Medway Clinical Commissioning Group

Benzodiazepine Prescribing Guidance – Primary Care

Prescribing Guidance

Medway Clinical Commissioning Group

Version 3

Version	Date	Amendments Made
Version 1.0	23/3/2018	Approved by Medicines Optimisation Group with amendments to patient agreement
Version 2.0	April 2018	Changes made to layout
Version 3.0	October 2018	Changes made to reflect comments following approval from Commissioning Committee May 2018. Addition made to summarise guidance from NICE and deprescribing.org (Page 8).

SUMMARY

- **Benzodiazepines should only be prescribed for SEVERE anxiety or SEVERE insomnia for short time treatment.**
- **Make sure your records reflect**
  - **Your assessment**
  - **Clinical indications**
  - **Management plan when prescribing**
  - **Ideally contraindications when your assessment deemed the patient UNSUITABLE for initiation or continuation of Benzodiazepines.**
- **Avoid In case of elderly patients (>65), and if given then only half the normal dose should be prescribed.**
- **Chronic users should be identified and measures taken to reduce dependency in such patients.**

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Benzodiazepine Prescribing Guidance

Background

Benzodiazepines are the most commonly used anxiolytics and hypnotics; they act at benzodiazepine receptors which are associated with gamma-amino butyric acid (GABA) receptors.

Prescribing of benzodiazepine drugs is widespread but dependence (both physical and psychological) and tolerance occur. This may lead to difficulty in withdrawing the drug after the patient has been taking it regularly for more than a few weeks; therefore prescribing should be for short courses only.

Prescribing Guidance and rationale

1. **New prescriptions for benzodiazepines should only be issued for short-term relief (no longer than four weeks) of severe anxiety or insomnia – There should be NO REPEAT Prescribing.**
    - Where possible, use alternatives to benzodiazepine therapy and direct patients to non-pharmacological interventions; consider talking therapies (IAPT).
    - Benzodiazepines are indicated for the short-term relief (2-4 weeks) of anxiety that is severe, disabling, or causing extreme distress.
    - Benzodiazepines should only be used for the treatment of insomnia when it is severe, disabling, or causing extreme distress.
    - Prescribe small quantities and do not issue further prescriptions without consultation.
    - All benzodiazepine prescribing should be on an acute prescription – this should be part of practice policy.
2. **The patient record must show that patient has been given appropriate advice on the risks, including the potential for dependence.**
    - There is a risk of dependence with benzodiazepines, even at therapeutic doses.
    - Do not prescribe benzodiazepines in someone with a history of misuse and dependence.
    - Chronic use (even at therapeutic doses) may lead to the development of physical and psychological dependence.
    - Record diagnosis/reason for prescribing using appropriate read codes.
    - Patients should be advised of the risk of dependence and impaired reaction times, that this may affect ability to drive or operate machinery. Also advise that the effects of alcohol may be exacerbated.
3. **The patient record must show that patients prescribed benzodiazepines are reviewed regularly.**
    - The initial review upon completion of the first prescribed course should assess response to the treatment(s) and reinforce non-drug treatment(s).
    - When prescribed as a hypnotic, where possible advise intermittent use.
    - A recent government report on drug misuse and dependence recommends that all patients receiving a benzodiazepine prescription be reviewed regularly, on at least a three-monthly basis.
    - Offer and regularly re-enforce self-help advice in addition to drug treatment.
4. **The records show that, if the patient is aged 65 or over, they or their carer(s) have been given advice on the risks.**
    - Hypnotics should be avoided in the elderly, who are at risk of becoming ataxic and confused and so liable to fall and injure themselves.

- Doses of diazepam for elderly (or frail patients) should not exceed half those normally recommended

5. **Chronic users (use of 4-8 weeks or longer) should be identified and encouraged to reduce.**
    - Having tried all the above measures, there will be a cohort of individuals where planned reductions, sleep hygiene measures and other support have not been effective.
    - Make practice policy not to put benzodiazepines on repeat prescription.
    - This cohort will be made up of individuals with longstanding and enduring mental illness and/or individuals with a significant past/current substance misuse history.
        i. If it is felt that benzodiazepines have been effective where alternative medications have not, then it is acceptable to continue prescribing as long as prescriptions are controlled and reviewed.
        ii. If there is a suspicion of diversion or abuse, then weekly post-dated scripts are recommended and to be issued from within regular review consultations.
        iii. Alternative support measures as well as alternative medications should continue to be offered.

Initiating a benzodiazepine

The first line treatment for non-severe anxiety and insomnia is non-drug treatment such as self-help and sleep hygiene advice.

When a Benzodiazepine is considered essential, the BNF makes the following recommendations:

- Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic, or psychotic illness.
- The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate
- Benzodiazepines should be used to treat insomnia only when it is severe, disabling or causing the patient distress.

Benzodiazepine and Z Drug properties (Taken from individual Summary of Product Characteristics (SPC))

Drug	Starting adult dose (See BNF for doses for elderly patients)	Peak Onset (Minutes)	Elimination half-life (Extended in elderly patients)(Hours)
Shorter Acting Benzodiazepine hypnotics			
Temazepam	10-20mg at night	30-60	5-22
Longer acting benzodiazepine hypnotics			
Nitrazepam	5-10mg at night	20-50	15-38
Z drug Hypnotics			
Zopiclone	7.5mg at night	15-30	5-6
Zolpidem	10mg at night	7-27	2
Zaleplon	10mg at night	30	2
Benzodiazepine anxiolytics (Longer acting)			
Diazepam	2mg Three times daily	30-60	20-100
Lorazepam	1-4 mg daily in divided doses	60-90	10-18

For comprehensive information on indications, contra-indications, cautions and side effects of the benzodiazepines and z-hypnotics, please refer to the latest edition of the BNF or the Summary of Product Characteristics (SPC) at http://www.medicines.org.uk .

Reducing long term prescribing of benzodiazepines

There is some evidence from the Medical Resources Centre (MeReC) suggesting that educational letters to patients detailing the problems associated with long term benzodiazepine use and encouraging them to gradually reduce, and if possible stop, their usage is a successful intervention, even in patients who have previously been advised to or attempted reduction.

Therefore it is recommended that practices send an educational letter to all suitable patients on the benzodiazepine register. Repeating the intervention, on an annual basis, may improve success rates.

When initiating a new patient on a benzodiazepine or Z drug, ensure that an acute prescription is supplied. A prescribing agreement form (appendix 2) may help manage patient expectations from the issue of the first prescription.

Appendices:

The following appendices contain information resources to support practices in reviewing benzodiazepine and 'z-drug' prescribing.

Appendix 1	Reduction and Withdrawal process
Appendix 2	Support resources for patients
Appendix 3	Benzodiazepine and Z drug audit
Appendix 4	Template Letter to patient – Invite for review
Appendix 5	Sample patient agreement template
Appendix 6	Equivalent doses of benzodiazepines
Appendix 7	Practice policy for benzodiazepine prescribing
Appendix 8	NICE Guidance on Stopping Benzodiazepines and Z drugs

Appendix 1

Reduction and withdrawal process

Discontinuation of benzodiazepine drugs should be gradual to minimise the risk of withdrawal effects such as confusion, toxic psychosis, convulsions, or a condition resembling delirium tremens.

The following stepwise discontinuation schedule, adapted from the BNF, can be used as a guide.

The reduction schedule may be tailored to the individual patient as required. A benzodiazepine can be withdrawn in steps of about one-eighth of the daily dose every fortnight.

A suggested withdrawal protocol for patients who have difficulty is as follows:

1. Transfer to equivalent daily dose of diazepam (see appendix 1) preferably taken at night
2. Reduce diazepam dose every 2–3 weeks; if withdrawal symptoms occur, maintain this dose until symptoms improve
3. Reduce dose further, if necessary in smaller steps; it is better to reduce too slowly rather than too quickly
4. Stop completely; period needed for withdrawal can vary from about 4 weeks to a year or more
   Benzodiazepine withdrawal syndrome may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but may occur within a day in the case of a short-acting one. It is characterised by insomnia, anxiety, loss of appetite and of body-weight, tremor, perspiration, tinnitus, and perceptual disturbances.

Some symptoms may be similar to the original complaint and encourage further prescribing; some symptoms may continue for weeks or months after stopping benzodiazepines.

Counselling may help. Beta-blockers should only be tried if other measures fail; antidepressants should be used only where depression or panic disorder co-exist or emerge; avoid antipsychotics.

See below for deprescribing Algorithm.

NHS
Medway Clinical Commissioning Group

deprescribing.org | Benzodiazepine & Z-Drug (BZRA) Deprescribing Algorithm

August 2018

Why is patient taking a BZRA?

If unsure, find out if history of anxiety, past psychiatrist consult, whether may have been started in hospital for sleep, or for grief reaction.

- Insomnia on its own OR insomnia where underlying comorbidities managed
  For those ≥ 65 years of age: taking BZRA regardless of duration (avoid as first line therapy in older people)
  For those 18-64 years of age: taking BZRA > 4 weeks

- Other sleeping disorders (e.g. restless legs)
- Unmanaged anxiety, depression, physical or mental condition that may be causing or aggravating insomnia
- Benzodiazepine effective specifically for anxiety
- Alcohol withdrawal

Continue BZRA

- Minimize use of drugs that worsen insomnia (e.g. caffeine, alcohol etc.)
- Treat underlying condition
- Consider consulting psychologist or psychiatrist or sleep specialist

Engage patients (discuss potential risks, benefits, withdrawal plan, symptoms and duration)

Recommend Deprescribing

Taper and then stop BZRA

(taper slowly in collaboration with patient, for example ~25% every two weeks, and if possible, 12.5% reductions near end and/or planned drug-free days)

- For those ≥ 65 years of age (strong recommendation from systematic review and GRADE approach)
- For those 18-64 years of age (weak recommendation from systematic review and GRADE approach)
- Offer behavioural sleeping advice; consider CBT if available (see reverse)

Monitor every 1-2 weeks for duration of tapering

Expected benefits:

- May improve alertness, cognition, daytime sedation and reduce falls

Withdrawal symptoms:

- Insomnia, anxiety, irritability, sweating, gastrointestinal symptoms (all usually mild and last for days to a few weeks)

Use non-drug approaches to manage insomnia

Use behavioral approaches and/or CBT (see reverse)

If symptoms relapse:

Consider

- Maintaining current BZRA dose for 1-2 weeks, then continue to taper at slow rate

Alternate drugs

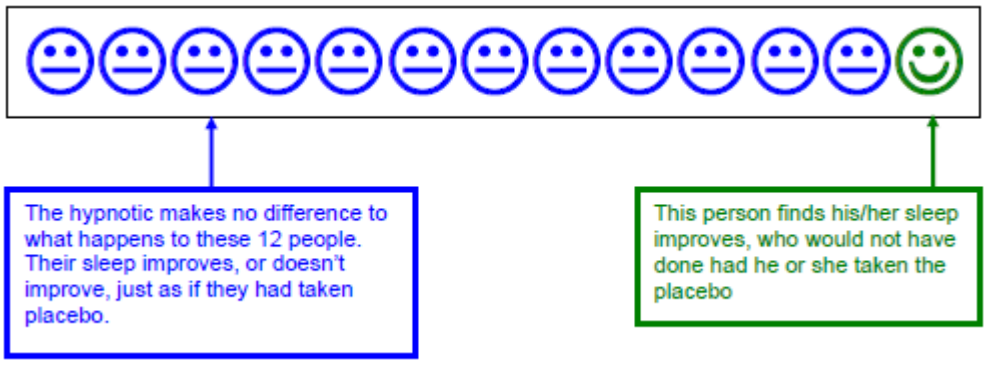
- Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this algorithm. See BZRA deprescribing guideline for details.

deprescribing.org Bruyère open

Appendix 2

Support resources for patients

Make use of patient decision aids. The former National Prescribing Centre (NPC) has a very useful tool. The picture below taken from the tool shows that if 13 people over the age of 60 were to be prescribed a benzodiazepine for insomnia for 5 days, only one patient would benefit.



The full tool can be down loaded via Link.

- NHS Choices – Insomnia https://www.nhs.uk/conditions/insomnia/
- Medway Talking Therapies – 0300 029 3000
- MIND - http://northkentmind.co.uk/my-dgsmind/
- Royal College of Psychiatrists – health advice on benzodiazepines http://www.rcpsych.ac.uk/healthadvice/treatmentsandwellbeing/benzodiazepines.aspx
- Patient UK – self help guide https://patient.info/health/insomnia-poor-sleep

Appendix 3

Audit to reduce the prescribing of Benzodiazepines and Z drugs for long term use for insomnia

Protocol

1. Identify all patients who have been prescribed a benzodiazepine (Diazepam, Lorazepam, Temazepam, Nitrazepam, Lormetazepam, Loprazolam, Oxazepam, Zopiclone, Zaleplon or Zolpidem), for longer than 3 months for primary insomnia
2. Exclude children under the age of 18 and pregnant women from the search
3. Document if a reducing regime has been attempted in the past
4. Send letter (appendix 4) to patient
5. Book a review with the patient
6. Discuss a reducing regime face to face when any of the listed medicines are next requested

Data Collection

See attached Excel Sheet

Review outcomes

The reviews should focus on the following:

- Raising patient awareness about the risks of benzodiazepines and z drugs when prescribed for long term use
- Manage patient expectations when initiating a benzodiazepine or Z drug – short term use and acute prescriptions only
- Reduce prescribing of long term benzodiazepines and Z drugs

Outcomes Summary

Patient ID	Date Letter sent	Date of patient review	Outcome of review (Reducing regime initiated?)

Appendix 4
Letter to be sent to patient

<practice letterhead>

Dear [patient]

I am writing to you because I note from our records that you have been taking [drug] for some time now. Family doctors are concerned about this kind of tranquilising medication when it is taken over long periods.

Our concern is that the body can get used to these tablets so that they no longer work properly. If you stop taking the tablets suddenly, there may be unpleasant withdrawal side effects that you will experience.

Research work done in this field shows that repeated use of the tablets over a long time is not recommended. More importantly, these tablets may actually cause anxiety and sleeplessness and they can be addictive.

We are writing to ask you to consider cutting down on your dose of these tablets and perhaps stopping them at some time in the future.

The best way to do this is to take the tablets only when you feel they are absolutely necessary. Try to take them only when you know that you have to do something that might be difficult for you. In this way you might be able to make a prescription last longer.

Once you have begun to cut down, you might be able to think about stopping them altogether. It would be best to cut down very gradually and then you will be less likely to have withdrawal symptoms

If you would like to talk more about this, we would be delighted to see you in the surgery at a mutually convenient time.

Yours Sincerely

Appendix 5 - Sample Patient Agreement Form

Patient Agreement for Benzodiazepines and Related Medications

Medication prescribed	
Review period (Weekly/Fortnightly/monthly)	
Maximum duration of treatment (The shortest duration of time necessary)	

The purpose of this agreement is for you to develop an understanding regarding the risks of taking benzodiazepines and related medications and the responsibilities both you and your doctor have.

- I understand that I am being prescribed a controlled drug.

The risks and benefits of this medication have been explained to me including:

- risk of dependence and addiction
- risk of drowsiness and confusion - which can lead to falls, injuries and road traffic accidents
- risk of lowered mood/depression
- risk of reduced breathing at night - particularly in people who have chronic respiratory problems e.g. asthma and COPD

My GP may only advise that I be prescribed this medication for a given period of time and will always aim to prescribe this medication at the lowest effective dose for the shortest duration of time necessary.

- I understand that I will require regular review with my doctor whilst taking this medication before repeat prescriptions are issued.

- I understand that there can be difficulties reducing and stopping this medication after long term use and if necessary I may be offered expert support in reducing and coming off this medication by a member of the local community drug team.

As the patient I agree that I am (Please tick each point):

- Responsible for the safe keeping of my medication and understand that if it is misplaced, damaged or stolen a replacement supply will not be prescribed earlier than the due date from the original issue.
- I agree that I will take my medication as prescribed and will not ask for medication to be prescribed earlier than it is due.
- I agree that I will not receive prescriptions for benzodiazepine medication or similar from any other source whilst I am being prescribed this medication by my GP.
- I will not sell, share or trade my medication.
- I will inform this GP practice if I receive medication from any other source.
- I agree to store my medication in a safe place - away from children and vulnerable people.
- I understand that this medication can affect my ability to drive safely.
- I understand that I am obliged to inform the DVLA that I am taking this medication
- I will not drive if I feel this medication is impairing my ability to drive safely.
- I will attend appointments for follow up appointments as advised by the surgery.

Patient Name		GP Name	
Patient Signature		GP Signature	
Date			

Appendix 6

Approximate equivalent benzodiazepine doses

Drug	Diazepam 2.5mg	Diazepam 5mg*	Diazepam 7.5mg	Diazepam 10mg
Lorazepam	0.25mg – 0.5mg	**0.5mg – 1mg**	0.75mg – 1.5mg	1mg – 2mg
Loprazolam	0.25mg – 0.5mg	**0.5mg – 1mg**	0.75mg – 1.5mg	1mg – 2mg
Lormetazepam	0.25mg – 0.5mg	**0.5mg – 1mg**	0.75mg – 1.5mg	1mg – 2mg
Nitrazepam	2.5mg	**5mg**	7.5mg	10mg
Oxazepam	7.5mg	**15mg**	22.5mg	30mg
Temazepam	5mg	**10mg**	15mg	20mg

*Doses equivalent to 5mg diazepam taken from the BNF1. Doses equivalent to other diazepam doses have been extrapolated

Appendix 7

Practice policy for managing patients prescribed benzodiazepines

- ✓ Benzodiazepines to be initiated and prescribed only as short term treatment (2-4 weeks only) in line with the advice in the BNF and other national guidance.
- ✓ The practice does not replace lost/stolen prescriptions.
- ✓ Benzodiazepines are controlled drugs (schedule 4) and should not be issued as repeat prescriptions.
- ✓ Lowest possible doses should be prescribed.
- ✓ Prescriptions should be limited to a maximum 28 day supply.
- ✓ Where benzodiazepines are essential, ensure that the choice of drug is in line with local prescribing advice/formulary.
- ✓ Where possible, patients should be moving towards taking their benzodiazepine on a PRN basis.
- ✓ Ensure that all patients with insomnia / anxiety are advised about non-drug treatments and self-help prior to use of benzodiazepines or z-drugs.
- ✓ Maintain an active and up to date register of patients who are currently prescribed benzodiazepines, or those who have had more than 28 days treatment in the last year.
- ✓ Maintain an active and up to date register of patients who are currently prescribed benzodiazepines, or those who have had more than 28 days treatment in the last year.
- ✓ Review patients prescribed benzodiazepines or z-drugs frequently (as a minimum once in 12 months) to ensure that every opportunity to reduce and stop is taken.
- ✓ Consider inviting patients to discuss reduction / stopping benzodiazepines by way of personalised letters annually. Keep records of these interventions.
- ✓ Where there is suspicion that a patient is abusing/misusing benzodiazepines, ensure that the patient is referred into local drug misuse shared care schemes (Turning Point).
- ✓ Document in patient records all notes of discussions with patient in relation to potential tolerance, addiction, loss of effectiveness, falls risk, driving.

Stopping benzodiazepines and Z drugs

- Assessing the persons readiness to stop - Does stopping the drug matter to the patient, and are their physical and psychological health and personal circumstances stable? Enquire about:
    - **Symptoms of depression** - Withdrawal can worsen symptoms of clinical depression. The priority is to manage depression first, before attempting withdrawal
    - **Symptoms of anxiety** - Withdrawal in the presence of significant anxiety is unlikely to succeed. However, when symptoms are reasonably well controlled and stable it may be possible to attempt careful drug withdrawal
    - **Symptoms of long-term insomnia** - If insomnia is severe, consider treating this with non-drug treatments prior to starting withdrawal
    - **Medical problems are well controlled and stable** - If other problems are causing significant distress, consider managing these first, prior to starting withdrawal
    - **Withdrawal in primary care** - Is there adequate social support with no previous history of complicated drug withdrawal and ability to attend regular reviews?
    - **Specialist advice or referral** - Consider where there is a history of alcohol or other drug use or dependence. Also where there is severe medical or psychiatric disorder or personality disorder. A history of drug withdrawal seizures where low tapering is recommended.

- Managing someone who wants to stop - Decide if the person can stop their current benzodiazepine or z-drug without changing to diazepam.
    - **Switching to diazepam is recommended for**:
        - People using short-acting potent benzodiazepines (alprazolam, lorazepam)
        - Preparations that do not allow small dose reductions (alprazolam, flurazepam, loprazolam, lormetazepam)
        - People likely to experience difficulty withdrawing directly from temazepam, nitrazepam, or z-drugs, due to a high degree of dependency (associated with long duration of treatment, high doses, and a history of anxiety problems)
    - **Seek specialist advice before switching to diazepam in people with hepatic dysfunction**. Diazepam may accumulate to a toxic level in these individuals. An alternative benzodiazepine without active metabolites (oxazepam) may be preferred
    - **Negotiate a gradual drug withdrawal schedule** (dose tapering) that is flexible. Be guided by the person in making adjustments so that they remain comfortable with the withdrawal
    - **Titrate the drug withdrawal according to the severity of withdrawal symptoms**
    - **Withdrawal may take 3-12months or longer**. Some people take less time
    - **Review frequently**, to detect and manage problems early and to provide advice and encouragement during and after the drug withdrawal
    - **If they did not succeed on their first attempt, encourage the person to try again**
    - Remind the person that reducing benzodiazepine dosage, even if this falls short of complete drug withdrawal, can still be beneficial
    - If another attempt is considered, reassess the person first, and treat any underlying problems (such as depression) before trying again

- How should benzodiazepines be withdrawn?
    - **Withdrawal should be gradual**(g. 5–10% reduction every 1–2 weeks, or an eighth of the original dose fortnightly, with a slower reduction at lower doses), and titrated according to the severity of withdrawal symptoms
    - **Withdrawal may take 3–12months or longer**. Some people take less time

- **Withdrawal may be undertaken with or without switching to diazepam**.
- **Additional information**: withdrawal should be tailored to the individual's needs. See NICE CKS - Benzodiazepine and Z-Drug Withdrawal and the Ashton Manual

- Managing withdrawal symptoms
  - **Review frequently** to detect and manage problems early, and to provide encouragement and reassurance during and after drug withdrawal
  - **Manage anxiety** and explain that anxiety is the most common withdrawal symptom
    - Reassure that anxiety is likely to be temporary. Consider slowing or suspending withdrawal until symptoms become manageable. Consider additional use of non-drug treatments
  - **Adjunct drug therapy should not be routinely prescribed**. May be considered only if other measures fail (e.g. propranolol for severe symptoms, such as palpitations, tremor, and sweating)
  - **Manage depression with antidepressants if required**. Consider suspending withdrawal until depression resolves or stabilises. See the NICE CKS topic on Depression
  - **Do not prescribe antipsychotics** which may aggravate withdrawal symptoms
  - **Manage insomnia**. See NICE CKS topic on Insomnia

- Advice to people undergoing withdrawal
  - **Gradual withdrawal** minimizes the risk of withdrawal effects
  - **Reassure** that the person will be in control of the rate of drug withdrawal. This can take 3-12 months or longer. Some people take less time
  - **Difficult points** can be managed with maintaining the current dose for a few weeks. Try to avoid increasing the dosage if possible
  - **Avoid** compensating for withdrawal by the use of alcohol, other drugs (prescription, non-prescription, or illicit drugs) or smoking
  - Stopping the last few milligrams is often seen as being particularly difficult. **Warn against prolonging the drug withdrawa**l to an extremely slow rate towards the end (g. reducing by 0.25 mg diazepam each month). Advise the person to consider stopping completely when they reach an appropriate low dose (e.g. diazepam 1 mg daily)
  - **Withdrawal symptom advice**:
    - With slow tapering, many people experience few or no withdrawal symptoms
    - If withdrawal symptoms are present with slow tapering then symptoms will disappear within a few months
    - Rarely some people will suffer from protracted withdrawal symptoms which will gradually improve over a year or longer
    - The acute symptoms of withdrawal are those of anxiety
    - Explain that some of the withdrawal symptoms may be similar to the original complaint and do not indicate a return of this
    - It is not possible to estimate the severity and duration of withdrawal symptoms for the individual
    - For information on managing withdrawal symptoms, see Managing withdrawal symptoms (above).

- Advice to people who do not want to stop taking benzodiazepines or z-drugs
  - **Do not pressurize the person to stop** if they are not motivated to do so
  - **Listen to the person**, and address any concerns they have about stopping
  - Explain that for most people who withdraw from treatment slowly, symptoms are mild and can usually be effectively managed by other means

- Reassure the person that they will be in control of the drug withdrawal and that they can proceed at their rate
- **Discuss the benefits of stopping the drug**. The discussion should include an explanation of tolerance, adverse effects, and the risks of continuing the drug. See **Reasons for stopping** for further information
- **Review at a later date if appropriate**, and reassess the person's motivation to stop
- **In people who remain concerned** about stopping treatment despite explanation and reassurance, persuading them to try a small reduction in dose may help them realize that their concerns are unfounded

References

- NICE Clinical Knowledge Summaries: Benzodiazepine and Z drug withdrawal. Available at https://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal (Accessed October 2018)
- Deprescribing – Is a benzodiazepine or Z drug still needed for sleep? Available at https://deprescribing.org/wp-content/uploads/2018/08/benzodiazepine-deprescribing-information-pamphlet.pdf (Accessed October 2018)