Guidelines for the prescribing of ORAL BENZODIAZEPINES AND Z-DRUGS (BDZ) (*Anxiolytics / Hypnotics*)

NHS Rotherham Clinical Commissioning Group

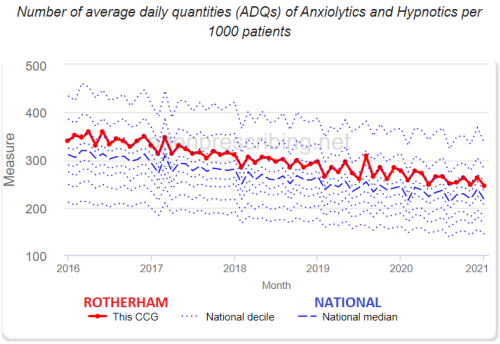
* KEY POINTS *

- Benzodiazepines and Z-drugs (BDZs) should only be prescribed as a last resort when non-pharmacological alternatives have been explored, tried and exhausted.
- BDZ should only be prescribed at the "lowest effective dose" for the "shortest time possible" (max 2 to 4 weeks). **Only issue as acute prescriptions, reviewing each time requested.**
- Royal College of Psychiatrists states *"around 4 in every 10 people who take them every day for more than 6 weeks will become addicted"* and therefore they should not be prescribed for longer than 4 weeks. **BDZs should not be added a patient's repeat medication** (in most circumstances)
- Risks associated with BDZs such as cognitive impairment, confusion, falls, dependence and withdrawal symptoms, are well-known and should be discussed with patients before prescribing
- Patients on long-term BDZs should be advised of the risks and offered/supported on a gradual reduction/withdrawal using national algorithms, guidelines and recommendations
- Law on driving (March 2015) updated guidance for prescribers and patients (*including leaflets*)

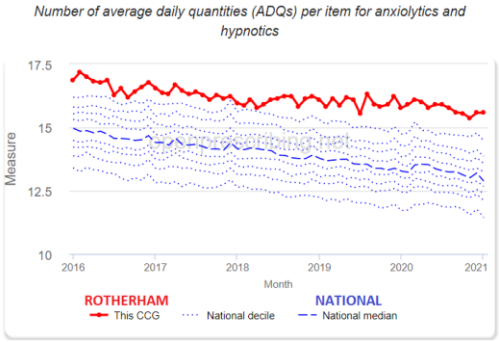
* PRESCRIBING DATA/TRENDS *

https://openprescribing.net

Average Daily Quantity (ADQ): Rotherham **v** National



BDZ "**prescriptions per 1000 patients**"

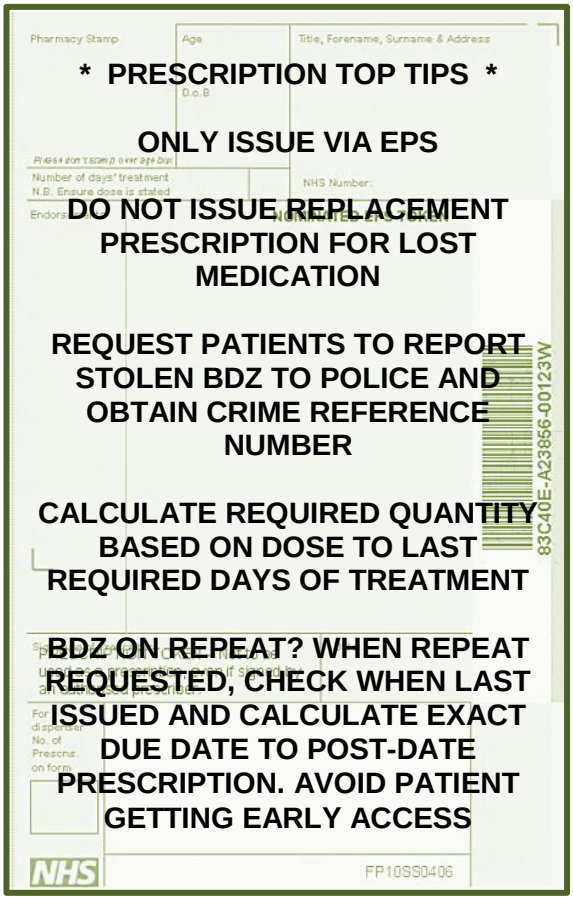


BDZ "**quantity per prescription**"

* MEDICATION REVIEWS *

- Patients who have been prescribed BDZs on repeats should be reviewed on a regular basis (at least 6 monthly) to assess their on-going suitability for long term prescribing
- Use read code "Benzodiazepine Clinical Management Plan" (snomed code: 1064271000000109) to document, in patient record, discussion re benefits of stopping and risk of continuing BDZs
- Best practice in the management of BDZ withdrawal available at NICE Clinical Knowledge Summaries
- Many BDZ reduction/stopping tools, including clinical system templates and leaflets based upon the various recommendations are available for use: Ardens Choice&Medication ?

Network Contract Directed Enhanced Service (DES) states a PCN is required to prioritise their PCN's patients who would benefit from a Structured Medication Review (SMR), which must include patients using one or more potentially addictive medications from the following groups: opioids, gabapentinoids, **benzodiazepines and z-drugs**.



* PRESCRIPTION TOP TIPS *

ONLY ISSUE VIA EPS

DO NOT ISSUE REPLACEMENT PRESCRIPTION FOR LOST MEDICATION

REQUEST PATIENTS TO REPORT STOLEN BDZ TO POLICE AND OBTAIN CRIME REFERENCE NUMBER

CALCULATE REQUIRED QUANTITY BASED ON DOSE TO LAST REQUIRED DAYS OF TREATMENT

BDZ ON REPEAT? WHEN REPEAT REQUESTED, CHECK WHEN LAST ISSUED AND CALCULATE EXACT DUE DATE TO POST-DATE PRESCRIPTION. AVOID PATIENT GETTING EARLY ACCESS

Produced by Raz Saleem (Prescribing Advisor – Medicines Management Team), March 2021

NEW DIAGNOSIS / INTIATIONS

ANXIETY (*anxiolytics*)

- Do not offer a benzodiazepine for the treatment of Generalised Anxiety Disorder (GAD) in primary or secondary care (except as a acute measure during crisis/SSRI initiation, up to 4 weeks maximum)
- Benzodiazepines should only be used acutely for short-term management of a specific circumstance as a single dose for anxiety prior to the specific trigger e.g. dental procedure (via Dentist), hospital procedure/surgery (via Hospital) or flying (Private GP/Travel Clinic)
- **Do not add benzodiazepines to repeats** unless requested by Secondary Care (e.g. Mental Health, Neurology or Substance Misuse) who should regularly monitor/review the patient and on-going need
- **Mild/Moderate**: self-help resources or patients can self-refer to RDaSH Improving Access to Psychological Therapies Team (IAPT) by calling 01709 447755 or via online referral form

Drug treatment *(low initial dose, titrate up slowly)* **First line:** sertraline **Second line:** citalopram or fluoxetine

- **Severe** (or not responding to drug treatment): refer patient to RDasH Community Mental Health Services (CMHS)

INSOMNIA (*hypnotics*)

- Identify and address any underlying causes of insomnia or associated co-morbidities
- Sleep onset insomnia (difficulty falling asleep) **v** sleep maintenance insomnia (difficulty staying asleep)
- Advise "good sleep hygiene" and review patient's sleep expectations (most adults need 6-9 hours)
- Zopiclone and Zolpidem are commonly known as Z-drugs. Though Z-drugs are not benzodiazepines, they act in a similar way to and have similar long-term usage problems as benzodiazepines
- Only use a Z-drug if insomnia is severe (disabling daytime impairment or causing the patient extreme distress). Ensure clinician-patient shared prescribing agreement and expectations from onset
- **Acute prescription only. Do not add to repeats.**

First line: zopiclone 3.75mg-7.5mg at bedtime **Second line:** zolpidem 5mg-10mg at bedtime

- Elderly patients: due to increased risk of adverse effects, always start with lowest dose
- All patients: prescribe "lowest dose that controls symptoms for the shortest period of time"
- 1st acute prescription should be for no longer than 7-14 days and then need for follow-up review
- Hypnotics are licensed for short-term use only (up to 4 weeks maximum)
- Counsel patient regarding caution with driving/using machinery (up to 12 hours after taking dose)
- If a patient does not respond to one Z-drug, do not switch to another hypnotic in an attempt to get a better response as there is no evidence to suggest that switching works. Re-visit causes of insomnia

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