NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Benzodiazepines and Z-drugs as Hypnotics and Anxiolytics

A support document consolidating national guidance, expert opinion and local resources to aid local practice including prescribing, de-prescribing/withdrawal and self-care.

Shaping better health

Contents

Background

Benzodiazepines are GABA receptor agonists which have hypnotic, anxiolytic, anticonvulsant, and muscle relaxant properties. The BNF groups benzodiazepines into hypnotics and anxiolytics[1].

Benzodiazepines as hypnotics

- Indicated to treat insomnia of recent onset only when it is severe, disabling, or causing the patient extreme distress. Tolerance to their effects develops within 3 to 14 days of continuous use and long-term efficacy cannot be assured. A major drawback of long-term use is that withdrawal can cause rebound insomnia and a withdrawal syndrome[2].
- Treatment should be limited to a maximum duration of 2 weeks (including any tapering off period).
- Hypnotics include nitrazepam and flurazepam (which are longer-acting) and loprazolam, lormetazepam, and temazepam (which are short-acting and therefore have little or no next-day 'hangover' effect)[1].

Benzodiazepines as anxiolytics

- 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].
- Anxiolytics include diazepam, alprazolam (not available on NHS prescription), chlordiazepoxide, and clobazam (which have a sustained action), and lorazepam and oxazepam (which are shorter acting)[1].

Z-drugs as hypnotics

- Non-benzodiazepine hypnotics. Like benzodiazepines, they are also GABA receptor agonists. There is no firm evidence of differences in the effect of z-drugs and shorter-acting benzodiazepines[1].
- Zolpidem is indicated for the short-term treatment of insomnia in adults in situations where the insomnia is debilitating or is causing severe distress for the patient.
- Zopiclone is indicated for the short-term treatment of insomnia in adults.
- Treatment should be limited to a maximum duration of 2 weeks (including any tapering off period).

Benzodiazepines as muscle relaxants and for back pain

- Diazepam is the only benzodiazepine licensed for muscle spasm in the UK.
- Benzodiazepines **should not** be used to treat back pain.
- NICE CKS on the management of low back pain (without radiculopathy)
  'Do *not* recommend the use of benzodiazepines for the management of muscle spasm associated with acute low back pain'.
- Benzodiazepines **should not** be used in the treatment of sciatica NICE NG59
- If a benzodiazepine is considered appropriate this should be prescribed as a **very short (2-5 days)** time-limited course to help minimise the high risk of adverse events and habituation.

Risks

Use of benzodiazepines or z-drugs is associated with

- Increased risk of death due to[1]
  - Over-sedation increasing risk of falls and accidents.
  - Poisoning from overdose.
  - Studies have shown that users of hypnotics exhibit an increased risk of cancer that does not appear to be fully explained by preferential prescribing in people with poor health.
- Tolerance — a higher dose is required to obtain the initial effect.
- Dependence — the person feels they need the medication to carry out day-to-day activities, and/or withdrawal symptoms occur upon stopping or dose reduction.
- Cognitive effects, anxiety, agoraphobia, emotional blunting, reduced coping skills, and amnesia.
- Reduced social functioning due to effects on memory, reduced ability to remember new people, appointments etc.
- Depression, either for the first time, or aggravation of pre-existing depression with possible precipitation of suicidal tendencies[1].

Older people are more vulnerable to the CNS depressant effects of benzodiazepines, possibly leading to falls, confusion, night wandering, amnesia, ataxia, and hangover effects. Impaired cognitive function and memory may be wrongly diagnosed as dementia[1].

Risk factors for benzodiazepine/z-drug dependence may include:

- Drug dose and length of exposure — frequent, long-term, high dose users are more likely to become dependent.
- Use of benzodiazepines with high potency and short elimination half-lives (such as lorazepam and loprazolam)— may lead to development of anxiety symptoms between doses, leading to more frequent dosing.
- Onset of effect — more fat-soluble drugs (such as diazepam) are absorbed faster and enter the central nervous system more rapidly, Rapid-onset drugs are associated with ‘good’ subjective effects, and therefore result in psychological reinforcement every time they are taken. Higher dose leads to better subjective effects.
- A history of current or past alcohol or other sedative-hypnotic dependence, or a family history of these.
- Use of recreational drugs.
- Co-morbid chronic psychiatric and personality problems, physical health problems (especially in older people), pain problems, or sleep difficulties[1].

Misused benzodiazepines are usually obtained through diversion from legitimate sources including pharmacies, pharmaceutical suppliers, and prescription. Higher prescribing rates are associated with increased misuse[5].

Withdrawal syndrome

- Benzodiazepine withdrawal syndrome may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but may occur within a day of stopping a short-acting one.
- Symptoms include
  - insomnia
  - anxiety
  - loss of appetite and of body-weight
  - tremor
  - perspiration
  - tinnitus
  - perceptual disturbances
- Symptoms may continue for weeks or months after stopping benzodiazepines[6].

Prescribing Advice - "Dos and Don'ts"

Do…

- Before starting or continuing treatment with a benzodiazepine or z-drug, ensure that all suitable management options, including non-pharmacological approaches and watchful waiting, have been discussed with and offered to the person as part of a shared decision-making consultation.
- Always consider alternatives to benzodiazepines, such as
  - non-pharmacological strategies e.g. CBT, mindfulness, social prescribing, www.sleepstation.org.uk (not currently funded BNSSG wide), Sleepio/calm/headspace apps (these would need to be patient funded). See page 8 for more options and details.
  - medication with less risk of dependence e.g. SSRIs.
- Always consider the potential for dependence or other harmful effects when prescribing benzodiazepines.
- Prescribe benzodiazepines/z-drugs as "acute" medication, not "repeat".
- Only prescribe small quantities and do not repeat the prescription without patient consultation.
- Manage patient expectations from the start. Patients should be aware that pharmacological intervention will only be brief due to the risks associated with long term prescribing.
- Document discussion of risk, benefit, and recommended usage schedule in patient consultation notes so clear for all clinicians.
- Keep prescribing on acute and include duration/frequency info in dosage line.
- Prescribe the lowest possible doses of benzodiazepines and only prescribe for up to 2-4 weeks. Benzodiazepines and z-drugs are licensed for anxiety and insomnia to a usual limit of 2-4 weeks - Use of medications outside the product license means the prescriber is taking on more responsibilities for risks to the patient.
- Use the lowest dose which will control symptoms, for shortest possible time.
- Use only for severe or disabling anxiety or insomnia[1].
- Where used as a hypnotic, advise intermittent use if possible.

- Advise patients of the risk of dependence and impaired reaction times. Advise that this may affect ability to drive or operate machinery. Also advise that effects of alcohol may be exacerbated.
- Prescribe the required diazepam dose as multiples of 2mg tablets. This has a psychological benefit, limits the risk of diversion, aids dose reduction and gives therapeutic flexibility.

Don't…

- Don't prescribe diazepam as 10mg tablets; ideally prescribe the required dose as multiples of 2mg tablets. This reduces the risk of diversion as the 10mg diazepam tablets are highly recognisable and have an increased street value.
- Don't use benzodiazepines for short-term mild anxiety. National Institute for Health and Care Excellence (NICE) guidelines state a benzodiazepine should not be used for treatment of generalised anxiety disorder[1].

Other Advice

- Caution should be used if initiating benzodiazepines in someone with a history of drug misuse and dependence as this is an additional risk.
- Elderly patients are particularly prone to adverse effects of benzodiazepines and, therefore, there is a need to be even more cautious when prescribing[9].
- Be aware that benzodiazepines cross the placenta, and may lead to neonatal side-effects[9]
- There are occasions where long term treatment is appropriate e.g. for seizure control, however insomnia and anxiety are not. There will be exceptional cases, where individuals with dependence may be provided with longer-term prescribing of benzodiazepines. Factors such as long duration of previous benzodiazepine prescribing, clear evidence of relevant pre-existing and concurrent comorbid mental health problems, or clear deterioration following previous adequate benzodiazepine detoxification are factors that clinicians may consider are relevant in such cases[11].
- If a prescriber thinks that a medicine is not in the person's best interests but a shared decision about starting or continuing a medicine cannot be reached with the person, the prescriber should follow the advice on 'handling patient requests for medicines you don't think will benefit them' in the General Medical Council guidance: good practice in prescribing and managing medicines and devices. The prescriber should:
    - not prescribe a medicine if they believe it is not in the person's best interests
    - explain the reasons for their decision to the person
    - document all discussions carefully and give a copy to the person
    - offer the person a second opinion[13]. https://www.gmc-uk.org/-/media/documents/prescribing-guidance-updated-english-20210405_pdf-85260533.pdf

Patient Decision Aid – Hypnotic Prescribing in over 60s[10]

Benefits of hypnotics: sleep time and night time awakenings
Imagine a group of 13 people aged 60 years or over, with primary insomnia. If they all take a hypnotic for at least five consecutive nights:

- About one person will sleep better. This means that, on average, they will only get an extra 25 minutes sleep each night and will wake up once less often every two nights (the green face).
- The hypnotic makes no difference to what happens to 12 people (the blue faces). Their sleep improves, or doesn't improve, just as if they had taken placebo.

But remember:

- It is impossible to know for sure what will happen to each individual person.
- All 13 people will have to take the hypnotic.

The hypnotic makes no difference to what happens to these 12 people. Their sleep improves, or doesn't improve, just as if they had taken placebo.

This person finds his/her sleep improves, who would not have done had he or she taken the placebo.

Harms of hypnotics
Imagine a group of 13 people aged 60 years or over, with primary insomnia. If they all take a hypnotic for at least five consecutive nights:

- About two will have adverse effects such as drowsiness or fatigue, headache, nightmares, nausea or gastrointestinal disturbances who would not have done had they taken placebo (the red faces).
- The hypnotic makes no difference to what happens to 11 people (the blue faces). They have adverse events, or don't have adverse events, just as if they had taken placebo

But remember:

- It is impossible to know for sure what will happen to each individual person.

The hypnotic makes no difference to what happens to these 11 people. They have adverse events, or don't have adverse events, just as if they had taken placebo.

These 2 people have an adverse event, who would not have done had they taken the placebo.

NICE Patient Decision Aids

- Medicines associated with dependence or withdrawal patient leaflet https://www.nice.org.uk/guidance/ng215/informationforpublic
- 'Should I Stop My Benzodiazepine or Z-Drug?' decision aids https://www.nice.org.uk/guidance/ng215/resources

Self-Care and Patient Support

BNSSG 'Lifestyle Prescription' on mental wellbeing
https://bnssg.icb.nhs.uk/library/mental-wellbeing-leaflet/ - Leaflet with advice to help you take responsibility for your own mental wellbeing through lifestyle changes.

BNSSG Remedy Social Prescribing Page
https://remedy.bnssg.icb.nhs.uk/adults/social-prescribing/

Benzodiazepines and z-drugs

- **BNSSG Remedy Non-Opiate Drug Dependence Page** https://remedy.bnssgccg.nhs.uk/adults/drug-and-alcohol-misuse/non-opiate-drug-dependence/ Local information and details of locally commissioned services that may be able to offer support.
    - **North Somerset –** We Are With You
    - **Bristol -** ROADS
    - **South Gloucestershire –** DHI
- **PostScript 360** https://postscript360.org.uk Support for individuals taking drugs associated with dependence including benzodiazepines, z-drugs, tranquilisers, gabapentinoids and 'legal highs'. They also provide training for health care professionals.
- **Narcotics Anonymous** https://ukna.org/ – Offers support, a telephone helpline, local support groups/meetings.
- **ADFAM** https://adfam.org.uk/ - A national charity working to improve life for families affected by drugs or alcohol. Offers a helpline and links to local support groups.
- **Breaking Free (Bristol only)** https://remedy.bnssgccg.nhs.uk/adults/drug-and-alcohol-misuse/breaking-free-bristol-only/ Breaking free is an online resource for patients with alcohol and drug problems, including prescribed medications, which is available for patients registered with a GP in Bristol.
- **NHS** https://www.nhs.uk/live-well/healthy-body/drug-addiction-getting-help/ - Patient information on how and where to get help with drug addiction.
- **Patient UK** https://patient.info/mental-health/insomnia-poor-sleep/benzodiazepines-and-z-drugs - Background information aimed at patients around benzodiazepines and z-drugs and associated issues.
- **Humankind** https://humankindcharity.org.uk/ Free, confidential support for alcohol, drugs, housing or mental health
- **Change Grow Live** https://www.changegrowlive.org/ A national health and social care charity. Help with challenges including drugs and alcohol, housing, justice, health and wellbeing

Sleeping

- **BNSSG Remedy Insomnia Page** https://remedy.bnssg.icb.nhs.uk/adults/sleep-medicine/insomnia/ Includes local guidance and details how patients can access CBTi - Silver Cloud (Silver Cloud is the only funded CBT-i service in BNSSG currently)
- **Sleepstation** https://www.sleepstation.org.uk/ Sleep Station is not currently commissioned for all BNSSG practices. However, some PCNs in BNSSG have secured funding and so practices may have access to this service.

- **NHS** https://www.nhs.uk/live-well/sleep-and-tiredness/ - Patient information on sleep and tiredness, possible causes and advice.
- **Patient UK** https://patient.info/mental-health/insomnia-poor-sleep - Background information aimed at patients on sleeping and associated problems. Useful self-care advice and sleep hygiene measures.
- **Royal College of Psychiatrists** https://www.rcpsych.ac.uk/mental-health/problems-disorders/sleeping-well - Patient aimed information about sleep and advice for poor sleep self-care and treatment.
- **Sleepio** https://www.sleepio.com/ - A digital sleep-improvement program featuring cognitive behavioural therapy techniques. **Currently not available on NHS locally so will require payment for full access.**

Anxiety

- **BNSSG Remedy IAPT Services** https://remedy.bnssg.icb.nhs.uk/adults/mental-health/iapt-services/
- **Second Step Wellbeing Services** https://remedy.bnssg.icb.nhs.uk/adults/mental-health/second-step-wellbeing-services/ Remedy page detailing who and how patients can access Second Step for mental wellbeing support
- **NHS** https://www.nhs.uk/oneyou/every-mind-matters/anxiety/ - NHS patient information around anxiety and management including self-care.
- **Vita Minds** https://www.vitahealthgroup.co.uk/nhs-services/nhs-mental-health/bristol-north-somerset-south-gloucestershire/# - Self-referral for psychological therapies.
- **Anxiety UK** https://www.anxietyuk.org.uk/ - Support and resources to help with anxiety. Offers telephone advice, access to therapists and support groups.
- **Royal College of Psychiatrists** https://www.rcpsych.ac.uk/mental-health/problems-disorders/anxiety-panic-and-phobias - Patient aimed information about anxiety and advice for self-care and treatment.
- **Mind** https://www.mind.org.uk/information-support/types-of-mental-health-problems/anxiety-and-panic-attacks/about-anxiety/ **-** Patient aimed information about anxiety and advice for self-care and treatment.

BNSSG Formulary

Comparison of oral benzodiazepines and z-drugs. Green are first line anxiolytics and hypnotics on BNSSG formulary, blue are second line and black are not on the BNSSG formulary or not included for sleep/anxiety (Correct as of June 2023 – available via https://remedy.bnssgccg.nhs.uk/). Note that specific BNSSG formulary indications for the different benzodiazepines differs – see Remedy for included indications.

Benzodiazepine agonist drug	Half Life of Parent Drug (hours)	Time to peak blood levels (hours)	Equivalence to diazepam 5mg
Diazepam	20-100	0.5-1.5	5mg
Lorazepam	10-20	2	0.5mg
Temazepam	8-22	0.8	10mg
Zopiclone	5-6	1.5-2	7.5mg
Oxazepam	4-15	1-5	10mg
Clonazepam	18-50	1-4	250mcg
Chlordiazepoxide	5-30	1-2	12.5mg
Alprazolam	12-15	1-2	250mcg
Loprazolam	4-15	4-5	0.5mg (to1mg)
Lormetazepam	11	1.5	0.5mg (to1mg)
Nitrazepam	18-25	2	5mg
Zolpidem	2	0.5-3	10mg

Table taken from reference 7, data from individual drug SPCs and the BNF

Drug Driving Law

It's illegal in England, Scotland and Wales to drive with legal drugs in your body if it impairs your driving[3].

Patients should be advised on the risks associated with benzodiazepines and z-drugs that could lead to impairment of their driving ability. Patients should be advised that it is their responsibility to decide not to drive if their driving may be impaired. If they do so they may be in breach of drug driving law and unable to use the statutory "medical defence".

Further details of the drug driving law can be found in this Department of Transport guide https://www.gov.uk/government/publications/drug-driving-and-medicine-advice-for-healthcare-professionals/drug-driving-guidance-for-healthcare-professionals

Withdrawing Hypnotics and Anxiolytics

For patients without a history of benzodiazepine dependence who have taken less than 4 weeks of benzodiazepine medication, it may be possible to stop without tapering, however, this should be reviewed on a case-by-case basis and caution should be exercised with patients who are at risk of seizures.

Withdrawal is possible in most people who are dependent on benzodiazepines once problems related to prolonged use are explained and discussed[1]. Everyone should be encouraged not to remain on benzodiazepines/z-drugs long term. The vast majority of patients will be able to reduce down and stop. Only a small minority may need to remain on benzodiazepines/z-drugs long term.

Withdrawal symptoms when the drug is reduced or stopped occur in approximately 40% of people who take benzodiazepines continuously for more than six weeks**.** Maximum intensity usually occurs between three and fourteen days but may continue for up to six weeks[1].

A protracted withdrawal syndrome occurs in a minority (up to 15%) of people, most of whom have taken benzodiazepines for many years. The most common symptoms and the typical time periods over which they gradually resolve include[1]:

- Anxiety — one year.
- Insomnia — six months to one year.
- Depression — six months to one year. May respond to antidepressant treatment.
- Adverse cognitive effects such as memory impairment, emotional blunting, reduced coping skills — six months to one year.
- Perceptual symptoms: tinnitus, paraesthesia, pain (usually in limbs) — at least one year.
- Motor symptoms: muscle pain, weakness, tension, painful tremor, jerks — at least one year.

In rare cases where benzodiazepine dependence is established, it can be extremely difficult to treat, may result in persistent withdrawal symptoms, and may become a long-term or even permanent state[1].

Withdrawal from prolonged hypnotic drug use may cause sleep disturbance for a few days while the normal rhythm is re-established. Broken sleep and vivid dreams may persist for several weeks[1].

Reports demonstrate that patients provided with information (e.g. letter from GP) explaining the disadvantages of regular use of these medicines will voluntarily reduce their usage[7]. An example letter that can be used to send to appropriate patients to prompt consideration of withdrawal can be found in Appendix 1, along with a follow up letter if the surgery wishes to take this approach.

For patients on opioids/concomitant opioid substitution therapy the Department of Health "Orange Guide" advises the following:-

> *If the patient is also receiving a long-term prescription of methadone for concomitant opioid dependence, the methadone dose should be kept stable throughout the benzodiazepine reduction period. Concurrent detoxification from both medicines is not recommended in a community setting[11].*

And so liaison with the local drug and alcohol service may be necessary.

Prior to hypnotic or anxiolytic withdrawal assess patients for:

- **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?
- **Consider specialist advice for complex cases**. 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[8]

Withdrawal may be undertaken with or without switching 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[8]

NICE guidance advises two potential approaches to making dose reductions. The first is a slow dose reduction of the individual's current benzodiazepine or z-drug. The second is to switch to an approximately equivalent dose of diazepam, which is then tapered down. Some individuals find it easier to reduce from diazepam because it is a long-acting benzodiazepine and therefore causes less withdrawal symptoms when doses are reduced. Furthermore, smaller dose reductions can be made due to the dose preparations available compared with other benzodiazepines.

Specific guidance on dose equivalents and switching to diazepam is available on NICE CKS here

It is advised to develop a practice wide approach/policy to benzodiazepine/z-drug prescribing and withdrawal, or more ideally a PCN wide approach involving the PCN Pharmacists. This will help ensure all patients are treated to the same standard and assure clinicians and surgery staff that everyone is giving the same clear message, help, and advice. It also helps to prevent "Dr shopping". Once an approach has been agreed, this should be discussed with patients from the outset and clinicians should be firmly supportive to patients to maintain an adherence to the prescribing plan.

- **Withdrawal should be gradual.** NICE advises a 5–10% reduction every 1–2 weeks, or an eighth of the original dose fortnightly, with a slower reduction at lower doses[1]. This is a little complex and for simplicity a pragmatic standard slow reduction of 2mg diazepam every 2-4 weeks will be suitable for most/all patients and easier to manage. Some patients may successfully be able to reduce more quickly who can be considered individually.
- **Withdrawal may take 3–12months or longer**. A slow reduction for patients on a 30mg diazepam starting dose will take longer than a year. Faster reductions at the higher doses and slower at the lower doses can keep the reduction plan to 1 year.
- **Only very rarely should doses of more than 30mg diazepam equivalent per day be prescribed[11].** Expert opinion is that rapid reduction is physically harmless in doses above 30mg.
- **Consider timing (e.g. during summer or periods of lower anxiety) of the start of withdrawal to help maximise success and regularly review patients during withdrawal**
- **Manage anxiety** and explain that anxiety is the most common withdrawal symptom and reassure that anxiety is likely to be temporary. Consider slowing or suspending withdrawal until symptoms become manageable.
- **Manage depression** with antidepressants if required. Consider suspending withdrawal until depression resolves or stabilises.
- **Do *not* prescribe antipsychotics** which may aggravate withdrawal symptoms
- **Manage insomnia.**
- If they did not succeed on their first attempt, encourage the person to try again
    - aim to stop any further escalation in dose
    - make a plan to attempt dose reduction again at a later date
    - clearly record the advice given to the person about the potential harms of continuing the medicine, and the reasons for continuing without a reduction, in the management plan
- 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[8]
- Surgeries should regularly audit their benzodiazepine/z-drug prescribing and withdrawal process
- Where available, and if considered necessary and appropriate, cognitive behavioural therapy (CBT) may be offered to help ameliorate withdrawal symptoms.

Advice to people undergoing withdrawal

- **Gradual** withdrawal minimizes the risk of withdrawal effects
- **Reassure** withdrawal can take 3-12 months or longer. Some people take less time
- **Difficult steps** 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 withdrawal to an extremely slow rate towards the end (e.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[8]
- Ensure the patient knows who to contact or where to seek support if they are having difficulties

Example slow withdrawal schedule – See Appendix 2

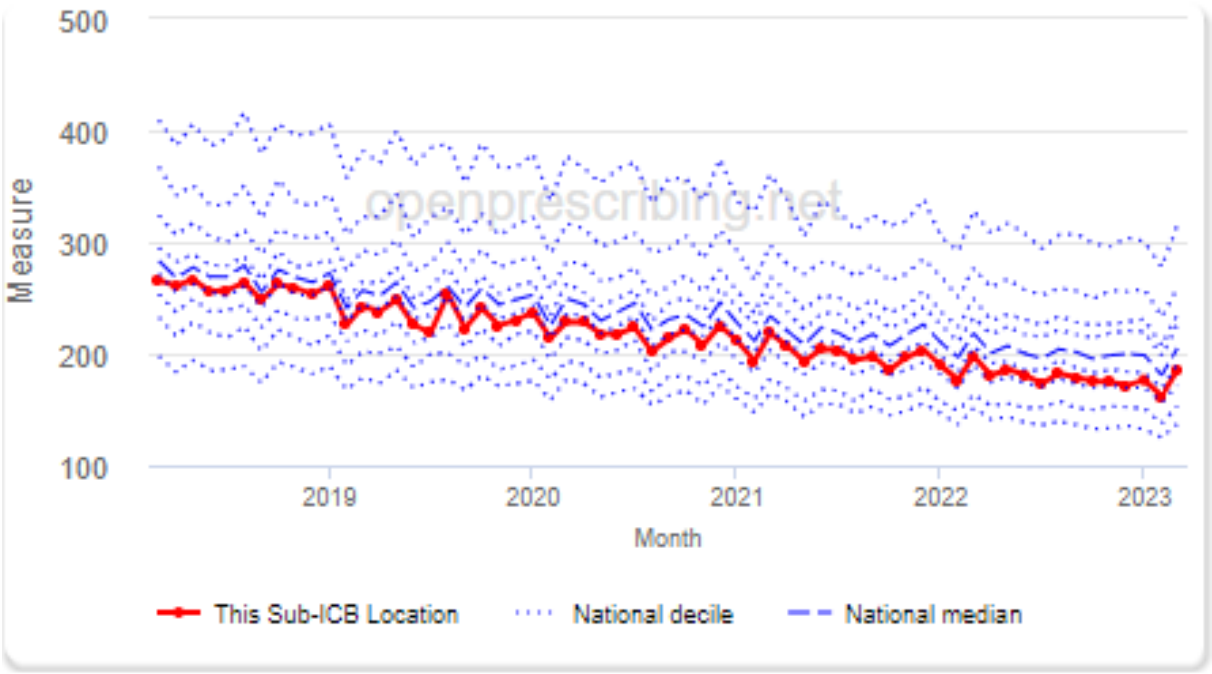
Further advice on withdrawal is available from NICE CKS **and the** DOH Drug misuse and dependence "Orange Guide".

Local Prescribing Stats

Over the past 12 months, April 2022 – March 2023, there were 216,912 benzodiazepine items prescribed by primary care in BNSSG costing £1,047,311 (data from openprescribing.net).

The below chart taken from openprescribing.net shows that the primary care prescribing of hypnotics and anxiolytics is falling overall, nationally and in BNSSG, with BNSSG lower than the national median trend.

Number of average daily quantities (ADQs) of Anxiolytics and Hypnotics per 1000 patients in BNSSG



The 10 most commonly prescribed hypnotics/anxiolytics in BNSSG over Jan-Mar '23 are listed below and ranked by number of items prescribed.

Presentation	Items	Quantity	Cost
Diazepam 2mg tablets	14,263	417,795	£12,304
Zopiclone 7.5mg tablets	12,920	185,641	£8,234
Diazepam 5mg tablets	7,745	202,258	£6,324
Zopiclone 3.75mg tablets	5,513	104,032	£6,661
Lorazepam 1mg tablets	2,975	80,648	£4,845
Zolpidem 10mg tablets	1,189	17,399	£820
Diazepam 10mg tablets	1,077	23,443	£830
Nitrazepam 5mg tablets	939	23,497	£2,144
Zolpidem 5mg tablets	928	18,901	£851
Temazepam 10mg tablets	823	21,971	£18,398

Practices can use openprescribing.net to access their individual pratice prescribing trends. This is useful for comparison against other surgeries in the area and to monitor trends in prescribing.

Appendix 1 – Example Initial Patient Letter

Dear [patient]

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

This type of medication can cause an increased risk of falls and accidents including car accidents, anxiety, agoraphobia, emotional blunting, reduced coping skills, negative effects on memory and increased risk of Alzheimer's, reduced ability to remember new people and appointments etc. and depression (this is not exhaustive). The body can get used to these tablets so that they no longer work properly and give the effect that they were prescribed to you for in the first place. Research shows that use of the tablets over a long time actually can cause anxiety and sleeplessness.

We would like you to consider reducing your use of this medication with a view to stopping it in the future. If you stop taking the tablets suddenly, there may be withdrawal side effects that you will experience. But we can support you to slowly reduce your dose over time which will greatly minimise the chance of any withdrawal effects. We can also provide help and information on additional support to manage the condition you were prescribed these tablets for. There are many other strategies available to patients to help manage insomnia and anxiety which will be much more effective than a long-term prescription for this medication.

If you would like further information about this type of medication there is some useful information on the Patient.info website available via this link https://bit.ly/2vyZNND or you can talk to your local Community Pharmacist.

Please carefully consider the information in this letter. We would like to see you for an appointment at the surgery to review this with you. Please contact the surgery to make a convenient appointment with your GP to discuss this further.

Yours sincerely,

Example Follow up Patient Letter

Dear [patient]

I am writing to you because I note from our records that you have been taking [drug] for some time now. We recently wrote to you explaining that clinicians are concerned about this kind of sedative medication when it is taken over long periods. We requested that you make an appointment to review your prescription, but to date we haven't seen you regarding this.

We will be following our practice policy on prescribing of this medication and initiating a reducing dose prescription for you with the aim of withdrawing this medication altogether. Please make careful note of your prescribed dosages as these will need to be followed exactly.

We would still like to see you to discuss this planned withdrawal and to offer you the reassurance and support you may need. Please make an appointment to do so.

Yours sincerely,

Appendix 2 - Example Slow Withdrawal Schedule

More example withdrawal schedules are available on the 'Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice' (reference number 7).

The table below shows an example of the rate at which a diazepam prescription could be reduced.

Weeks	Daily dose	Number of tabs per day	Number of tabs per week
1 – 2	Diazepam 30 mg	15 x 2 mg	105 x 2 mg
3 – 4	Diazepam 28 mg	14 x 2 mg	98 x 2 mg
5 – 6	Diazepam 26 mg	13 x 2 mg	91 x 2 mg
7 - 8	Diazepam 24 mg	12 x 2 mg	84 x 2 mg
9 -10	Diazepam 22 mg	11 x 2 mg	77 x 2 mg
11 – 12	Diazepam 20 mg	10 x 2 mg	70 x 2 mg
13 – 14	Diazepam 18 mg	9 x 2 mg	63 x 2 mg
15 – 18	Diazepam 16 mg	8 x 2 mg	56 x 2 mg
19 – 22	Diazepam 14 mg	7 x 2 mg	49 x 2 mg
23 – 26	Diazepam 12 mg	6 x 2 mg	42 x 2 mg
27 – 30	Diazepam 10 mg	5 x 2 mg	35 x 2 mg
31 – 34	Diazepam 8 mg	4 x 2 mg	28 x 2 mg
35 – 38	Diazepam 6 mg	3 x 2 mg	21 x 2 mg
39 – 42	Diazepam 4 mg	2 x 2 mg	14 x 2 mg
43 – 46	Diazepam 3 mg	1½ x 2 mg	11 x 2 mg
47 – 50	Diazepam 2 mg	1 x 2 mg	7 x 2 mg
51 - 54	Diazepam 1 mg	½ x 2 mg	4 x 2 mg

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