1 Introduction

1.1 Although benzodiazepines and Z drugs (zopiclone, zolpidem and zaleplon) may have a valid place in the short-term management of severe anxiety and insomnia, tolerance and dependence can occur with these drugs.

1.2 This aim of this document is:

- To support the current guidance on the rational, safe and effective prescribing of benzodiazepines within Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW)

- Promote effective communication on any transfer of prescribing with primary care colleagues
1.3 It is expected that these guidelines will be followed in the majority of cases where these medicines are used. However, in light of the complex nature of conditions and treatment packages amongst patients under the care of the Trust there may be some circumstances where prescribing outwith these standards is necessary; the reasoning for this should be fully documented in clinical records.

2 General prescribing principles

2.1 Indications for benzodiazepine and Z drug (where indicated) use

- Short term treatment of severe anxiety disorders
- Acute alcohol withdrawal
- Severe insomnia (Z drug)
- Control of arousal/agitation

2.2 General prescribing principles

- These principles should be applied each time benzodiazepines or Z-drugs are prescribed and are applicable across all areas of benzodiazepine and Z drug prescribing.

2.2.1 Initiation of therapy

- On initiation of therapy the following points should be considered

  o Existing physical health issues and/or prescribed medicines/illicit drug use that could affect sleep, and refer to primary care if appropriate
  o Provide advice on good sleep hygiene e.g. relaxation techniques, avoiding daytime napping, large alcohol/fluid/caffeine/food intake/nicotine/exercise before bedtime and information/reassurance on the varying amount of sleep required by an individual
  o Consider assessing for re-experiencing symptoms of trauma – i.e. poor sleep due to nightmares. Veterans for example may be reluctant to volunteer such information
  o Do not offer benzodiazepines to women in pregnancy and the postnatal period except for the short-term treatment of severe anxiety and agitation
  o Consider referring a woman to a secondary mental health service (preferably a specialist perinatal mental health service) for preconception counselling if she has a current or past severe mental health problem and is planning a pregnancy
• **Prescribing points**
  
  o Benzodiazepines and Z drugs should only be used in the short term i.e. less than 4 weeks
  
  o The lowest effective dose should be prescribed
  
  o Prescribing in the elderly should be done with caution
  
  o The use of benzodiazepines and Z drugs to treat short term ‘mild’ anxiety, is inappropriate and unsuitable
  
  o Benzodiazepines and Z drugs should not be prescribed for panic disorder, phobic or obsessional states; or to treat chronic psychosis
  
  o There should be a clear plan, stating the indication, intended duration of treatment, and plans for review and discontinuation, documented in the patient’s clinical notes for all newly prescribed benzodiazepines and Z drugs
  
  o All benzodiazepines and Z drugs have a ‘street value’, especially ‘high’ strength formulations. Diazepam 10mg tablets should therefore not be prescribed or supplied and the dose should instead be made up of lower strength 2mg and 5mg tablets
  
  o Prescriptions for benzodiazepines and Z drugs should not be for greater than 4 weeks at a time, ideally 1-2 weeks
  
  o Benzodiazepines and Z drugs should not routinely be prescribed above BNF doses
  
  o Where benzodiazepines/Z drugs are initiated during an inpatient stay, as a regular or “as required” medication, their use, dose, indication, frequency and continued use should be reviewed regularly at ward review. This review should be documented in the clinical notes
  
  o If a benzodiazepine/Z drug needs to be prescribed out of hours during an inpatient stay, the ward doctor should review the prescription the next working day to ensure it is not continued unnecessarily
  
  o All benzodiazepines/Z drugs should be reviewed before discharge and, if not discontinued as an in-patient, a plan to reduce the drug as an outpatient should be made. A copy of the plan should be sent to the patient’s GP (see section 3 –
Transferring benzodiazepine prescribing to primary care) and Community Mental Health Team

- Combination of different benzodiazepines should be avoided (excluding use when hypnotic plus anxiolytic is used)

**Advice to patients**

- Patients should be warned of the side effects and tolerance / dependence potential effects and written information, appropriate to their needs, should be provided to the patient. There are patient information leaflets available on the intranet:
  
  

- Patients should be reminded about the importance of keeping their medication in a safe place, out of the reach of children

- Benzodiazepines are the most likely psychotropic medication to impair driving performance. Alcohol will potentiate these effects

- Doctors have a duty of care to advise their patients of the potential dangers of adverse effects from medication and interactions with other substances, especially alcohol

- Drug Driving Law changes in March 2015 saw a zero tolerance approach to 8 drugs most associated with illegal use and a road safety risk based approach to 8 drugs most associated with medical use, 6 of them benzodiazepines

- The new law gives the police powers to test and arrest drivers suspected of driving after taking certain controlled drugs in excess of specified levels. It also provides a medical defence if the patient is taking medicine in accordance with instructions from a healthcare professional provided they’re not considered to be impaired when driving

- If a patient drives and take prescription medicine, it may be helpful for them to keep evidence of this with them in case they’re stopped by the police
2.2.2 Continuation

- Tolerance and dependence is associated with the longer-term (greater than 4 weeks) use of benzodiazepines
- Longer term use is not recommended and should be avoided wherever possible
- An inpatient stay can be a suitable time to review and make changes to long term benzodiazepines/Z drugs whilst the patient is in a supportive environment
- The longer term use of benzodiazepines should be reviewed regularly at least every 3 months (more frequently during an in-patient stay)
  E.g. weekly) with documented evidence in the clinical notes
- If long term benzodiazepines can be discontinued, they should be withdrawn gradually as detailed in 2.2.3

2.2.3 Discontinuation

- Consider gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding
- Benzodiazepines should not be stopped abruptly and should be withdrawn gradually (especially in patients who have been on longer term therapy i.e. greater than 4 weeks) as at least one third of long term users experience problems on dose reduction or withdrawal. Maudsley lists the physical and psychological problems on withdrawal from benzodiazepines⁶ In patients on longer term benzodiazepines, treatment cessation should be conducted in a planned, stepwise manner, under clinical supervision, with particular attention paid to assessment of mental state
- Benzodiazepines with a shorter half-life (e.g. lorazepam, temazepam) are associated with a higher risk of discontinuation reactions
- In patients who have been taking shorter-acting benzodiazepines, it may be preferable to switch the patient to diazepam (with a longer half-life) as part of the discontinuation plan; diazepam may be given as a single daily dose and is available in different strengths (2mg and 5mg tablets and liquid) therefore offers the advantage of a more flexible dose regimen. (See dose conversion table Appendix 1)
Although gradual rather than abrupt withdrawal is more acceptable to patients, note that there is no evidence to support the differential efficacy of different tapering schedules, either fixed dose or symptom guided. Gradual dose reduction accompanied by psychological interventions, patient engagement and support from carers is more likely to be successful than supervised dose reduction alone or psychological reduction alone. Maudsley provides a suggested taper schedule. See also the resources in Appendix 2.

Time needed to withdraw can vary from 4 weeks to a year or more.

If a patient has continued withdrawal problems or complex needs, consider seeking appropriate specialist advice.

3 Interface between primary and secondary care

3.1 Transferring benzodiazepine prescribing from secondary care to primary care

3.1.1 When prescribing is to be transferred from Secondary Care to Primary Care the following information should be relayed to the GP in the form of a written treatment plan. This includes those situations where benzodiazepines have been initiated during inpatient treatment.

- Indication for use
- Expected duration of treatment
- When the treatment will be reviewed and by whom
- Advice about discontinuation (where indicated)
- Who to contact within Secondary Care if problems arise
- Rationale for patients prescribed benzodiazepines outwith BNF recommendations.

3.2 Patients transferred to secondary care

3.2.1 Prescribers in secondary care, who have patients referred to them currently taking benzodiazepines, should be mindful that primary care may already have a plan in place to reduce and/or stop the benzodiazepine. These plans should be considered when prescribing benzodiazepines in secondary care. GPs referring patients to secondary care should communicate any relevant history and management plans in the referral letter.

4 Longer term use of benzodiazepines

4.1 As a general rule long term prescribing of benzodiazepines and Z drugs is not recommended. The drugs should be used in the short term for the above
indications for a maximum of 4 weeks. It is recognised however that there are patients for whom long term benzodiazepines are deemed clinically appropriate and where stopping would be detrimental to their mental health. In these cases prescribers should document a clear rationale in the patient's notes and if prescribing is transferred this should be communicated effectively (see point 3 above) to the receiving provider of care. The appropriateness of the prescription should still be reviewed on a regular basis and recorded in the clinical notes.

References


5. https://www.gov.uk/drug-driving-law


8. NICE guidelines (CG192) Antenatal and postnatal mental health: clinical management and service guidance, Published date: December 2014 http://www.nice.org.uk/guidance/cg192 accessed 30/10/2015
## Appendix 1

### Equivalent benzodiazepine doses

<table>
<thead>
<tr>
<th>Drug</th>
<th>BNF (1)</th>
<th>Maudsley (3)</th>
<th>Bazire (4) ¹</th>
<th>DoH (7)</th>
<th>Ashton Manual (2) ²</th>
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<tbody>
<tr>
<td>Diazepam</td>
<td>5mg</td>
<td>5mg</td>
<td>5mg</td>
<td>5mg</td>
<td>5mg</td>
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<tr>
<td>Alprazolam</td>
<td>250 micrograms</td>
<td>500 micrograms (0.25-0.5mg)</td>
<td>250 micrograms</td>
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<tr>
<td>Chlordiazepoxide</td>
<td>12.5mg</td>
<td>12.5mg</td>
<td>15mg (10-25mg)</td>
<td>15mg</td>
<td>12.5mg</td>
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<tr>
<td>Clobazam</td>
<td>10mg</td>
<td>10mg</td>
<td>10mg</td>
<td></td>
<td></td>
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<tr>
<td>Clonazepam*</td>
<td>250 micrograms</td>
<td>0.5-1mg</td>
<td>500 micrograms (0.25-4mg)</td>
<td>250 micrograms</td>
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</tr>
<tr>
<td>Flurazepam</td>
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<td>7.5-15mg</td>
<td>7.5-15mg</td>
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<tr>
<td>Loprazolam</td>
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<td>500 micrograms</td>
<td>0.5-1mg</td>
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<tr>
<td>Lorazepam</td>
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<td>500 micrograms</td>
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<td>500 micrograms</td>
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<tr>
<td>Lormetazepam</td>
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<td>500 micrograms</td>
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</tr>
<tr>
<td>Nitrazepam</td>
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<td>5mg</td>
<td>5mg (2.5-20mg)</td>
<td>5mg</td>
<td>5mg</td>
</tr>
<tr>
<td>Oxazepam</td>
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<td>15mg</td>
<td>15mg (10-40mg)</td>
<td>15mg</td>
<td>10mg</td>
</tr>
<tr>
<td>Temazepam</td>
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<td>10mg</td>
<td>10mg</td>
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<td>10mg</td>
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</table>

¹ Inter-patient variability and differing half-lives mean the figures can never be exact and should be interpreted using clinical and pharmaceutical knowledge

² These equivalents do not agree with those used by some authors. They are firmly based on clinical experience but may vary between individuals. Ashton also provides equivalent doses of benzodiazepines not prescribed in the UK.

*Please note:* While there is broad agreement in the literature about equivalent doses of benzodiazepines, clonazepam has a wide variety of reported equivalences and particular care is needed with this drug (4).
Appendix 2

Further Information/Education Resources for Clinicians

- The MHRA benzodiazepine training module
  [http://www.mhra.gov.uk/ConferencesLearningCentre/LearningCentre/Medicineslearningmodules/Reducingmedicinerisk/Benzodiazepineslearningmodule/index.htm](http://www.mhra.gov.uk/ConferencesLearningCentre/LearningCentre/Medicineslearningmodules/Reducingmedicinerisk/Benzodiazepineslearningmodule/index.htm)

- Information from the Royal College of Psychiatrists on anxiety, insomnia etc for patients that may be useful in practice
  [http://www.rcpsych.ac.uk/expertadvice/problemsdisorders.aspx](http://www.rcpsych.ac.uk/expertadvice/problemsdisorders.aspx)

- Training module from BMJ – Benzodiazepine dependence: an update on management
  [http://n3.learning.bmj.com/learning/search-result.html?moduleId=6059529](http://n3.learning.bmj.com/learning/search-result.html?moduleId=6059529)