" (P7); "*I was visiting my friend at her house, and because I was off my face on blues and didn't give a fuck about anything, I decided to nick her laptop – I thought that she wasn't looking when I did it, but she saw everything and was going to call the cops, so I had to give it her back*" (P7) [see: Harmful Consequences]

Indeed, one of the most salient aspects of these diazepam derangements and delusions is **lack of reflexivity** (secondary consciousness). That is, normal self-monitoring of ongoing behaviour, awareness of changes in your surroundings, and thinking about how you are coming across to other people are significantly reduced or even eliminated. This can result in bizarre, spontaneous and/or unpredictable behaviour: "*you do stupid things, totally out of character*" (P3); "*you think you are acting normal when you aren't – once I thought I had been talking to my Mum, but the next day I found out I'd been talking to my Dad*" (P4); "*you become oblivious to what anyone else is doing*" (P1); "*you think you feel alright, but you are really off it, you can't even walk or talk properly*" (P7); "*you never think about what you are doing, you just do it – no planning before and no memory after*" (P8).

Participants' expressed different views about the effects of diazepam on **sexual desire**, experience, and performance. For instance: "*blues can make you feel horny*" (P2); "*I've no interest in sex at all on them*" (P10); "*you can go at it for hours on blues, just like with gear*" (P3); "*On wobblies I have trouble unzipping my jeans, let alone screwing*" (P12).

The **residual** stage of diazepam intoxication mainly involved falling into a deep sleep for many hours. After sleeping, some users reported experiencing regular diazepam **come-downs**, some only occasionally, and some not at all. Come-downs usually consisted of feeling fuzzy-headed, 'rough' and 'edgy' for several hours. The duration and intensity of come-downs is probably determined by such

consumption factors as amounts used, methods of use, and other drugs used. Come-downs were also restricted to non-dependent users – those who had become dependent on diazepam were more likely to experience post-intoxication withdrawals lasting several days or weeks, rather than a come-down lasting less than a day.

## 2.4 Harmful consequences

The main harmful consequences of diazepam use which were reported by participants can be summarised under four headings: dependence, overdose, health damage and social problems.

**Dependence.** There was general agreement that using diazepam generally led to physical dependence (craving and withdrawals) within about one month of daily use, though some regular users claimed they had never experienced withdrawals: *“I’ve never rattled after running out of blues, even after using them every day for months – probably because most of them are duds or really weak”* (P3). Some participants reported current dependence on diazepam, and some reported having been dependent in the past, while most stated that they knew people who had developed a diazepam ‘habit’. A ‘habit’ was defined by participants as involving consumption factors like daily use and heavy use; by psychological indicators like craving and tolerance; and by behavioural indicators like taking diazepam to the exclusion of other activities, or continuing regular use despite experiencing significant health problems (notably injuries) and social problems (notably crime). One participant claimed that *“addiction to diazzies is more common round here than heroin addiction”* (P10).

There was a consensus that the clearest sign of a diazepam habit was **withdrawal symptoms** when someone stopped ‘necking blues’ after regular use. Numerous withdrawal symptoms were mentioned, but the most frequently mentioned mental symptoms included anxiety, agitation, panic attacks, fatigue, insomnia and nightmares; while the most commonly mentioned physical symptoms included stomach cramps, vomiting, sweating, muscle aches, tremors/shakes and palpitations. As one participant put it: *“it’s like a nervous breakdown, food poisoning and flu all at the same time”*

(P2).

The severity and long duration of diazepam withdrawals was emphasised by several participants: *“benzoes are much harder to get off than heroin”* (P1); *“it took my doctor two years to wean me off diazepam, reducing me by 2 mg each week – even then the withdrawals were still unbelievably horrible, just unreal”* (P13). She added *“I’ve also come off smack and coke, but the diazepam rattle was much much worse – I felt so crazy I wanted to do myself in, and ended up smashing my house up”* (P13). Another participant, who reported having had an intermittent diazepam habit for four years, stated that *“if I stop taking wobblies and go cold turkey, I go through about seven days of total hell, and then it’s still many more weeks before I feel OK again”* (P10).

**Overdose.** Participants were in general agreement that overdoses on diazepam usually occurred when it was mixed with alcohol or other drugs: *“There’s no chance of O’Ding when you take vallies on their own”* (P4); *“taking gear and blues together is more likely to cause overdoses”* (P2); *“it’s drinking booze on top of blues that does people in”* (P12). Participants in the first focus group discussed a recent case in which a local diazepam user was found dead: *“the papers said that he had O’Ded on blues and booze”* (P4) [see Section 1.2]. Some participants also commented that using large doses of diazepam after a period of abstinence may also explain some overdose cases – for instance, when someone *“leaves prison and necks a load of blues when their tolerance has dropped off”* (P10). Another factor thought to increase the risk of diazepam overdose was the huge variation in the potency of different batches from week to week: *“you might pay the same price for the latest batch of pills as you did for the last batch, and they might even look the same – but whereas taking 50 of the previous batch did nothing for you, you take 50 of the latest batch and end up O’Ding”* (P1).

Even so, only one of the 13 participants admitted that they had ever personally required hospital treatment for an overdose on diazepam (combined with other drugs): *“I’d taken blues to come down off a 3-day wiz binge, and while I was off my head I shot up heroin and O’Ded – no-one could wake me, and I ended up in hospital, and the doctor gave me a shot*

*in the arse and I came round” (P7). Another participant (P9) reported that he had overdosed on diazepam once, but recovered without hospital treatment (he had become unconscious with his friends initially unable to wake him, but he gave no further details of this incident).*

**Health problems.** Damage to health mainly involved injuries arising from violence and accidents, rather than diseases: *“I leaned on a double-glazed window, and put my hand right through it, cutting it to shreds – but I didn’t feel a thing at the time” (P8); “I woke up with cuts and bruises all over my hands, and when I asked my mate what had happened he told me I had been fighting with him” (P9). One participant attended the focus group on crutches, and when asked how he came about his injuries he replied that “I was off my head on blues and on my way home about midnight, when I suddenly had this thought that a mate had some gear, so I rang his bell loads but there was no answer, so I tried to get into his flat by climbing a drainpipe, but fell off and broke my leg” (P5).*

**Social problems.** The most salient effects on social behaviour involved crime, particularly offences involving stealing, disorder, and aggression –and especially when diazepam was used at the same time as alcohol: *“blues and booze equal trouble” (P1); “you have no morals on blues and drink” (P7); “the blues around right now are called ‘charge sheets’ because when you mix them with alcohol you usually end up doing something which gets you nicked” (P9). Many participants provided descriptions of spontaneous violent or acquisitive crimes by themselves or friends while under the influence of diazepam and alcohol: “you don’t plan crimes – you just neck the blues and drink, get off your head, then suddenly go grafting to make more money to get more blues” (P6); “I woke up with over £100 in notes and several watches scattered around me, with grazed knuckles and cut hands – but I have no idea what I had done or where this stuff came from” (P4); “a cop tried to nick me, so I jumped on him and kept hitting him – they threw me in the van, so I quickly necked the rest of my blues, and woke up six hours later in a police cell” (P5). There was general agreement that it was best to avoid driving while using diazepam, though some users had learned this lesson the hard way: “my mate just smashed his car up while off his head on blues” (P8).*

Diazepam use had also caused problems for most participants in their **relationships** with other people, particularly family members and partners: *“my Mum says to me that when I am on wobblies I act like a total knobhead – when I deny it she says ‘you can’t tell me you’ve had nowt because you look off your head ... she says she would prefer it if I went back to using smack, because I was less trouble, less messy and more chilled out then” (P7); “my girlfriend says I look awful on them, and that I get nasty and act like a dickhead” (P8); “my brother won’t come near me if I’m on the blues” (P2).*

## 2.5 Interventions

As noted earlier, several participants were being prescribed diazepam by doctors (though the reasons were not made clear), and only one participant had reported needing hospital treatment for overdosing. Some participants mentioned that they had sought and been given useful advice about their diazepam use from staff at Lifeline Redcar, and all participants indicated that they were interested in obtaining more information about the effects and risks of diazepam and other benzodiazepines

When asked what they thought were the best ways of getting information about diazepam to current and potential users, and who the main target groups should be, almost all participants agreed that the focus should be on teenagers and secondary schoolchildren, and about half thought that cartoon formats and/or communications technology were the best ways of putting the information across: *“you should focus on the young kids, because they know the least” (P1); “most of them don’t even know that blues are habit-forming, and are likely to turn to gear when the blues run out” (P4); “you should use cartoons and pictures to get the information across” (P12); “cartoons would be best because kids are more likely to look at them than leaflets which are just all words” (P2); “I can’t read, so leaflets would be no good to me” (P8); “you should get ex-users to go into schools, to talk to them about the bad side of using blues” (P6); “you should get the information across on Facebook and the Internet, and mobiles and Ipods too” (P7); “you could reach the kids most at risk through children’s services, schools and hostels” (P13).*

Asked what kind of advice would be most useful

to people using diazepam or at risk of using it, several suggestions were made: “never inject them” (P4); “don’t mix it with gear, don’t drink on top, and don’t do it alone” (P7); “show them the scary side of doing wobbles, like falling on your face and losing your teeth” (P6); “provide drawings and photos of the tablets, to help people identify them” (P10). Lastly, most participants in the third focus group agreed that the best way of reducing the risks of diazepam use would be “to legalize them, because it would be less harmful if people were using proper ones from the chemist rather than the crap that’s being knocked out around here” (P11).

### 3. Conclusions

The conclusions of this report focus on the core advice which users of diazepam need to be given – both by drug agency staff, and in publications aimed at continuing users of this new drug. To summarise and organise this advice, the Risk CAMP-MAP model will be utilised (Newcombe 1992, 2009). This model categorises advice and information about safer drug use under seven types of risk - context of use, amounts used, methods of use, patterns of use, mixing drugs, access to drugs, and the product itself – which are directly linked to the four main types of harmful consequence, notably: dependence, overdose, health damage and social problems.

Advice on safer drug use should always start with the same key point: if you want to avoid any risk or harm from using a drug, then do not start using it. However, given that many people are clearly intent on continuing to use illicit diazepam for the foreseeable future, we conclude that the following advice on safer use should help reduce harm to current users.

**Context of use:** diazepam users should avoid using on their own or with strangers (i.e. use with friends), and avoid putting themselves or others at risk while intoxicated – particularly by avoiding driving, operating machinery, using tools, cooking, and looking after children. Diazepam affects driving skills like braking speed as much as if not more than alcohol – and it is a criminal offence to drive when intoxicated on diazepam or any controlled drug.

Diazepam users should take special care when smoking – dropped lit cigarettes causes fires. The safest place to take diazepam is at home or in a friend’s home.

**Amounts used:** new or occasional users should get an optimal effect from taking one or two 10 mg tablets – taking any more than five tablets is likely to result in deep sleep rather than a happy buzz. Daily or regular users will develop tolerance, meaning that they will need higher and higher doses to get the same effect – though they should remember that if they abstain from using for a while (eg. while in prison, during a drought), their tolerance will quickly drop off, and they should start off by using smaller doses again. When a new batch of diazepam tablets is on sale, users should check with friends (not the dealer) how strong they are before taking any. The motto to keep in mind is: ‘you can always take more, but you cannot take less’ (i.e. once you have swallowed them).

**Methods of use:** swallowing is the safest way of using diazepam. Injecting tablets is very dangerous and will soon damage veins – but if someone does plan to inject diazepam or any drug, they should get advice and help from their local needle exchange scheme.

**Patterns of use:** the best way to avoid becoming physically dependent on diazepam is not to use it every day – daily use can lead to a habit and withdrawals within two or three weeks. Even using on most days of the week can lead to a habit after one or two months.

**Multi-drug use (mixtures):** many if not most of the problems caused by diazepam arise when it is taken at the same time as other drugs – particularly depressant drugs such as alcohol, sedatives (eg. zopiclone) and opiates (notably heroin or methadone). The safest way of using diazepam is to take it by itself, and particularly to avoid mixing it with alcohol or opiates. When used to come down off stimulants (such as amphetamine or ecstasy), or to deal with bad trips on hallucinogens (eg. LSD or magic mushrooms), one or two 10 mg tablets should be sufficient.

**Access:** prescription tablets are the safest, because they permit the user to know what dose they are taking, and they do not

contain any adulterants. However, doctors are increasingly reluctant to prescribe benzodiazepines, so the main sources used by dealers are the internet and importations from other countries – rather than diverted pharmaceutical supplies. Also, some tablets are made illegally by criminal gangs, both in Britain and abroad. All sources other than prescribed tablets are more likely to contain variable doses, other drugs, and toxic adulterants (including blue dyes).

**Products:** prescribed diazepam tablets in Britain come in three forms, and can be identified by their colour: 2 mg (white), 5 mg (yellow) and 10 mg (blue). Prescribed diazepam in Britain is often generic and so, apart from a scored line on one side, will be unbranded and unmarked (i.e. there are no words or symbols on the tablets). Even so, genuine diazepam tablets may still be imprinted with brand names such as 'Roche', 'Mano' or 'MSJ' - though these may have been imported, i.e. not dispensed by community pharmacies in Britain. Non-round tablets, crumbly tablets, and those which transfer blue dye to the hands or lips are the most likely to be fakes and to contain adulterants.

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## Appendix 1: Drug prevalence and treatment statistics for Redcar & Cleveland

**Table A: Annual prevalence of problem drug use, and rates among 15-64s**

	Numbers				Rates per 1,000			
	PDU	Opiate	Crack	IDU	PDU	Opiate	Crack	IDU
2004/05	1326	990	309	427	14.9	11.1	3.5	4.8
2005/06	930	812	391	490	10.5	9.1	4.4	5.5
2006/07	957	792	330	412	10.6	8.8	3.7	4.6
North-East					9.4	8.0	4.3	4.1
England *					9.8	8.1	5.4	3.5

**Table B: Annual number of drug treatment cases, and retention rate**

	Number	Retained (%)
2003/04	451	77/188 (41)
2004/05	474	92/162 (57)
2005/06	516	148/199 (74)
2006/07	597	153/195 (78)
2007/08	786	189/274 (69)
2008/09	834~	

### Notes

Years are financial years (April 1st to March 31st).

PDU = problem drug user IDU = injecting drug user

Opiate = mainly heroin Crack = cocaine freebase

Table A: the annual statistical reports compiled by the Centre for Drug Misuse Research (Glasgow) and the National Drug Evidence Centre (Manchester) provide estimated ranges for four groups of problem drug users – all PDUs, opiate users, crack-cocaine users and drug injectors - in the 15-64 year old age range. These ranges are based on 95% confidence intervals, and are the source of the mid-point estimates in this table.

The annual reports also break down figures by three age-bands: 15-24, 25-34 and 36-64.

\* The regional (North-East) and national (England) rates are for 2006/07.

Table B: retained = number of persons remaining in treatment for 12 weeks or more / [out of] number of *new presentations* (i.e. persons who started a treatment journey during that year). % retained was based on a different denominator in 2003/04 and 2004/05 (i.e. *number discharged*) ~ 834 aged over 18 years (678 in effective treatment)

### References

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## Appendix 2: Annual number of prescriptions for hypnotosedatives dispensed in England, 2007 to 2009 (thousands)

### (a) Benzodiazepines

	<u>2007</u>	<u>2008</u>	<u>2009</u>
diazepam	4723	4863	5014
temazepam	3255	3122	2969
nitrazepam	1250	1173	1101
lorazepam	882	899	931
clonazepam	474	521	575
chlordiazepoxide	273	259	240
clobazam	148	160	174
oxazepam	189	180	172
loprazolam	108	104	96
midazolam	55	67	95
lormetazepam	119	92	72
alprazolam	<1	<1	0
flurazepam	0	<1	0
<b>Total</b>	<b>11476</b>	<b>11440</b>	<b>11439</b>

### (b) Z-drugs

	<u>2007</u>	<u>2008</u>	<u>2009</u>
zopiclone	4415	4692	4993
zolpidem	687	696	712
zaleplon	32	29	28
<b>Total</b>	<b>5134</b>	<b>5417</b>	<b>5733</b>

**Source:** NHS: Prescription Cost Analysis (PCA) system (prescribed in UK, dispensed in England). Includes hypnotics and anxiolytics. Numbers are thousands, rounded to nearest thousand.