

## **BENZODIAZEPINE PRESCRIBING SUPPORT PACK**

### **Background**

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. Hypnotics and anxiolytics should therefore be reserved for short courses<sup>1</sup>.

### **Types of benzodiazepines**

**Hypnotics:** ideally use short acting drugs for less hangover effects and daytime sedation, particularly in the elderly.

**Anxiolytics:** long acting drugs require fewer daily doses and are less likely to cause withdrawal problems; they may therefore be preferred.

### **Prescribing benzodiazepines**

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

A useful patient friendly self-help guide is available from [Patient UK](#). Alternatively, the [NHS choices](#) website has lots of information and help for patients suffering with insomnia.

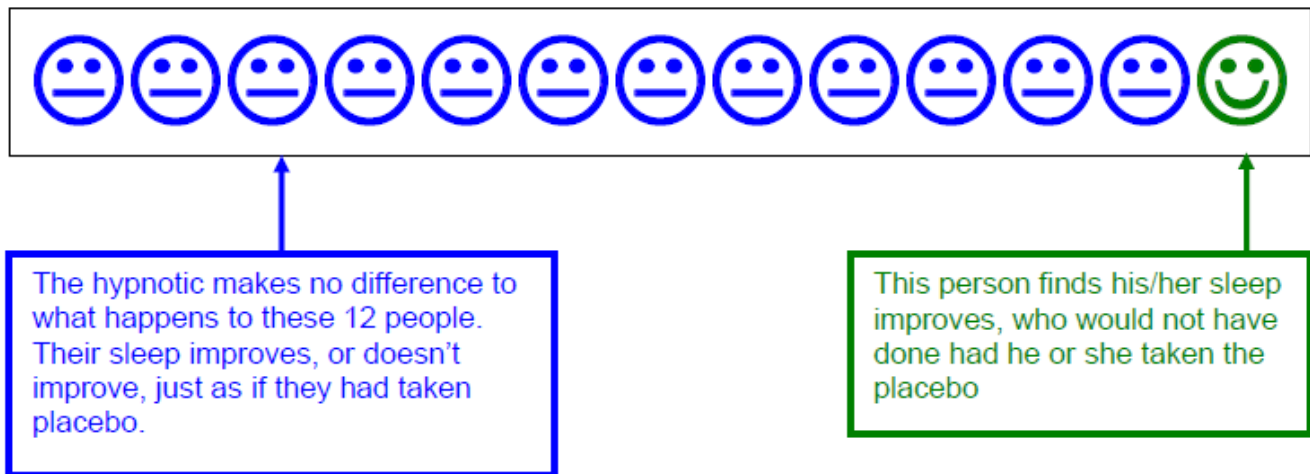
### **When a Benzodiazepine is considered essential, the BNF makes the following recommendations:**

1. 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.
2. The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate
3. Benzodiazepines should be used to treat insomnia **only** when it is severe, disabling, or causing the patient extreme distress.

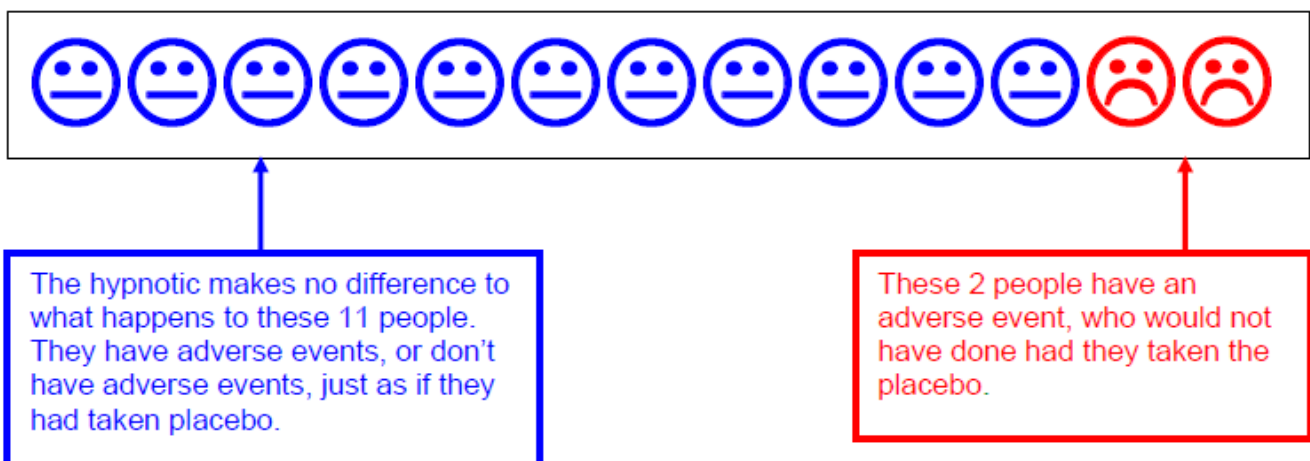
### **Tips for prescribing benzodiazepines safely**

- Use the lowest possible dose for the shortest possible duration.
- Prescribe small quantities and **do not** issue further prescriptions without consultation.

- Prescribe on a “when required” basis to encourage the patient to take the drug only when they feel it is absolutely necessary
- Advise the patient of the potential for dependence and other side effects; stress that the prescription is for short term use only.
- Offer and regularly re-enforce self-help advice in addition to drug treatment.
- Record diagnosis/reason for prescribing using appropriate read codes.
- Make use of patient decision aids. An excerpt from the insomnia patient decision aid published by the National Prescribing Centre in 2010 is shown below – if 13 people over the age of 60 were prescribed a benzodiazepine for primary insomnia for 5 days, only one person would benefit.



Additionally, as shown below, of those 13 people who take the benzodiazepine for 5 days, two people would have an adverse event. Therefore the risk of an adverse event is greater than the likely benefit.



The National Prescribing Centre became the NICE Medicines and Prescribing Centre in 2012. However, the original full patient decision aid on insomnia from the National Prescribing Centre can be downloaded from the [archived NPC website](#).

### Strategies for reduction in long term prescribing:

Evidence suggests<sup>2</sup> 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.

There is also evidence that patient consultations encouraging benzodiazepine reduction are successful but this strategy is more time-consuming than patient letters and does not appear to result in significantly greater reductions.

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

### 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 8) 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 (which may aggravate withdrawal symptoms).

## References

The following documents/reference sources have been used to compile this resource and are referenced throughout the document.

1. [BNF online](#)
2. NPC MeReC Rapid Review: [Letters to patients may help to reduce benzodiazepine use](#)
3. National Prescribing Centre [Patient Decision Aid for Insomnia](#) (Download from hyperlink or double click icon):



Adobe Acrobat  
Document

4. Department of Health [Chief Medical Officer \(CMO\) update](#) 2004 – benzodiazepine warning.

## Appendices

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

*Blue text indicates a hyperlink: hold down the "ctrl" key and click to jump to location.*

<a href="#">Appendix 1:</a>	Template audit for benzodiazepine prescribing
<a href="#">Appendix 2:</a>	Suggested benzodiazepine formulary
<a href="#">Appendix 3:</a>	Template letter to patients to invite discussion about dose reduction
<a href="#">Appendix 4:</a>	Template letter to care homes to invite discussion about dose reduction
<a href="#">Appendix 5:</a>	Tips for managing difficult patients / identifying overuse of benzodiazepines
<a href="#">Appendix 6:</a>	Formulary Factsheet on benzodiazepine prescribing
<a href="#">Appendix 7:</a>	National evidence to support reduction in benzodiazepine prescribing
<a href="#">Appendix 8:</a>	Equivalent doses of benzodiazepines
<a href="#">Appendix 9:</a>	Practice tips for managing patients prescribed benzodiazepines

## Appendix 1

### Template Audit of benzodiazepine prescribing

Audit criteria		Cycle 1 Date:	Cycle 2 Date:
1.	Practice has a policy for prescribing of benzodiazepines and Z-drugs		
2.	Total number of patients prescribed more than 28 days dose of benzodiazepines per year.		
3.	Number of those patients that were reviewed at least once during the last 12 months		
4.	If the number of those patients that were reviewed at least once during the last 12 months is <100% please give brief reasons (continue on a separate page if necessary)		
5.	Number of patients where prescribing is associated with involvement of other agencies (Genesis, CADAS, SEDCDAT and Psychiatric services)		
6.	Number of patients assessed for motivation to decrease/stop		
7.	Number of patients >75 assessed for risk of falls		
8.	Number of patients on benzodiazepine register		
9.	Letter sent to care homes regarding use of prescribed benzodiazepines in nursing and residential homes	Y / N	

## Appendix 2

### Suggested benzodiazepine formulary

<b>Drug</b>	<b>Suggested indication(s)</b>
<b>Nitrazepam 5mg</b>	ON for 7 nights to restore sleep pattern
<b>Temazepam 10mg</b>	(tablets) -ON for occasional use (less than twice a week)
<b>Diazepam 2mg</b>	Short term for specific anxieties
<b>Diazepam 5mg</b>	1-2 ON or BD/TDS for severe muscle spasm in severe low back pain
<b>Diazepam 2mg/5mg syrup with plain syrup BP</b>	serial dilutions for benzodiazepine withdrawal regime
<b>Lorazepam 1mg</b>	(half or one) for aeroplane phobia (or free use of other benzodiazepines)
<b>Midazolam</b>	via syringe driver in palliative care (or free use of other benzodiazepines)
<b>Chlordiazepoxide</b>	for acute symptoms of alcohol withdrawal

### Appendix 3

<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 tranquilizing 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.

I am 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 4

<practice letterhead>

Dear **[patient]**

I note from our records that a number of residents at your home are taking regular night time and/or day time benzodiazepines. We are looking at this area of prescribing and the risks associated with taking these drugs, especially in elderly.

We would appreciate your assistance with this matter. The residents listed below are registered with our practice and prescribed regular benzodiazepines.

**[Patient name]**

**[Patient name]**

**[Patient name]**

I would very much appreciate it if you could try reducing these medicines to a “when required” basis rather than regular doses, in order to reduce the risk of dependence, tolerance and falls.

If you would like to discuss this matter further, please do not hesitate to contact me at the surgery.

Yours Sincerely

## Difficult patients

Benzodiazepines and 'z-drugs' are liable to abuse, misuse or diversion. The following best practice tips have been taken from the NHS Dorset guidance on Managing Difficult Patients, which is available to download in full from the [Pan-Dorset Formulary](#) website.

Where a patient is prescribed benzodiazepines and 'z-drugs', particularly if the prescribing has been long term, and there is a risk of the patient attempting to obtain a prescription before it is due, or consulting multiple GPs for a prescription, **GP practices** can:

- Consider drawing up a contract, between the patient and the practice, specifying how the patient will be managed and is expected to behave.
- Have a named doctor deal with this patient.
- Put a warning on the patient's computerised record, to ensure anyone dealing with this patient is aware of the specific management plan/contract.
- Ask the patient to nominate a local community pharmacy to dispense their medicines. Send all prescriptions (or have them collected by) the nominated pharmacy.
- Limit the quantity supplied on the prescription e.g. only give 7 or 14 days.
- Have a tight repeat prescribing process. Nominated members of staff who regularly produce prescriptions will build knowledge and recognise if patients are over using benzodiazepines or z-drugs.

**Community pharmacies** can:

- Contact the patient's GP if directions or quantity on the prescription are unclear or ambiguous. Be satisfied of the intentions of the prescriber (and ensure that the prescription has not been amended by the patient).
- Be aware of patients who continually attempt to get supplies early before their prescription should be needed and report concerns to the patients GP.
- Manage specific patients in conjunction with a GP and ensure that all pharmacy staff (including locums) are aware of the management plan for that individual.
- Ensure any issues with a patient who is difficult to manage are reported back to the named GP responsible for the patient

## FORMULARY QUICK REFERENCE GUIDE: BENZODIAZEPINES

Benzodiazepines are indicated only for the short term relief (2 – 4 weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short term psychosomatic, organic or psychotic illness. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress<sup>1</sup>.

First line treatment for non-severe anxiety and insomnia is in non-drug treatment including self-help advice. Written sleep hygiene advice should be given to all patients presenting with insomnia. Useful self-help guides are available on the [Patient UK website](#).

### ***When A Benzodiazepine is considered essential...***

- Use the lowest possible dose for the shortest possible duration.
- Advise the patient to take the drug only when they feel it is necessary – prescribe on a PRN basis.
- Offer or re-enforce self-help advice in addition to benzodiazepines.
- Advise the patient of the potential for dependence and other side effects; stress that the prescription is for short term use only. Use the NPCi patient decision aid.
- Keep the benzodiazepine as an ‘acute’ item so that repeat prescriptions are not generated without review.
- Prescribe small quantities.
- Record diagnosis and rationale for prescribing using appropriate read codes.

***Hypnotics:*** ideally use short acting drugs for less hangover effects and daytime sedation, particularly in the elderly. Temazepam should be used as the hypnotic drug of choice.

***Anxiolytics:*** long acting drugs require fewer daily doses and are less likely to cause withdrawal problems; they may therefore be preferred. Diazepam should be used as the anxiolytic drug of choice.

### **Suggested Benzodiazepine Formulary**

- **Nitrazepam 5mg** – At night for 7 nights only to restore sleep pattern
- **Temazepam 10mg** – At night for occasional use (less than twice a week)
- **Diazepam 2mg** – Short term for specific anxieties
- **Diazepam 5mg** – 1-2 ON or BD/TDS for severe muscle spasm in severe low back pain
- **Diazepam 2mg/5mg syrup with plain syrup BP** – Serial dilutions for benzodiazepine withdrawal regime
- **Lorazepam 1mg** – 0.5mg – 1mg for phobia of flying, or palliative care
- **Midazolam** – Via syringe driver in palliative care (or free use of other benzodiazepines)

- **Chlordiazepoxide** – Acute symptoms of alcohol withdrawal

**Avoid prescribing benzodiazepines for patients undergoing alcohol or substance misuse detoxification unless this is part of a shared care arrangement with a community drugs and alcohol service.**

Discontinuation of benzodiazepine drugs should be gradual to minimise the risk of withdrawal effects. A stepwise discontinuation schedule for this is available in the BNF as a guide. The schedule may be tailored to the individual patient as required.

Long term benzodiazepine use can be strictly defined as prescription of benzodiazepine drugs continuously for more than 4 weeks, **or** patients receiving three or more prescriptions for a benzodiazepine drug in the past 12 months.

Physical and psychological dependence can occur with long-term use. In addition people may develop tolerance to their effects and gain little therapeutic benefit. Benzodiazepines have also been linked with falls in the elderly.

There have been several case reports of dose escalation, dependence and withdrawal reactions with “Z-drugs” (zopiclone and zolpidem). For this reason, these drugs are best avoided, especially in patients withdrawing from benzodiazepines. Other drugs, such as antihistamines, low dose antidepressants and antipsychotics are associated with a risk of CNS and other adverse effects, particularly in the elderly and should also be avoided.

### **The Bottom Line**

1. Benzodiazepines to be initiated and prescribed only as short term treatment (2-4 weeks only)
2. Use the lowest possible dose for the shortest possible duration.
3. Prescribe small quantities and **do not** issue further prescriptions without a consultation.
4. Benzodiazepines should **not** be issued on repeat prescriptions

**Add your practice specific information here.....**

## Appendix 7

### Evidence to support reduction in benzodiazepine prescribing

#### ***Benzodiazepines link to dementia***

A recent French cohort study published in the British Medical Journal demonstrated an association between benzodiazepine use among elderly adults and the risk of developing dementia. The study followed just over a thousand elderly adults for 15 years. The participants were initially free from dementia but those who started taking benzodiazepines after the first three years of the study were 60% more likely to develop dementia than those who did not use these drugs.

The researchers reported that in their cohort study of elderly adults, new use of benzodiazepines was associated with increased risk of dementia. They said: “Considering the extent to which benzodiazepines are prescribed and the number of potential adverse effects of this drug class in the general population, indiscriminate widespread use should be cautioned against.”

There were some important limitations of the study, including difficulty in establishing the exact cause of dementia and what role benzodiazepines play. Disturbed sleep can be an initial sign of dementia, so the use of sleeping tablets may be triggered by early dementia and not vice versa.

Nevertheless, this was a well-conducted study that adds to the growing body of opinion that benzodiazepines should only be a “treatment of last resort” for severe acute insomnia or anxiety and should be taken for no longer than two-to-four weeks at a time.

A [“Behind the Headlines”](#) summary of the study is available on the NHS Choices website.

#### ***Letters to patients may help to reduce benzodiazepine use***

A National Prescribing Centre (NPC) MeReC Rapid Review described a systematic review and meta-analysis of three randomised controlled trials (RCTs) conducted in UK general practices found that ‘minimal interventions’ for long-term users of benzodiazepines can help them to reduce or stop their medication at six months, without causing adverse consequences. Minimal interventions were defined as a letter, self-help information, or short consultation with a GP. The number needed to post for the tailored letter was about 12 for one additional person to stop using benzodiazepines at six months.

Prescribers should be familiar with NICE guidance on insomnia which advises that after nondrug therapies have been explored, hypnotics should be used in the lowest dose possible for no more than 4 weeks with benzodiazepines, or 2 – 4 weeks with z drugs (zopiclone, zolpidem, and zaleplon). NICE guidance on generalised anxiety disorder (GAD) in adults recommends that benzodiazepines are not offered for the treatment of GAD in primary or secondary care except as a short-term measure during crises.

For patients who have been using benzodiazepines long-term, it would seem reasonable to consider trying a simple intervention, such as a tailored letter advising them to reduce or stop taking their benzodiazepine, or a single consultation by their GP.

Tips for things to include in letters to patients prescribed benzodiazepines or 'z-drugs' long term:

- Explain your concern over the individual patient's long-term use of a hypnotic/s – ideally name the specific drug(s) and possibly the extent of use over a defined period.
- Highlight potential side effects when taken over a prolonged period.
- Ask the patient to consider a reduction in their use.
- Include advice on how to gradually reduce or cease the drug(s) whilst reducing the likelihood of withdrawal symptoms.
- Invite the patient to make an appointment to discuss the issue further.

### ***Addiction to benzodiazepines and codeine: supporting safer use***

The Medicines and Health Regulatory Agency Drug Safety Update for July 2011 highlighted two published reports commissioned by the Department of Health on addiction to prescribed and over-the-counter medicines, as follows:

[Addiction to medicine: an investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription-only or over-the-counter medicine](#) (National Treatment Agency for Substance Misuse, May 2011).

[The changing use of prescribed benzodiazepines and z-drugs and of over-the-counter codeine containing products in England: a structured review of published English and international evidence and available data to inform consideration of the extent of dependence and harm](#) (The National Addiction Centre, King's College London, and School of Social and Community Medicine, University of Bristol, 2011).

### **Background to the reports**

Since the 1980s, there have been concerns about the risk of dependence and withdrawal reactions after long term use of benzodiazepines. For more than 20 years, the duration of use of these products has been limited to 2–4 weeks.

Reports from National Treatment Agency and National Addiction Centre showed that the overall level of prescribing of benzodiazepines decreased between 1991 and 2009. This fall was mainly in the use of benzodiazepines as hypnotics. Use of anxiolytic benzodiazepines increased during this period. The data also showed a gradual increase in sales of over-the-counter codeine-containing medicines since these were placed on the market in 2006.

A regional breakdown of data showed very large variations in prescribing practice across England. The reason for this regional variation is unclear.

Given the risks associated with the use of benzodiazepines, patients should be prescribed the lowest effective dose for the shortest time possible. Maximum duration of treatment should be 4 weeks, including the dose-tapering phase.

Over-the-counter codeine-containing medicines should be used for the short-term (3 days) treatment of acute, moderate pain which is not relieved by paracetamol, ibuprofen, or aspirin alone.

See MHRA Drug Safety Update [September 2009](#) and [July 2011](#)).

## Appendix 8

### 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 BNF<sup>1</sup>. Doses equivalent to other diazepam doses have been extrapolated.*



## Appendix 9

### Areas to be included in a practice policy for managing patients prescribed benzodiazepines

1. 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.
2. Benzodiazepines are controlled drugs (schedule 4) and should not be issued as repeat prescriptions.
3. Lowest possible doses should be prescribed.
4. Prescriptions should be limited to a maximum 28 day supply.
5. Where benzodiazepines are essential, ensure that the choice of drug is in line with local prescribing advice/formulary.
6. Where possible, patients should be moving towards taking their benzodiazepine on a PRN basis.
7. Ensure that all patients with insomnia / anxiety are advised about non-drug treatments and self help prior to use of benzodiazepines or z-drugs.
8. 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.
9. 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.
10. Consider inviting patients to discuss reduction / stopping benzodiazepines by way of personalised letters annually. Keep records of these interventions.
11. Where there is suspicion that a patient is abusing/misusing benzodiazepines, ensure that the patient is referred into local drug misuse shared care schemes (e.g. CADAS or SEDCDAT).
12. Document in patient records all notes of discussions with patient in relation to potential tolerance, addiction, loss of effectiveness, falls risk, driving.