Prescribing guidelines for Benzodiazepines in Adults

Amendment History

VERSION	DATE	AMENDMENT HISTORY
		Comments
Version 1.0	2007	Current guidance
Version 2.0	September 2016	Draft version to ratify
	December 2016 (Version 2.1)	Updated following feedback from ACE
Version 3.0	January 2017	Draft version to ratify
Version	March 2017	Updated paragraph on page 8-9 regarding long term use of benzodiazepines

REVIEWERS
This document had been reviewed by:

NAME	DATE	TITLE/RESPONSIBILITY	VERSION
ACE		Assurance Framework for managing clinical policies and guidelines	8

APPROVALS
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RELATED DOCUMENTS
These documents will provide additional information:

REFERENCE NUMBER	DOCUMENT TITLE	VERSION

APPLICABLE LEGISLATION

N/A

GLOSSARY OF TERMS

TERM	ACRONYM	DEFINITION
Clinical Commissioning Group	CCG	
Area Clinical Effectiveness Committee	ACE	

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Background

Benzodiazepines are clinically effective for a number of indications including the reduction of anxiety, the induction and maintenance of sleep, muscle relaxation and the treatment and prevention of epileptic seizures. These properties are shared by most benzodiazepines, to varying degrees, depending on their potency and pharmacokinetic properties.

Benzodiazepines have a range of well documented adverse effects that may outweigh the benefits in certain patient populations including psychomotor impairment (which may increase the risk of falls and accidents), development of tolerance and dependence, potential for abuse and "selling on" and other psychiatric symptoms (e.g. depression, disinhibition).

GENERAL GUIDANCE

Benzodiazepines should be used at the lowest effective dose for as short a duration as possible

Consideration of alternatives to benzodiazepines should include a balanced appraisal of the relative benefits and risks of the range of options, in acute and longer-term treatment. Non-pharmacological interventions should always be considered as alternatives or additions to pharmacological treatment.

Dependence is recognized as a significant risk in some patients receiving treatment for longer than one month, and health professionals should be conscious of this when considering the relative benefits and risks of treatment. The potential risks of long-term treatment need to be considered prior to starting short-term treatment.

COMMON INDICATIONS

Treatment of anxiety disorders

- NICE guidance on generalised anxiety disorder (GAD) in adults advocates a stepwise approach to management, offering or referring for the least intrusive, most effective intervention first. Therefore, non-drug interventions should be the mainstay of treatment for many people, with drugs generally reserved for more severe illness or when symptoms have failed to respond to non-drug interventions.
- NICE recommends that benzodiazepines are not offered for GAD in primary or secondary care except **as a short-term measure during crises.**
- Where benzodiazepine treatment is required, the following regimes are recommended for 2 – 4 weeks (review after 2 weeks)

Guidelines for Benzodiazepine Prescribing in Primary Care

Current prescribing recommendations:

1. 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.
2. The use of benzodiazepines to treat short-term "mild" anxiety is inappropriate and unsuitable.
3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress.

Non-drug treatments:

- First line treatment for non-severe anxiety and insomnia is not-drug treatment including self-help advice.
- Written sleep hygiene advice should be given to all patients (or carers of patient) with insomnia (see attached leaflet).
- Useful self-help guides are available on the following website: http://www.nhs.uk/conditions/insomnia/pages/treatment.aspx and http://www.nhs.uk/conditions/anxiety/pages/treatment.aspx

If a benzodiazepine drug is considered essential:

- The lowest possible dose should be used for the shortest possible duration.
- Patients should be advised to take the drug only when they feel it is necessary – prescribe as 'when required'.
- Self-help advice should be offered or re-enforced in addition to drug treatment.
- Patients should be advised of the potential for dependence and other side effects; stress that the prescription is for short-term use only.
- Only small quantities should be prescribed and repeat prescriptions should not be issued without regular patient review.
- The relevant diagnosis should be recorded in the patient's notes.
- **Hypnotics**: ideally use short-acting drugs for less hangover effects and daytime sedation, especially in the elderly. Temazepam is currently the least expensive short-acting hypnotic benzodiazepine drug and should therefore be used as the drug of choice where necessary.
- **Anxiolytics**: long-acting drugs require fewer daily doses and are less likely to cause withdrawal problems; they may therefore be preferred. Diazepam is currently the least expensive long-acting anxiolytic benzodiazepine drug and should therefore be used as the drug of choice where necessary.

Long-term benzodiazepine prescribing:

- Given the CSM recommendations above, long-term use can strictly be defined as prescription of benzodiazepine drugs continuously for more than 4 weeks.
- Patients should be informed of the risks associated with long-term prescribing or benzodiazepines.
- Regular review, and where appropriate attempts to reduce or discontinue benzodiazepine therapy, should be undertaken for all patients.

Strategies for reduction of long-term benzodiazepine prescribing:

- There is evidence that sending educational letters to patients explaining 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 about (or attempted) reduction. The evidence shows a 17 – 33 % reduction in usage.
- There is also evidence that patient consultations encouraging benzodiazepine reduction are successful.
- Additionally, there is evidence demonstrating the effectiveness, in terms of reducing long-term benzodiazepine prescribing, of educational interventions aimed at prescribers, including information provided by pharmacists.

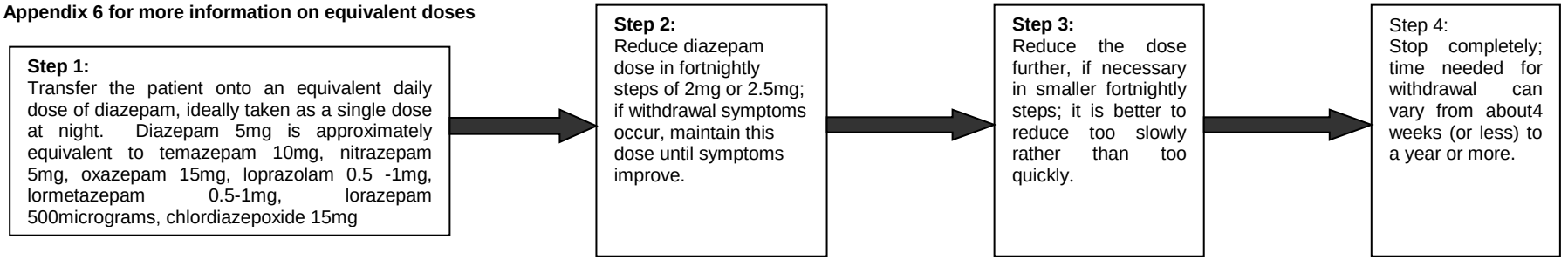
Based on Guidelines previously developed by
Bradford South & West Primary Care Trust, August 2001

NHS
Dudley
Clinical Commissioning Group

Benzodiazepine reduction – practical advice:

Discontinuation of benzodiazepine drugs should be gradual to minimise the risk of withdrawal effects. 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.

See Appendix 6 for more information on equivalent doses



Alternative drugs:

- There have been several case reports of dose escalation, dependence and withdrawal reactions for both zopiclone and zolpidem.
- For this reason, these drugs are best avoided 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 therefore also be avoided.

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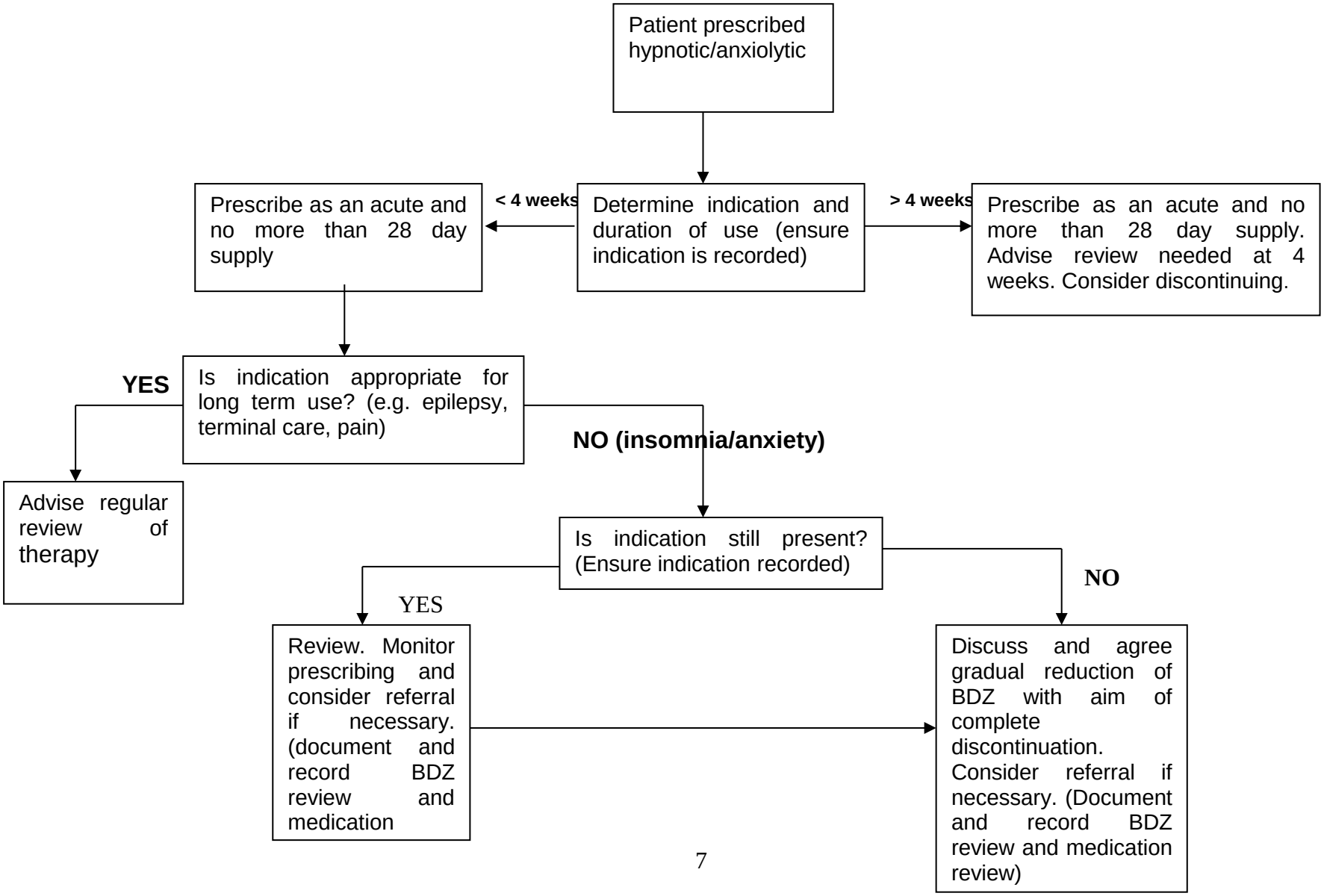
Based on Guidelines previously developed by
Bradford South & West Primary Care Trust, August 2001

FLOW CHART FOR REVIEW OF PATIENTS PRESCRIBED BENZODIAZEPINE AND RELATED DRUGS



Summary of Benzodiazepines Guidelines

1. **New prescriptions for benzodiazepines should only be issued:**
   For short-term relief (no longer than four weeks) of severe anxiety or insomnia.

   Summary:

- 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.

2. **The records show that the patient has been given appropriate advice on the risks, including the potential for dependence.**

   Summary:

- There is a risk of dependence with benzodiazepines, even at therapeutic doses.

- Chronic use (even at therapeutic doses) may lead to the development of physical and psychological dependence.

3. **The records show that patients prescribed benzodiazepines are reviewed regularly.**

Summary:

- The initial review upon completion of the first prescribed course should assess response to the treatment(s) and reinforce non-drug treatment(s).

- 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.

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.**

   Summary:

- 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 debilitated patients) should not exceed half those normally recommended

5. **2. Chronic users (use of 4-8 weeks or longer) should be identified and encouraged to reduce.**

6. 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.

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.

a. 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.
b. 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.
c. Alternative support measures as well as alternative medications should continue to be offered.

Summary:
A structured programme for identifying long-term users, coupled with a strategy for gradually withdrawing benzodiazepines, may result in many patients enjoying an improved quality of life.

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Appendix 1

Dear

I am writing to you because I note from our records that you have been taking …….<drug>…. for some time now. Recently, family doctors have become concerned about this kind of tranquillizing 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 effects which you will experience. Research work done in this field shows that repeated use of the tablets over a long time is no longer 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 to me personally about this, I would be delighted to see you in the surgery at a mutually convenient time.

Yours sincerely

Appendix 2

Dear

From our records we notice that you are currently taking _____, which is known as a benzodiazepine.

Benzodiazepines are sedative drugs, which are prescribed by your Doctor to reduce anxiety, to encourage sleep or to act as a muscle relaxant. In the **SHORT** term they can relieve the symptoms of stress and anxiety and promote sleep.

Benzodiazepines can cause many problems, one of which is that they become ineffective after continuous use. Some people experience side effects such as drowsiness, forgetfulness, confusion, depression and digestive problems. They are also habit forming. Some people may also experience:

- Tolerance- a need for larger doses to get the same effect.
- Withdrawal symptoms- these vary from one person to another and may include anxiety, sleeping problems, panic attacks and nausea.

If you want to come off these tablets, DO NOT stop suddenly. Even though most people have NO problems coming off these tablets, withdrawal needs to be gradual and under the supervision of your Doctor.

As a practice we have agreed that you must see your Doctor or Practice Pharmacist for a review before getting your next prescription for this medication. Please book an appointment for a review before your next prescription is due.

At the same time we would like to review all the medication you take and would be happy to answer any questions regarding your medication.

Please take time to read the enclosed information leaflets, which we hope you will find useful.

If you have any questions please do not hesitate to contact your Doctor or Practice Pharmacist.

Yours Sincerely,

Appendix 3

Dear

We are writing to you because we note from our records that you have been taking _____ for some time now. We are concerned about this kind of medicine 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 and they have side effects, such as anxiety and sleeplessness. They may make you unsteady on your feet, and even cause you to fall. They also reduce your ability to do everyday tasks safely, such as driving. Research has shown that repeated use of these tablets over a long time is no longer recommended and that they can be addictive.

We do not want you to stop taking the tablets suddenly as this could cause unpleasant effects in some people. The best way to do this is to cut down very gradually, then you will be less likely to have any withdrawal effects. You should take the tablets only when you feel they are absolutely necessary.

Please take time to read the enclosed information leaflets, which we hope you will find useful. To encourage you to cut down we will reduce the amount of tablets on your next prescription.

If you have any concerns please contact your Doctor or the practice pharmacist. If we do not hear from you then we will assume that you are happy for us to amend your next prescription.

Yours Sincerely,

Appendix 4

NHS Dudley Clinical Commissioning Group

HELP WITH SLEEP

INFORMATION FOR CARERS

- Older people need less sleep at night, particularly if they doze during the day.
- It is important to have a set time for getting up; The time for going to bed can be more flexible.
- It is normal for older people to awaken several times during the night. This is not harmful. Being awake does not necessarily mean that the individual is distressed. Resting in bed is almost as good as sleeping.
- A good night's sleep may follow a sleepless night, without the need to resort to a sleeping pill.
- Physical symptoms, especially pain, which disturb sleep should be treated in their own right.
- The doctor should be alerted to symptoms of anxiety or depression.
- A range of activities should be encouraged in order to maintain alertness and interest in life.
- Sleeping pills are addictive. They should only be used on occasions when they are really needed.
- Sleeping pills can have "hangover" effects the next day causing difficulty with concentration, dizziness, drowsiness, and falls.
- As a carer, you should feel able to discuss your own feelings with the doctor. You are entitled to periods of respite care to enable you to have a much needed break!

Adapted from original material in the report of the Scottish National Medical Advisory Committee on the management of anxiety and insomnia

NHS Dudley Clinical Commissioning Group

SLEEP ADVICE

THE FOLLOWING IS A LIST OF THINGS YOU CAN DO TO HELP YOU TO SLEEP:

1. Take regular exercise.
2. Avoid sleeping (including naps) during the day.
3. Try to keep a regular time for going to bed and getting up to establish a routine.
4. Make sure your bedroom is warm but well ventilated and that your bed is comfortable.
5. Block out light and noise in your bedroom or, if this is not possible, try using a sleep mask and ear plugs.
6. Avoid tea, coffee, cola, alcoholic drinks and smoking for a couple of hours before bedtime. Caffeine (in tea, coffee and cola) and nicotine (in cigarettes) act as stimulants and can stop you getting to sleep. Alcohol may interrupt your sleep by making you thirsty, or by making you visit the toilet during the night; it can also make you wake up early.
7. Having a hot, milky drink (without caffeine) before going to bed can help you to feel sleepy. It is also best to avoid eating a meal just before bedtime.
8. Having a warm bath before bed can also help by making you more relaxed.
9. If you lie awake in bed for more than half an hour, do not stay in bed. Get up and try reading or listening to some soothing music until you feel tired.
10. When you get into bed, try to clear your mind of thoughts. If you find yourself worrying or going over the day's activities in your mind, try setting aside some time earlier in the evening for clearing your head.
11. Relaxation tapes can also help.

Appendix 5 THE GOOD SLEEP GUIDE

DURING THE EVENING

- Put the day to rest. Think it through. Tie up "loose ends" in your mind and plan ahead. A notebook may help.
- Take some light exercise early in the evening. Generally try to keep yourself fit.
- Wind down during the course of the evening. Do not do anything that is mentally demanding within 90 minutes of bedtime.
- Do not sleep or doze in the armchair. Keep your sleep for bedtime.
- Do not drink too much coffee or tea and only have a light snack for supper. Do not drink alcohol to aid your sleep - it usually upsets sleep.
- Make sure your bed and bedroom are comfortable - not too cold and not too warm.

AT BEDTIME

- Go to bed when you are "sleepy tired" and not before.
- Do not read or watch TV in bed. Keep these activities for another room.
- Set the alarm for the same time every day, seven days a week, at least until your sleep pattern settles down.
- Put the light out when you get into bed.
- Let yourself relax and tell yourself that "sleep will come when it's ready". Enjoy relaxing even if you don't at first fall asleep.
- Do not try to fall asleep. Sleep is not something you can switch on deliberately but if you try to switch it on you can switch it off!

IF YOU HAVE PROBLEMS GETTING TO SLEEP

- Remember that sleep problems are quite common and they are not as damaging as you might think. Try not to get upset or frustrated.
- If you are awake in bed for more than 30 minutes then get up and go into another room.
- Do something relaxing for a while and don't worry about tomorrow. People usually cope quite well even after a sleepless night.
- Go back to bed when you feel "sleepy tired".
- Remember the tips from the section above and use them again.
- A good sleep pattern may take a number of weeks to establish. Be confident that you will achieve this in the end by working through the "**GOOD SLEEP GUIDE**"!

This guide has been adapted from material originally prepared by Dr Colin Espie.

THE GOOD RELAXATION GUIDE

DEALING WITH PHYSICAL TENSION

- Value times of relaxation. Think of them as essentials not extras. Give relaxation some of your best time not just what's left over.
- Build relaxing things into your lifestyle every day and take your time. Don't rush. Don't try too hard.
- Learn a relaxation routine, but don't expect to learn without practice.
- There are many relaxation routines available, especially on audio tape. These help you to reduce muscle tension and to learn how to use your breathing to help you relax.
- Tension can show in many different ways - aches, stiffness, heart racing, perspiration, stomach churning etc. Don't be worried about this.
- Keep fit. Physical exercise, such as a regular brisk walk or a swim, can help to relieve tension.

DEALING WITH WORRY

- Accept that worry can be normal and that it can be useful. Some people worry more than others but everyone worries sometimes.
- Write down your concerns. Decide which ones are more important by rating each out of ten.
- Work out a plan of action for each problem.
- Share your worries. Your friends or your general practitioner can give you helpful advice.
- Doing crosswords, reading, taking up a hobby or an interest can all keep your mind active and positive. You can block out worrying thoughts by mentally repeating a comforting phrase.
- Practice enjoying quiet moments, e.g. sitting listening to relaxing music. Allow your mind to wander and try to picture yourself in pleasant, enjoyable situations!

DEALING WITH DIFFICULT SITUATIONS

- Try to build up your confidence. Try not to avoid circumstances where you feel more anxious. A step by step approach is best to help you face things and places which make you feel tense. Regular practice will help you to overcome your anxiety.
- Make a written plan and decide how you are going to deal with difficult situations.
- Reward yourself for your successes. Tell others. We all need encouragement.
- Your symptoms may return as you face up to difficult situations. Keep trying and they should become less troublesome as your confidence grows.
- Everyone has good days and bad days. Expect to have more good days as time goes on.
- Try to put together a programme based on all of the elements in "The Good Relaxation Guide" that will meet the needs of your particular situation. Remember that expert guidance and advice is available if you need further help.

Appendix 6

UKMI Q&A 293.5

What are the equivalent doses of oral benzodiazepines?

Prepared by UK Medicines Information (UKMi) pharmacists for NHS healthcare professionals
Before using this Q&A, read the disclaimer at https://www.sps.nhs.uk/articles/about-ukmi-medicines-qas/
Date prepared: 24th June 2016

Background

Benzodiazepines are the most commonly used anxiolytics and hypnotics (1). There are major differences in potency between different benzodiazepines and this difference in potency is important when switching from one benzodiazepine to another (2). Benzodiazepines also differ markedly in the speed in which they are metabolised and eliminated. With repeated daily dosing accumulation occurs and high concentrations can build up in the body (mainly in fatty tissues) (2). The degree of sedation that they induce also varies, making it difficult to determine exact equivalents (3).

Answer

Advice on benzodiazepine conversion

NB: Before using Table 1, read the notes below and the Limitations statement at the end of this document.

Switching benzodiazepines may be advantageous for a variety of reasons, e.g. to a drug with a different half-life pre-discontinuation (4) or in the event of non-availability of a specific benzodiazepine. With relatively short-acting benzodiazepines such as alprazolam and lorazepam, it is not possible to achieve a smooth decline in blood and tissue concentrations during benzodiazepine withdrawal. These drugs are eliminated fairly rapidly with the result that concentrations fluctuate with peaks and troughs between each dose. It is necessary to take the tablets several times a day and many people experience a "mini-withdrawal", sometimes a craving, between each dose. For people withdrawing from these potent, short-acting drugs it has been advised that they switch to an equivalent dose of a benzodiazepine with a long half life such as diazepam (5). Diazepam is available as 2mg tablets which can be halved to give 1mg doses. This means the dose can be reduced in stages of 1mg every 1-4 weeks or more. It is difficult to obtain such low doses of other benzodiazepines (6).

Extra precautions apply in patients with hepatic dysfunction as diazepam and other longer-acting drugs may accumulate to toxic levels. Diazepam substitution may not be appropriate in this group of patients (3).
Concomitant kidney or liver failure should be taken into consideration when prescribing all benzodiazepines (1).

Table 1: Approximate equivalent doses of oral benzodiazepines licensed in the UK (see advice above). Table adapted for use based on local prescribing data.

Drug	BNF (1)	Maudsley (3)	Bazire (4)a	DoH (7)	Ashton Manual (2)b
Diazepam	5mg	5mg	5mg	5mg	5mg
Chlordiazepoxide	12.5mg	12.5mg	15mg (10-25mg)	15mg	12.5mg
Clobazam	10mg		10mg		10mg
Clonazepam*	250 micrograms	0.5-1mg	500 micrograms (0.25-4mg)		250 micrograms
Loprazolam	0.5-1mg		0.5-1mg	500 micrograms	0.5-1mg
Lorazepam	500 micrograms	500 micrograms	500 micrograms	500 micrograms	500 micrograms
Lormetazepam	0.5-1mg	500 micrograms	0.5-1mg		0.5-1mg
Nitrazepam	5mg	5mg	5mg (2.5-20mg)	5mg	5mg
Oxazepam	10mg	15mg	15mg (10-40mg)	15mg	10mg
Temazepam	10mg	10mg	10mg	10mg	10mg

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

Limitations

- The effect of drug interactions affecting benzodiazepine pharmacodynamics and pharmacokinetics is not covered in this Medicine Q&A.
- Detailed guidance on the management of benzodiazepine dependence and withdrawal is not provided in this Medicine Q&A.

References

1. Joint Formulary Committee. British National Formulary. [Online]. London: BMJ Group and Pharmaceutical Press; Accessed via https://www.medicinescomplete.com/mc/bnf/current/PHP78112-hypnotics-and-anxiolytics.htm on 17/5/2016
2. Ashton CH. Benzodiazepines: How they work and how to withdraw (aka The Ashton Manual) 2002 Chapter I. http://www.benzo.org.uk/manual/bzcha01.htm Accessed on 24/5/2016

Appendix 7

Driving

SHOULD A PERSON TAKING BENZODIAZEPINES OR Z-DRUGS AND DRIVE?

The following advice should be given to people who take benzodiazepines:

You should not drive if you feel drowsy, dizzy, and unable to concentrate or make decisions.

It is now an offence to drive if you have more than a specified amount of benzodiazepine in your body whether your driving is impaired or not.

Roadside drug screening tests have been introduced into the UK since March 2015. These test the saliva for drugs that impair driving. If you have a positive roadside drug test for benzodiazepines, the police may ask you to provide a blood sample to measure the amount of benzodiazepine in your body.

If you are found to have more than the specified amount of benzodiazepine, as long as your driving is not impaired, you are taking your medicine on the advice of your GP, or your pharmacist, you will be able to raise a 'statutory defence' and the police may not prosecute you.

It may be helpful to keep evidence with you while you are driving, that you are taking a benzodiazepine in accordance with medical advice. Suitable evidence may include: your medication box with the pharmacy label on, or the other half of your prescription with the list of medicines prescribed by your doctor.

The DVLA provides no advice for people taking z-drugs.

For more information, see the 'At a glance guide' available on the DVLA website.

Reference:
http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal#!scenario