Prescribing and withdrawing Benzodiazepines and “Z” drugs

A Resource for General Practice

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These guidelines have been formulated to assist medical practitioners in relation to the appropriate prescribing of benzodiazepines and Z drugs (Zaleplon, Zolpidem, Zopiclone). They are based on best evidence available and expert opinion from the literature. They are not intended to be a list of do’s and don’ts. Appropriate assessment and clinical judgement of each patient’s condition is necessary for the best clinical outcomes.

These guidelines have been produced in consultation with a range of practitioners including Consultant Psychiatrist in Addictions, Addiction Nurses and Pharmacists.

Although this group of drugs have been of some use in the treatment of anxiety and sleep disorders, they have shown potential for abuse and dependence can occur after a relatively short period of use (O’Brien, 2005; Stevens & Pollock, 2005).

**CSM ADVICE**

Benzodiazepines are indicated for the short-term relief (two to four weeks only) for 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.

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

CSM 1988  DoH 2004
2. Indications for Use of Benzodiazepines and Z drugs

a. Benzodiazepines

Benzodiazepines are the most commonly used anxiolytics and hypnotics. They act at benzodiazepine receptors which are associated with gamma amino butyric acid (GABA) receptors (Roy-Byrne, PP, 2005; Wafford, 2005). They can cause a paradoxical increase in hostility and aggression and the effects range from talkativeness and excitement to aggressive and antisocial acts (Deakin et al, 2004; Rich et al, 2006, Berman, Jones and McCloskey, 2005). They may impair judgement and increase reaction time, and so affect the ability to drive or operate machinery (Gustavsen et al, 2008; Stewart, 2005); they also increase the effects of alcohol. Tolerance to their effect develops within 3-14 days of continuous use and long-term efficacy cannot be assured (Kan et al, 2004). A major drawback of long-term use of hypnotics is that withdrawal can cause rebound insomnia and a withdrawal syndrome (Ashton, 2005).

Withdrawal of a benzodiazepine should be gradual to avoid confusion, toxic psychosis, convulsions or a condition resembling delirium tremens (Ashton, 2005). Benzodiazepine withdrawal syndrome can occur any time up to three weeks after stopping treatment with a long-acting medication or within a day of stopping a short-acting one. Further information is available in the BNF sections 4.1.1. and 4.1.2.

Licensed indications for ANXIOLYTICS (BNF 61)

Diazepam – Short term use in anxiety or insomnia, adjunct in acute alcohol withdrawal, status epilepticus, febrile convulsions, muscle spasm, peri-operative use.

Chlordiazepoxide - Short term use in anxiety, adjunct in acute alcohol withdrawal

Lorazepam – Short term use in anxiety or insomnia, status epilepticus, peri-operative use

Oxazepam – Short term use in anxiety.

Licensed indications for HYPNOTICS (BNF 61)

Temazepam – Short term use in insomnia & peri-operative use

Nitrazepam – Short term use in insomnia

Loprazolam – Short term use in insomnia

Lormetazepam – Short term use in insomnia.


All three Z drugs (zopiclone, zolpidem and zaleplon) act at benzodiazepine receptors (or sub-types) and hypnotic dependence and loss of efficacy has been shown after a few weeks of treatment. All carry a risk of dependence and withdrawal effects, including rebound insomnia. Hangover effects and impaired psychomotor performance similar to temazepam and nitrazepam are reported with zopiclone and zolpidem. There is no significant difference in adverse effects between benzodiazepines and zopiclone and not enough data to choose one over the other. There is no significant difference in sleep latency between benzodiazepines and zopiclone. The risk of hip fracture is as likely with z drugs as with other benzodiazepines. The half life of zaleplon is one hour; this has potential for abuse as a ‘date rape’ drug, due to the similarity with flunitrazepam (Rohypnol®) and triazolam.

In summary

• There is no conclusive evidence that the “Z” drugs offer reduced abuse potential

• They offer no clinically significant advantages over benzodiazepines

• They are more expensive than traditional benzodiazepines and are not recommended as a substitute.
Licensed indications for Z DRUGS (BNF 61)

Zaleplon – **Short term use** in insomnia – up to 2 weeks
Zolpidem – **Short term use** in insomnia – up to 4 weeks
Zopiclone – **Short term use** in insomnia – up to 4 weeks

c. Special Considerations

**Older people (over 65 years)**

- Prescribing of benzodiazepines should be avoided as the increased risk of becoming ataxic and confused leads to falls and injuries, in particular hip fractures (Cummings, RG. & LeCouter, DG. 2003; Wagner et al. 2004)
- Record in notes that the patient or carer has been given advice on non-drug therapies for anxiety and insomnia and the risks of benzodiazepine use
- If prescribing is considered essential, use doses less than half of those normally recommended
- The elderly are particularly vulnerable to adverse drug reactions because of the declining renal function, changes to hepatic metabolism and increased sensitivity to certain drugs. For example, diazepam will have a longer half life
- Insomnia may be due to poorly controlled arthritic pain or underlying depression, neither of which will benefit from sleeping pills
- Exercise programmes are likely to be beneficial to improve sleep quality in the elderly. The programme may include 16 weeks of regular, moderate intensity exercise, four times per week
- Older people may experience problems swallowing medicines. The following are available in liquid formulations:
  - Temazepam oral solution S/F 10mgs in 5mls
  - Diazepam oral solution 2mgs in 5mls
  - Diazepam strong oral solution 5mg in 5mls.

**Pregnancy and Breast Feeding**

- Benzodiazepines and Z-drugs should generally be avoided in pregnancy and lactation. Non drug treatments are preferred. Pharmacological intervention may be required in severe circumstances and specialist opinion should be sought
- Seek specialist opinion for the management of pregnant or breast feeding patients who are currently taking benzodiazepines.

**Problems at birth**

Babies exposed to benzodiazepines and z-drugs during pregnancy are at risk of the following:

- Low birth weight
- Breathing difficulties
- “Floppy muscles”
- Unstable body temperature
- Alterations in heart rate/function
- Altered EEG measurements
- Withdrawal syndrome (Iqbal et al, 2002; Wikner et al, 2007).
Consequences of parental use

Cognitive and other health problems due to parental benzodiazepine/z-drug use can impair parental skills (Robertson et al, 2000) with negative consequences for the children and family.

Research shows a direct link between parental benzodiazepine use (mainly maternal), and subsequent benzodiazepine use/misuse in their adolescent children (Barnard & McKeeganey, 2004; Beckwith et al, 1999).

Despite published guidance on the appropriate use of benzodiazepines as anxiolytics or hypnotics and the appropriate use of the Z drugs for the short-term management of insomnia, inappropriate prescribing of these drugs remains a concern. Guidance regarding the appropriate prescribing has been addressed by CSM, NICE and the CMO. Below is a list of some measures that can be employed to assist with the control and monitoring of prescribing practices.

a. New prescriptions for benzodiazepines and “z” drugs (zopiclone/zolpidem/zaleplon)

- Only use for the short-term treatment of severe anxiety or insomnia (anxiety maximum of 4 weeks, insomnia maximum of 10 nights)
- Duration should be as short as possible. The risk of dependence increases with dose and duration
- Ensure all new prescriptions are NOT entered onto repeat prescribing systems
- Discharge medication from hospital must NOT be repeated, unless the patient was previously receiving benzodiazepines
- Record annually that a patient receiving a prescription for a benzodiazepine has been advised on non-drug therapies for anxiety or insomnia
- Non-drug strategies can be effective in the management of anxiety and insomnia and may address the underlying cause, rather than just relieving symptoms
- Record that the patient has been given appropriate advice on the risks of treatment, including potential for dependence. Chronic use may lead to the development of physical and psychological dependence
- Supplement with sleep guides, diaries and leaflets eg. self-help for anxiety
- Exclude co-existing physical/mental illness if symptoms persist.

b. Long term users

- Record annually the prescribed indication and that advice has been given on non-drug therapies for anxiety and insomnia.
- Document that advice has been given on the risks, including potential for dependence, drowsiness, falls, reduction of coping skills, promotion of sick role, impairment of judgement and dexterity.
- There is a statistically increased risk of involvement in a road traffic accident, due to impairment of driving. Cognitive impairment may be persistent and includes Visio-spatial and attention difficulties.
- Patients must be reviewed regularly, at least 3 monthly. Response to treatment should be assessed and non-drug treatment(s) re-enforced.
- Chronic users (4-8 weeks or longer) should be identified and encouraged to reduce. There should be a structured programme for identifying long-term users along with a suitable strategy for gradual withdrawal of benzodiazepines in those who are suitable and agreeable to withdraw.
- As diazepam has a long half-life with different strengths available, patients on benzodiazepines should generally be converted to an equivalent dose of diazepam before reducing the dose. Exceptions are Triazolam, Zolpidem and Zapelon. These drugs are eliminated so quickly (half-life 2 hours) that people are practically withdrawn each day, after a dose the night before. For this reason, they can be stopped abruptly without substitution of a long-acting benzodiazepine.
4. Targeting patients for reduction

a. Where to start?
Decide on the most appropriate treatment group to start with for your practice, for example:

- All patients taking one particular benzodiazepine
- Those patients in one particular age bracket eg.: 45-55
- Those on a long acting benzodiazepine
- Patients receiving other sedative agents
- Patients receiving high doses of temazepam (>20mg per day)
- Young people whose dependence may impair aspects of ‘normal daily life’ eg. driving and operating machinery
- Recent chronic users.

b. Groups to avoid:-

- Patients with serious mental illness
- Poly-drug users already being seen by community addiction services
- Patients with a diagnosis of epilepsy requiring benzodiazepines as part of their anticonvulsant therapy
- Pregnant women.
Benzodiazepines are potentially addictive drugs; physical and psychological dependence can develop within weeks of regular use (Ashton, 2005). They are increasingly used in conjunction with other substances of abuse. They are used in this context to increase the “effect” obtained from opiates, and alleviate the withdrawal symptoms of other drugs of abuse such as alcohol, cocaine and amphetamines (Perera, 1987).

a. Principles of Assessment

- Early detection and intervention are important factors in successful outcomes
- Prescribers should be able to recognise the risk or potential for benzodiazepine dependence in all diagnostic groups (psychiatric AND non-psychiatric cases) and age groups
- Patients known to be opiate dependent, or known to use other illicit drugs, have an increased possibility of becoming dependent on very high doses of benzodiazepines
- Confirmation of diagnosis of dependence should be confirmed with a history and a positive urinary drug screen for benzodiazepines and regular drug screens thereafter
- Assessing motivation to change is an essential component in the management of dependency
- Screening for benzodiazepine misuse should include measures to regularly review repeat prescriptions for tranquillisers and hypnotic medication.

b. Actual Assessment

1. Check for evidence of benzodiazepine dependence

- Note the patient’s physical presentation – drowsiness, disinhibition, dilation of pupils; and note the frequency of consistency of presentation over several weeks
- It is recommended that the patient’s benzodiazepine use be assessed over a several week period before a diagnosis of dependence is made unless there is compelling evidence at an earlier point.

2. Try to establish the Pattern of benzodiazepine usage

- Date of onset of benzodiazepine use and which drug(s)
- Date of onset of dependence and frequency of use
- Average daily dose and dosage intervals
- Duration of any successful withdrawal from benzodiazepines
- If positive to above, longest period of abstinence.

NB. Street or illicit sources of benzodiazepines may be different strengths from prescribed sources. The former are often weaker and this should be considered when prescribing.
3 Establish Type of Dependency

There are three main types of benzodiazepine dependence that are recognised; these include:

i. Therapeutic dose dependence
ii. Prescribed high dose dependence and
iii. Recreational high dose abuse and dependence.

The type of dependence must be established- the following questions can aid this process.

- Are the benzodiazepines prescribed or non-prescribed?
- If prescribed what is the indication for the benzodiazepine?
- Is there any additional non-prescribed use?
- Patient’s reasons for taking non-prescribed benzodiazepines.

4 Therapeutic Dose Dependence

Patients who have developed dependence on therapeutic doses of prescribed benzodiazepines.

Characteristics of Therapeutic Dose Dependence

- They have taken benzodiazepines in prescribed low doses for months or years
- They have gradually come to “need” them in order to carry out their normal activities of daily living
- They have continued to take their medication even though the original indication for it has gone
- They experience withdrawal symptoms when they try to reduce or stop their use
- They may contact the practice frequently to request repeat prescriptions
- They may try to obtain additional prescriptions from other sources such as out of hours
- They experience anxiety if the next prescription is not ready or easily obtainable
- They may have increased the dosage since the original prescription
- They may have anxiety symptoms, panics, agoraphobia, depression and increasing physical symptoms despite continuing to take benzodiazepines (Ashton, 2005).

5 Prescribed High Dose Dependence. eg. Diazepam 30mgs or more.

A minority of patients who start on prescribed benzodiazepines begin to “need” ever-larger doses.

Characteristics of Prescribed High Dose Dependence

- They may try to persuade their Doctor to escalate the doses and/or the number of tablets on the prescription
- On reaching the prescriber’s limits they may present at hospitals or register at other practices to obtain more prescriptions
- They may combine benzodiazepine misuse with excessive alcohol consumption or with other sedative drugs
- They tend to be highly anxious, depressed and may have a personality disorder
- They tend not to use illicit drugs, but may obtain benzodiazepines from “street” sources, which may include a relative’s or acquaintances continuing, unnecessary, prescribed benzodiazepines.
Recreational High Dose Abuse and Dependence

High dose dependence in this category may develop as poly-drug abusers attempt to increase the intensity and duration of the “effect” they get from illicit drugs – especially opiates – and to cope with the withdrawal symptoms and stimulating effects of others such as cocaine or amphetamines and alcohol.

Characteristics of Recreational High Dose Abuse and Dependence

- A very high tolerance develops, making it difficult to detect the actual scale of drug consumption
- Users may be taking well in excess of 100mgs daily in a single dose. Doses of up to 1000mgs are occasionally reported in clinical practice
- There may be a concurrent alcohol problem, and the user may have been introduced to benzodiazepines during previous alcohol detoxification
- Detail any history of previous severe withdrawal (including history of seizures) or post-withdrawal reaction
- Concomitant severe medical or psychiatric illness
- Co-morbid use of other drugs and alcohol
- Driving history: Patient’s should be reminded of DVLA guidelines. http://www.dft.gov.uk/dvla/medical/ataglance.aspx See Appendix 1
- Establish level of motivation to change
- Urine drug testing as appropriate – note whether the presence or absence of benzodiazepines in the urine fits with the patient’s history, bearing in mind that higher dosing will result in a longer duration of detection.
6. Advice on withdrawing Benzodiazepines and ‘Z’ drugs

a. General Advice

Patients should have joint control over the programme and be offered ADVICE, GUIDANCE and SUPPORT.

Withdrawal of a benzodiazepine should be gradual as abrupt withdrawal can cause:

- Confusion
- Toxic psychosis
- Convulsions.

The benzodiazepine withdrawal syndrome may not develop until 3 weeks after stopping a long acting benzodiazepine, but may occur within a few hours of stopping a short acting one. Some symptoms may continue for weeks or months after stopping the drug. Symptoms of withdrawal syndrome include:

- Insomnia
- Anxiety
- Loss of appetite
- Loss of body weight
- Tremor
- Perspiration
- Tinnitus
- Perceptual disturbances, eg. intolerance of loud noises or bright lights, experience numbness or pins and needles.

b. Benzodiazepine Withdrawal

A flow chart is available to assist with benzodiazepine withdrawal. Please see section 11 – Resources for GPs.

A suggested protocol is as follows:-

1. Transfer patient to an equivalent daily dose of diazepam (refer to the table on next page), preferably taken at night.
2. Diazepam tablets are flat and scored. They can be split in half allowing stepwise reduction. Oral solutions are also available as 2mg/5ml and 5mg/5ml.
3. Reduce the diazepam dose in fortnightly steps of 2 to 2.5mg; if withdrawal symptoms occur maintain this dose until symptoms improve.
4. Reduce the dose further, if necessary in smaller fortnightly steps, it is better to reduce too slowly than too quickly.
5. The speed of withdrawal may be dependent on the initial dose and duration of treatment.
6. The time needed for withdrawal can vary from 4 weeks to one year or more.
7. If there are difficulties with the withdrawal, referral to the Benzodiazepine nurse may be considered.
8. Support and education is needed to help the client to achieve withdrawal and this can be helped by the use of counselling. Spiegel suggests that there are two phases in helping clients withdraw from benzodiazepine use (Speigal, 1999)

Phase one  The key task is to provide clients with education about dependence and withdrawal.

Phase two  The key task is to help clients deal with any negative symptoms that they experience as the drug is reduced.

These symptoms may affect the client both physically and psychologically, but anxiety and panic are the most common symptoms experienced, here the use of cognitive behavioural approaches are advocated.

c.  Approximate Equivalent Doses of Benzodiazepines

<table>
<thead>
<tr>
<th>Benzodiazepines</th>
<th>Half-life (hrs)</th>
<th>Market Aim</th>
<th>Approximately Equivalent Oral dosages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam (Xanax®)</td>
<td>6-12</td>
<td>A</td>
<td>500mcg, 250mcg</td>
</tr>
<tr>
<td>Chloridiazepoxide (Librium®, Tropium®)</td>
<td>5-30 [36-200]</td>
<td>A</td>
<td>25mg, 15mg</td>
</tr>
<tr>
<td>Clobazam (Frisium®)</td>
<td>12-60</td>
<td>A, E</td>
<td>20mg, 10mg</td>
</tr>
<tr>
<td>Diazepam (Valium®)</td>
<td>20-100 [36-200]</td>
<td>A</td>
<td>10mg, 5mg</td>
</tr>
<tr>
<td>Flunitrazepam (Rohypnol®)</td>
<td>18-26 [36-200]</td>
<td>H</td>
<td>1mg, 500mcg</td>
</tr>
<tr>
<td>Flurazepam (Dalmane®)</td>
<td>40-250</td>
<td>H</td>
<td>15-30mg, 7.5-15mg</td>
</tr>
<tr>
<td>Loprazolam</td>
<td>6-12</td>
<td>H</td>
<td>1-2mg, 0.5-1mg</td>
</tr>
<tr>
<td>Lorazepam (Ativan®)</td>
<td>10-20</td>
<td>A</td>
<td>1mg, 500mcg</td>
</tr>
<tr>
<td>Lorometazepam</td>
<td>10-12</td>
<td>H</td>
<td>1-2mg, 0.5-1mg</td>
</tr>
<tr>
<td>Nitrazepam (Mogador®)</td>
<td>15-38</td>
<td>H</td>
<td>10mg, 5mg</td>
</tr>
<tr>
<td>Oxazepam</td>
<td>4-15</td>
<td>A</td>
<td>20mg, 15mg</td>
</tr>
<tr>
<td>Temazepam</td>
<td>8-22</td>
<td>H</td>
<td>20mg, 10mg</td>
</tr>
</tbody>
</table>

| Non-benzodiazepines with similar effects | |
|-----------------------------------------| |
| Zaleplon (Sonata®)                     | 2 H 20mg 10mg |
| Zolpidem (Stilnoct®)                   | 2 H 20mg 10mg |
| Zopiclone (Zimovane®)                  | 5-6 H 15mg 7.5mg |

All medications or brands in bold are available on the NHS. Those in italics are not available.
NB These equivalents are based on clinical experience and may vary between individuals. (Ashton Manual 2002c, Sweetman 2005, Taylor et al., 2007, BNF 61 2011, Lader et al., 2009)

1. Half-life: time taken for blood concentration to fall to half its peak value after a single dose. Half-life of active metabolite shown in square brackets. This time may vary considerably between individuals.

2. Market aim: although all benzodiazepines have similar actions, they are usually marketed as anxiolytics (a), hypnotics (h) or anticonvulsants (e).

3. These equivalents do not agree with those used by some authors. They are firmly based on clinical experience but may vary between individuals.

4. These drugs are chemically different from benzodiazepines but have the same effects on the body and act by the same mechanisms.

5. All these drugs are recommended for short-term use only (2-4 weeks maximum).

d. ‘Z’ Drug Withdrawal

Zopiclone (Zimovane®), Zolpidem (Stilnoct®) and Zaleplon (Sonata®)

There is little information available on how to withdraw patients from these hypnotics if they have been on them long-term. In the absence of specific information, we recommend the following for patients that are considered for withdrawal.

1. The patient IS NOT converted to diazepam.

2. Dosage should be withdrawn gradually on an individual patient basis.

3. Dose reductions should be made at not less than 2 week intervals.

4. If the patient suffers from withdrawal symptoms/problems maintain their current dose until symptoms improve. Then continue the withdrawal regime - in smaller steps if necessary.

An example of a withdrawal regime:

A patient on zopiclone 15mg at night :

Weeks 1 and 2: Zopiclone 7.5mg tablets one at night AND one 3.75mg at night

Weeks 3 and 4: Zopiclone 7.5mg tablets one at night

Weeks 5 and 6: Zopiclone 3.75mg tablets one at night

Weeks 7 and 8: Possibly then could have 3.75mg alternate nights

e. Strategies for withdrawal:-

1. Minimal Intervention

   Use of a standard letter (see Appendix 2)

   Standard letter sent to patients identified by means of a computer search. If a letter is sent this should be recorded in the patient’s notes. There is evidence that this alone may achieve a success rate of 20-40% (Cormack et al, 1994; Ashton 2005; Lader 2009)

2. A longer consultation

   Those patients responding to the above approach or those attending the surgery for some other reason may be identified and invited to attend for a review consultation.

3. Non-Drug methods

   Relaxation therapy, tapes and leaflets may help (see Appendix 3). Exercise programmes may help as a substitute for drug treatment of insomnia.
4. **Referral to Benzodiazepine nurse**
Consider referral to this service provided by Local Addictions Service if you have attempted withdrawal and there have been difficulties with this and the patient has mild to moderate mental health difficulties. The patient may require further psychological help with the withdrawal (see Appendix 4).

f. **Summary of advice on withdrawal**

**Anxiety Summary**

- Anxiety may be a normal response to stressful situations, but may occur as a symptom of another syndrome eg. depression. Explain that anxiety is the most common acute withdrawal symptom
- Attempts to reduce the normal anxiety response may impair performance
- Behaviour therapy is the treatment of choice for phobias, whereas CBT is effective in the management of panic and generalised anxiety disorder.
- Antidepressants are also useful adjuncts, and are significantly better than tranquillisers in the management of anxiety. Depressive illness is frequently misdiagnosed as anxiety neurosis
- The prevalence of anxiety disorder in general practice is second to depressive illness and adjustment reactions.

**Insomnia Summary**

- Primary insomnia is a chronic and relapsing condition
- The aetiology of insomnia is uncertain. Prevalence increases with age, with an estimate of up to 45% in people over the age of 65
- Risk factors in all age groups include hyper-arousal, chronic stress and daytime napping.
7. Other tips/troubleshooting

- Treat any symptoms of depression
- Advise patient to avoid or reduce stimulants, e.g. caffeine, alcohol
- Advise patient that insomnia will pass. Plan for this and offer practical advice (Good Sleep Guide – Appendix 5)
- Teach the patient about the reflex action of adrenaline, to help understanding of symptoms of withdrawal. The patient will then be less afraid, leading to less adrenaline production and will be familiar with the reflex action
- Encourage the patient to use exercise as a means of reducing anxiety levels.
Withdrawal Effects

“Whenever I tried to cut out or reduce the dosage completely, I became extremely anxious, had hot sweats, was very irritable and couldn’t sleep or relax. I then went back on medication.”

Effects following a gradual withdrawal schedule

“I do not feel as drugged up and am much more alert in the mornings.”
“Mentally and physically I feel much better. My temperament is much better; before, I felt edgy and moody in the mornings.”

“I am learning to overcome a few poor nights’ sleep. I find by having a positive attitude I am able to settle back into a good sleeping pattern without being obsessed with sleep.”

Comments on short term prescribing & preventing chronic usage

“My previous medication (nitrazepam) which I initially took for a sleep disorder, became a quick fix……was masking anxiousness or other problems that came along, and unfortunately became an addiction”

“I am grateful to leave behind a dark cloud”

“As a long term user my memory is very poor. Before, it was excellent.”

“I get hyperactive rather than drowsy.”

“In a stressful situation I still get sweaty tense and have a panic attack.”

“My sleep pattern hasn’t improved. It takes a few hours before I sleep.”

“I can honestly say that there has been no improvement in sleep pattern for 12 years.”
9. Community Addiction Service

a. Role of the Community Addictions Team (CAT)

The benzodiazepine service has been operational from 2003, for the clients of the South Eastern Trust Area, who experience problems or would like to reduce or discontinue use of benzodiazepines or z drugs. This service offers support to adults from 18 years and above who are prescribed these medications.

This service has now developed to include a Benzodiazepines reduction clinic, with close liaison with the GP which follows prioritised need based on analysis of prescribing data and discussions at area level.

We provide a comprehensive substance misuse assessment for patients. The outcome of this assessment may indicate areas of work to focus upon. These may include supportive counselling, harm reduction, education, relaxation and stress management, and promotion of healthy lifestyles, sleep hygiene and the importance of adding structure to the day. Furthermore referral to specialised services for grief, etc. may be indicated.

This work is provided within GP practices and at appropriate Trust premises by the staff within the SE Trust area. Screening clinics are also available where the GP can liaise with the nurse and discuss any referral. The screening clinics are designed as a collaborative approach for the management of this client group. These clinics provide thorough assessment, psycho-education, provision of evidence based literature and commencement of reduction regimes tailored to the client’s needs.

The model of therapy used will have a cognitive behavioural approach, and includes motivational interviewing, solution-focused therapy, brief interventions and educational materials will be provided. It is supported by research, anonymised data collection with the outcomes analysed and reported on at regular intervals to the Addiction Services Manager and the prescribing team.

b. Summary of work carried out by CAT in conjunction with the Pharmacy and Medicines Management Team in Eastern area GP practices [dates]

The Health and Social Care Board (HSCB) Eastern Area, Public Health Agency (PHA) and Community Addiction Teams within South Eastern and Belfast Trusts have been working in partnership for over 8 years to reduce benzodiazepine prescribing in the area. The Eastern Area Prescribed Drug Misuse Group is an informal advisory group that was set up to share information and best practice regarding the management of patients being prescribed drugs of potential abuse. The group has representation from the Eastern Area Prescribing Team, the Eastern Drug and Alcohol Co-ordination Team (EDACT), and Trust Addiction Services Teams.

The aim of the joint working group is to improve the quality of care for people taking prescribed drugs of potential abuse (e.g. benzodiazepines). To date the majority of work done has focused on benzodiazepines and ‘z drugs’ (hypnotics: zaleplon, zolpidem and zopiclone). Prescribed Drug Misuse Practitioners (PDMPs) are specially trained mental health nurses. Their role is to address specific needs of individuals who have a dependency on Benzodiazepines and / or ‘z drugs’ and to raise awareness within local communities by education on the complexities associated with benzodiazepine use.
Benzodiazepine withdrawal or reduction is undertaken where appropriate. PDMPs operate 2 main models of working:

a. Run clinics based in GP practices for a finite time period, where the practice can refer patients into the service.

b. Accept referrals from a number of GP practices and patients attend clinics held outside the GP practice e.g. in trust premises.

Practices are identified from analysis of prescribing data and prioritised through discussion between prescribing advisers and PDMPs during quarterly meetings.

Prescribing data indicates trends in the prescribing of benzodiazepines and the three “z” drugs and the graph below shows the contrast between GP practices which have received support from the CAT and those which have not from May 2008 to April 2010.

Practices can be analysed individually and the graphs below illustrate the impact of the PDMPs in two practices, one from Belfast and one from the South Eastern Trust area.
c. **CAT Contact Details**

CAT services are based at three locations in the South Eastern Trust:

- **Community Addiction Services**
  - North Down & Ards Sector
    - Lough House
    - Ards Hospital
    - BT23 4AS
    - Tel No: (028) 9151 2159
  - Lisburn Sector
    - TSL House
    - 38 Batchelors Walk
    - Lisburn
    - Tel: (028) 9266 8607

- **Community Addiction Services**
  - Down Sector
    - Shimna House
    - Downshire Hospital
    - Downpatrick
    - Tel: (028) 4461 3311

For further help and advice contact:-

- Michael Gracey, Prescribed Drug Misuse Nurse, North Down & Ards Community Addictions Team
  - Tel No: (028) 9151 2159
- Marian Hamill, Prescribed Drug Misuse Nurse, Lisburn, TSL House 38 Batchelors Walk, Lisburn
  - Tel No: (028) 9266 8607
- Marian Hamill, Prescribed Drug Misuse Nurse, Shimna House, Downshire Hospital, Ardglass Road, Downpatrick
  - Tel. No: (028) 4461 3311 Ask for Shimna House

**d. Guidelines for making referrals to the CAT service (Appendix 4)**

The Service will accept referrals of all GP’s patients from within the South Eastern HSC Trust catchment area.

The Community Addiction Service is aimed at those clients who have a dependency on alcohol or drugs. These clients are more likely to respond to briefer intervention by a single practitioner. The service is available to patients of age 18 years and over.

Referrals should be made using the appropriate referral form - Section 11

Information on the referral form should include, (within the appropriate section provided):

- A brief description of reason for referral to the service
- Any risk issues, (those clients who pose a moderate to severe degree of risk
- Any other health/care workers who may be involved with the patient
- Any relevant medication, preferably a printout of the most recent drug history
- Name and dosage of the prescribed medication and the agreed schedule of dosage reduction.

When it has been agreed with your patient to refer him/her to the service, the referral form must be signed by the patient, thus giving informed consent. Referrals in relation to the reduction programmes must be sent to the appropriate area team.

Upon receipt of the referral form the patient shall receive correspondence offering them the opportunity to contact the service and confirm their willingness to engage. If they fail to respond to this letter, one further letter is sent offering a further date and if they fail to respond, a letter will be sent to the referrer advising on non-engagement.

When the client agrees to engage, a mutually agreed appointment is made. If the client fails to keep two consecutive appointments, they will be discharged back to your care.

*NB. Please use the referral forms provided rather than standard GP forms or letters.*
10. Resources for GPs

1. Referral forms

South Eastern Health and Social Care Trust

Addiction Service

Substance Misuse - Referral Form

This is a referral form to specialist drug and alcohol agencies. If the client is in need of immediate help with serious physical problems, please use regular medical / emergency services.

Forename ........................................... Surname ........................................... Age ....... DOB ..........................

Address (C/O) .............................................................................................................................

................................................................................................................................. H&C No: ..............................

Post Code .......................... Tel No ...................................... GP ................................................

Please fill in details by obtaining clients view of the situation.

This information is essential in prioritising appointment for assessment

Referrer’s Details – Please add attachments from your own assessment if necessary

Name .................................................. Designation .................................. Date ..........................

Relationship to Client ..................................... Length of time known Client ..........................

Agency Address ..........................................................................................................................

..............................................................................................................................................

Post Code .................................. Telephone No ..................................................................

<table>
<thead>
<tr>
<th>Alcohol Use:-</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever felt you should cut down on your drinking?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Have people annoyed you by criticising your drinking?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Have you ever felt bad or guilty about your drinking?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Average amount of alcohol consumed in a usual day</td>
<td></td>
</tr>
</tbody>
</table>

Any previous periods of abstinence / Past Treatment


Current family, relationships, housing, work, employment, finances etc.

<table>
<thead>
<tr>
<th>Drug Use: -</th>
<th>Specify which</th>
<th>Prescribed (YES/NO)</th>
<th>Route (IV, Smoke, oral, sniff other)</th>
<th>Problem – physical/psychological health, family, relationships, work, Housing, employment, finances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/crack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSD/XTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvents/inhalants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin/ DF118</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranquilisers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other -</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Client's view of main problem and additional relevant information

In order to assist prioritisation, please indicate if problems below are applicable or use ‘comments’ box

<table>
<thead>
<tr>
<th>Accessibility needs (please highlight)</th>
<th>Disabled</th>
<th>Transport</th>
<th>Childcare responsibilities</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client is pregnant (Due Date / /)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client presents as risk to self</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are concerns for their mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client has physical health conditions or symptoms that are likely to require treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a fear the client may represent a safety threat to others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Family known to Family & Childcare Services | Currently | Y | N | Past | Y | N | Not known |
Are there any Childcare concerns? | Yes | No | If yes, please specify Agencies involved |

Additional information:

Dependents < 17 years? | Details:

(Please note: the client (unless communication is indicated otherwise) will be sent a letter following receipt of this completed form inviting them to contact the service to arrange an appointment date and time.

**Client Consent** (Delete where applicable)

I consent to

- This referral being made
- Details of the date/time of my appointment being sent to the referrer.
- Confirmation of my appointment attendance being sent to the referrer
- Being contacted at home/by telephone/by mobile only

Signed........................................... Name........................................... Date...........................................
2. Benzodiazepine reduction flowchart

Stabilisation
- Provide crisis intervention.
- Provide safe withdrawal.
- Provide relapse management.
- Teach basic life skills.

Education
- To provide information on the consequences of benzo use.
- To provide anxiety education and sleep hygiene.

Counselling
- To provide individual and group counselling.
- To implement clients treatment plan.

Referral and Assessment
- To gather basic information on the client.
- To administer standardised assessment instruments.
- To develop a withdrawal management plan.

Short term
- Increase in client's motivation to stay in treatment.
- Improve client health status.
- Withdraw clients from benzos.

Long term
- To improve clients participation in treatment.

Program Logic Model for Benzodiazepine Dependence
- To reduce psychoactive substance use.
- To reduce risk behaviour.

To improve the general well-being of the client.
3. Sample letter to patient on a hypnotic

Dear……………………….

You have been prescribed ………………………………………………….., one of a group of medicines known as the benzodiazepines. This medicine can help you cope with a short period of severe stress; it is not intended for long-term treatment and can be habit forming.

If you are being treated for sleeplessness you will be given tablets for up to 10 nights only. Treatment for longer often makes sleep difficulties worse and may even make it difficult to stop the drug, so please do not ask for further supplies when these run out. Try to do without a sleeping tablet 1, 2 or 3 nights a week. Avoid drinks such as coffee, tea and cola after 3.00pm; these contain caffeine, which can keep you awake. Avoid late-night exercise and mental stimulation.

If you are being treated for anxiety you will be given a supply of medicine for a short period.

Avoid alcoholic drinks when taking a benzodiazepine, particularly when first starting treatment.

Do not drive or operate machinery while under the effects of these drugs.

Yours sincerely

Dr ………………………..
Dear………………………….

I am writing to you because I note from our records that you have been taking ................................................ for some time now. Recently, family doctors have become concerned about this kind of tranquillising 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, you may experience unpleasant withdrawal effects. For these reasons, 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. 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 whenever it is convenient for you to attend.

Yours sincerely

Dr ..........................
11. Patient/carer information leaflets

a. Reducing your Benzodiazepines

**Alternatives to benzodiazepines and “Z” drugs**

Benzodiazepines offer short-term relief of problems and your doctor may only prescribe these drugs for a short period of time to help you cope while your symptoms are severe. If you experience ongoing problems, it makes sense to start thinking about other ways of coping. You may consider:
- Regular exercise
- Listening to music
- Learning relaxation techniques
- Herbal alternatives

Follow the ‘Good sleep Guide’ available from your GP surgery or Community Pharmacy.

**Further sources of help and advice**

Your local doctor or practice nurse will usually be able to advise on self-help groups in your area. Advice is also available from your community pharmacist.

Community Addiction Teams also provide help and support. You can contact them via your GP or directly.

**Information for People Taking Sleeping Tablets, Benzodiazepines and “Z” Drugs**

These drugs cause drowsiness which may continue the next day. If affected do not drive or operate machinery. Avoid alcoholic drink.

**What are benzodiazepines and “Z” drugs and what are they used for?**

Benzodiazepines are a group of medicines which are often used to treat anxiety e.g. diazepam, or used as sleeping tablets e.g. temazepam or nitrazepam. The “Z” drugs (zopiclone, zopidem and zaleplon) are other sleeping tablets that are similar to benzodiazepines in how they work. These medicines are usually very good at easing the symptoms of anxiety or aiding sleep and are meant for short-term use i.e. 2-4 weeks. You should only take these medicines if your doctor has prescribed them for you – do not take medicines intended for other people. Illegal versions of these are also available via the internet or on “the street”. Common street names include: Valium, Vali, diaz, zac, z pass, zep, win, sleepers, cox, Mogadon, temaz, fives, teen, white, men, downers.

The quality of this is unknown and you should not buy or take these.

**What happens if you take a benzodiazepine or “Z” drug for longer than 4 weeks?**

You can usually stop taking one of these medicines without any problems if you only take them for 2-4 weeks. Longer use may cause problems such as tolerance and dependence.

Tolerance

If you take a benzodiazepine or “Z” drug regularly, after a few weeks the body and brain become used to it and the drug gradually loses its effect. You then need a higher dose for it to work in the same way. In time, the higher dose will not work and you will need an even higher dose. This effect is called tolerance.

Because of “tolerance”, the tablets may not help your original anxiety or insomnia problem if you take them for a long time.

**Dependence**

There is a good chance that if you take a benzodiazepine or “Z” drug for more than 4 weeks you will become dependent on them. This means that withdrawal symptoms can occur if the tablets are stopped suddenly and these may include:
- inability to sleep
- sweating
- headache
- tremor
- feeling sick
- palpitations
- muscle spasms

You may end up taking more medication to prevent withdrawal symptoms.

**Stopping benzodiazepines or “Z” drugs**

It is best to talk to your doctor or pharmacist about how to come off benzodiazepines or “Z” drugs. Some people can stop taking them without any difficulty. However, to keep withdrawal effects to a minimum, it is often best to reduce the dose gradually over a number of weeks or months before finally stopping. Withdrawal symptoms may last for just a few days, but in some people can last for many weeks. Symptoms may not start for up to 2 days after stopping your tablets and tend to be worse in the first week or so. Some people experience minor lingering symptoms for several months.

**Practical Advice when you are coming off benzodiazepines or “Z” drugs**

- You may have disturbed sleep when you are coming off the tablets. Try to anticipate and accept this.
- Consider telling friends and family that you are stopping the tablets. They may give you encouragement and support.
- Consider joining a local self-help group. Advice and support from other people in similar circumstances can be very helpful.
- Avoid taking extra tablets in times of stress.
- Do not make up for the lack of tablets by drinking alcohol, taking other drugs (prescription, non-prescription or illicit) or smoking.

**Benefits of stopping benzodiazepines or “Z” drugs**

Stopping these medicines can have many benefits for your health including:
- Improved memory and reaction times
- Lower levels of anxiety and enjoyment of life
- More energy and ability to do things.

Prepared by: EHSS& Prescribing Team and Belfast and South East Trusts’ Community Addiction Teams. February 2009.
b. Advice for patients on Benzodiazepines

What are benzodiazepines?

Benzodiazepines are drugs that can reduce anxiety and help sleep problems. They should only be used for very short periods in patients with severe symptoms.

What are the effects?

Short term:
- Reduced alertness
- Drowsiness. This may effect your ability to drive or operate machinery
- Reduced tension and anxiety.

Long term:
- Dependence on the drug
- Reduced alertness may lead to accidents or falls
- Poorer memory
- Lack of emotion
- Tasks take longer to complete
- The short-term effects continue.

What may happen when the drug is withdrawn?
- Your muscles may ache and strange sensations may be felt on the skin
- You may feel restless and anxious
- You may feel sick and weight loss may occur
- You may sweat more than normal
- You may have difficulty sleeping
- You may feel more frightened or panicky. At first you can have a reduced ability to cope with stress
- Eventually your anxiety will disappear and you will become more assertive.

Why does this happen?

Benzodiazepines in the brain block your emotional responses. When you reduce the drug, your brain becomes over-stimulated again. This can magnify your feelings and senses.

This is why your doctor will very slowly reduce your medication to ease the withdrawal process. Hopefully these side effects will be kept to a minimum.
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 tea or coffee 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 fall asleep at first.
- Do not try to fall asleep. Sleep is not something that you can switch on deliberately!

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 20 minutes, 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 these tips above and use them again.

Prepared by: EHSSB Prescribing Team and Belfast and South East Trusts Community Addiction Teams.
Dec 2008
d. **The Good Relaxation Guide**

The following tips should help towards better relaxation.

a. **Value times of relaxation**
   a. Think of them as essentials not extras. Give relaxation some of your best time not just what’s left over.
   b. Build relaxing things into your lifestyle every day and take your time. Don’t rush. Don’t try too hard.
   c. Learn a relaxation routine, but don’t expect to learn without practice. There are many relaxation routines available, especially on audio tape. These may help you to reduce muscle tension and to learn how to use your breathing to help you relax.
   d. Tension can show in many ways – aches, stiffness, heart racing, perspiration, stomach churning etc. Don’t be worried about this.

b. **Keep fit. Physical exercise, such as a regular brisk walk or a swim, can help to relieve tension**

c. **Accept that worry can be normal and that it can be useful. Some people worry more than others but everyone worries sometimes.**
   a. Write down your concerns. Decide which ones are more important by rating each of them out of ten.
   b. Work out a plan of action for each problem.
   c. Share your worries. Your friends or your general practitioner can give you helpful advice.
   d. 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.

d. **Practice enjoying quiet moments, eg. sitting, listening to relaxing music. Allow your mind to wander and try to picture yourself in pleasant, enjoyable situations.**

e. **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 overcome your anxiety.**
   a. Make a written plan and decide how you are going to deal with difficult situations.
   b. Reward yourself for your successes.
   c. Tell others. We all need encouragement.
   d. Your symptoms may return as you face up to difficult situations. Keep trying and they should become less troublesome as your confidence grows.
   e. Everyone has good days and bad days. Expect to have more good days as time goes on.

f. **Try to put together a programme based on all 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.
e. Help with sleep

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 isn’t harmful. Being awake does not necessarily mean that the individual is distressed.

Resting in bed can be 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 depression or anxiety.

A range of activities should be encouraged in order to have an interest and alertness in life.

Sleeping pills are addictive. They should only be used for a few days 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!
SLEEP DIARY

It will help us to find the best way to deal with the problem you are having with sleep at the moment if you can keep a sleep diary for a short time. All you have to do is to use the chart below to note down the pattern of your sleep (how much you sleep and when) and the quality of your sleep. It is best to try to fill in the diary as soon as possible after getting up; it only takes a few minutes. If this is not possible, make sure you fill it in before the end of the day — it is very difficult to remember details of sleep after more than one night.

When you come back to see me, we can discuss what you have written in your sleep diary. This should help us to decide together the best way to deal with the problem.

Name .........................................................................................................

Measuring the Pattern of Your Sleep

1. At what time did you get up this morning?
2. At what time did you go to bed last night?
3. How long did it take you to fall asleep (mins)?
4. How many times did you wake up during the night?
5. How long were you awake during the night (in total)?
6. About how long did you sleep altogether (hours/minutes)?
7. How much alcohol did you take last night?
8. How many sleeping pills did you take to help you sleep?

Measuring the Quality of Your Sleep

Please answer these questions about the quality of your sleep using the following scale:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Very</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Day

1. Do you feel well this morning?
2. How enjoyable was your sleep last night?
3. How mentally alert were you in bed last night?
4. How physically tense were you in bed last night?

Adapted from original material in the report of the Scottish National Medical Advisory Committee on the management of anxiety and insomnia.
It will help us to find the best way to deal with the anxiety you are feeling at the moment, if you can keep an anxiety diary for a short time. Use it to keep a note of when and where you feel anxious, and how anxious you feel. The chart below is designed to make this as easy as possible. The best way to record how anxious you feel is by using an anxiety scale. On this chart the scale is 0-10, where 0 = not anxious at all, 5 = moderately anxious and 10 = extremely anxious.

By filling in the chart it will be easier to identify the times and situations where you feel most anxious. When you come back to see me, we can discuss what you have recorded in your anxiety diary. This should help us to decide together the best way to deal with the problem.

<table>
<thead>
<tr>
<th>Day, date &amp; time</th>
<th>Where are you?</th>
<th>What are you doing?</th>
<th>Anxiety scale 0 - 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Watching news on the TV</td>
<td>News of a disaster</td>
<td>Not at all</td>
</tr>
<tr>
<td>Tuesday 31 Jan 22.10</td>
<td></td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>

Adapted from original material in the report of the Scottish National Medical Advisory Committee on the management of anxiety and insomnia.
h. **Drug diary**

Drug diary date: ..........................................................

<table>
<thead>
<tr>
<th>Day</th>
<th>What</th>
<th>Reason for drug use</th>
<th>When, where, who with</th>
<th>How did you feel?</th>
<th>How much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Thursday</td>
<td></td>
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<tr>
<td>Friday</td>
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<tr>
<td>Saturday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benzodiazepine Dependence Self-Report Questionnaire (Short Version)

**Name of respondent:**  | **Sex: M / F** | **Age (years):** | **Benzodiazepines:**
---|---|---|---

**INSTRUCTION:** The statements in this questionnaire are **only** about the sleeping tablets and tranquillisers which are indicated to you. Please judge the statements as they have applied to you yourself over the past six months and draw a circle around the **most appropriate answer**

<table>
<thead>
<tr>
<th>Statement</th>
<th>that is absolutely untrue for me</th>
<th>that is untrue for me</th>
<th>that is partly true, partly untrue for me</th>
<th>that is true for me</th>
<th>that is absolutely true for me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I take another dose of medication on time, because otherwise I would suffer complaints</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I get nervous if my medication is out of reach</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. other people have urged me to use less medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I take more medication than is written on the label</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I feel safe when I have my medication with me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. at present, the medication is less effective than it used to be</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. my medication is gone too quickly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. the medication is getting me into trouble</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I alter what is written on the prescription</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I have been thinking about giving up the medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. just before I take my medication, that is the only thing I can think about</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I spend a great deal of time thinking about medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I think the medication is destroying my life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I go and get a new prescription before the appointed time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I take a lot of medication in one go</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Bendep-SRQ (SV)** © C.C. Kan UMC St. Radboud Nijmegen, PO Box 9101, 6500 HB Nijmegen, The Netherlands. E-mail: C.Kan @czzopsy.azn.nl
If you have never considered trying to cut down on your medication use or stopping, you are not required to answer any of the questions below and you have finished the questionnaire.

Please read on if you have ever tried to use less or stop!

Using fewer sleeping tablets or tranquillisers can lead to complaints. Below a list of examples of these complaints is given. Please indicate the extent to which you were troubled by each of the complaints the last time you tried to use less or stop by drawing a circle around the most appropriate answer.

<table>
<thead>
<tr>
<th>Complaint</th>
<th>none or hardly any trouble</th>
<th>slight trouble</th>
<th>quite a lot of trouble</th>
<th>a great deal of trouble</th>
<th>a very great deal of trouble</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. feeling depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. tiredness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. shaking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. irritability</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. restlessness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Computation sum scores of the Bendep-SRQ Rasch-scales:

Convert the raw scores into dichotomized scores*: 1 and 2 ➔ 0; 3, 4 and 5 ➔ 1

<table>
<thead>
<tr>
<th>Problematic Use</th>
<th>3</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>13</th>
<th>Sum Score</th>
<th>Rasch-norms:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0= very low; 1= moderate; 2= high;</td>
</tr>
<tr>
<td>Dichotomized score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3, 4 and 5= very high</td>
</tr>
<tr>
<td>Preoccupation</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>11</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raw score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0= very low; 1= low; 2= moderate;</td>
</tr>
<tr>
<td>Dichotomized score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3= high; 4 and 5= very high</td>
</tr>
<tr>
<td>Lack of Compliance</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>14</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raw score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0= low; 1= high;</td>
</tr>
<tr>
<td>Dichotomized score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2, 3, 4 and 5= very high</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raw score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0= very low; 1= low; 2= moderate;</td>
</tr>
<tr>
<td>Dichotomized score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 and 4= high; 5= very high</td>
</tr>
</tbody>
</table>

*Bendep-SRQ (SV) © C.C. Kan UMC St. Radboud Nijmegen, PO Box 9101, 6500 HB Nijmegen, The Netherlands. E-mail: C.Kan @czzopsy.azn.nl
j. BDZ withdrawal symptom questionnaire

Each moderate score is given a rating of 1 and each severe score a rating of 2. The maximum score possible is 40, unless of course additional symptoms are included.

Note also whether the symptoms occurred when the tablets were reduced or stopped, or if the symptoms occurred when the tablets were the same.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No</th>
<th>Yes - moderate</th>
<th>Yes - severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling unreal</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Very sensitive to noise</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Very sensitive to light</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Very sensitive to smell</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Very sensitive to touch</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Peculiar taste in mouth</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pains in muscles</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Muscle twitching</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Shaking or trembling</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pins and needles</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dizziness</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feeling faint</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feeling sick</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feeling depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sore eyes</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feeling of things moving when they are still</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Seeing or hearing things that are not really there (hallucinations)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Unable to control your movements</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Any new symptoms (describe each below)
1.
2.
3.
4.

If the individual attains an overall score above 20 seek specialist medical help.
If the individual endorses a number of severe symptoms seek specialist medical help.
If the individual reports a number of new symptoms seek specialist medical help.

Source
**COMMUNITY ADDICTIONS TEAM**

**DRUG REDUCTION REGIME**

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Drug</td>
</tr>
<tr>
<td>Directions</td>
</tr>
<tr>
<td>Time</td>
</tr>
<tr>
<td>(Day)</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Weekly Total</td>
</tr>
</tbody>
</table>

Signed

Date

DD/Sept98
I. **Self help groups**

**Anxiety, Panic & Phobias**

Northern Ireland Association for Mental Health (028) 9032 8474

Aware Defeat Depression 08451 202 961

Rethink (028) 9040 2323

Mindwise 08454 560 455 or (028) 9040 1616

**Drug Dependence**

National Drugs Helpline 0800 776 600

Narcotics Anonymous 07810 172 991

Battle Against Tranquillisers 01179 663 629

**Bereavement**

Cruse Bereavement Care (local group) (028) 9127 2444

**Sexual Abuse**

NEXUS (028) 9032 6803

**Domestic Violence**

Womens Aid ( 24hr Helpline) 08009 171 414

Belfast/Lisburn (028) 9066 6049

North Down & Ards (028) 9127 3196

For further information please see [www.wellnet-ni.com/orgs](http://www.wellnet-ni.com/orgs)
Appendix 1

At a glance guide to the current medical standards of fitness to drive.

Driver and Vehicle Licensing Agency:

The “At a Glance” booklet is available to view online in PDF format. It is recommended that you access the current online version at:


This is an example of the information, correct at Feb 2010:

<table>
<thead>
<tr>
<th>DRUG MISUSE AND DEPENDENCY</th>
<th>GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE</th>
<th>GROUP 2 ENTITLEMENT VOC – LGV/PCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference to ICD10 F10.1-</td>
<td>Persistent misuse of, or dependency</td>
<td>Persistent misuse of, or</td>
</tr>
<tr>
<td>F10.7 inclusive is relevant</td>
<td>on these substances, confirmed by</td>
<td>dependency on these</td>
</tr>
<tr>
<td></td>
<td>medical enquiry, will lead to</td>
<td>substances, will require</td>
</tr>
<tr>
<td></td>
<td>licence refusal or revocation</td>
<td>revocation or refusal of a</td>
</tr>
<tr>
<td></td>
<td>until a minimum one year</td>
<td>vocational licence for a</td>
</tr>
<tr>
<td></td>
<td>period free of such use has</td>
<td>minimum three-year period.</td>
</tr>
<tr>
<td></td>
<td>been attained. Independent</td>
<td>Independent medical</td>
</tr>
<tr>
<td></td>
<td>medical assessment and</td>
<td>assessment and urine</td>
</tr>
<tr>
<td></td>
<td>urine screen arranged by DVLA, may be</td>
<td>screen arranged by DVLA, will</td>
</tr>
<tr>
<td></td>
<td>required. In addition favourable</td>
<td>normally be required. In</td>
</tr>
<tr>
<td></td>
<td>Consultant or Specialist report may</td>
<td>addition favourable Consultant</td>
</tr>
<tr>
<td></td>
<td>be required on reapplication.</td>
<td>or Specialist report will be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>required before relicensing.</td>
</tr>
</tbody>
</table>

Multiple substance misuse and/or dependency – including misuse with alcohol – is incompatible with licensing fitness
13. Case histories

Case A

55 year old lady with intermittent anxiety symptoms. She has regularly taken Diazepam 2mgs for many years. She admits to only using them infrequently.

Discussion

MUST DO’S:

During the history taking establish if there are any symptoms suggestive of mild depression or generalised anxiety disorder. Exclude physical illness such as thyrotoxicosis or an arrhythmia.

OPTIONS:

• Reduction of the amount available on each monthly script & monitoring
• Advice regarding addiction and side effects
• Self-help material on ways to cope with the symptoms, alternative methods
• Review & see if further intervention or referral is needed.

Case B

A 31 year old lady has been taking Temazepam 10mg for 2 years following a mild depression associated with sleep disturbance. Her depression has resolved but she continues with the tablets. At her annual medication review you discuss the need for further scripts.

Discussion

MUST DO’S:

The patient may be concerned that she cannot do without them. Support and reinforce a suggestion of slow withdrawal.

OPTIONS:

• Good Sleep Guide
• Documentation of your discussion and the addictive nature of the medication and its side effects
• Discussion of alternative methods
• Advice about withdrawal. Suggest a gradual tapered reduction
• Arrange a follow up consultation
• This is likely to be temporary, if no previous history.
Case C
A new male patient 26 years complains of tiredness and early insomnia. He has many worries and ‘stresses’ following moving house and starting a new job. He works long hours and finds it difficult to ‘relax’.

Discussion
MUST DO’S:
Include in the history how long the symptoms have been going on for. Ask about anxiety symptoms and depression. Take a sleep history. What self-help methods has the client tried?

OPTIONS:
Supportive advice and other questions may include:
• Exclusion of physical illness
• An evaluation of the client’s caffeine levels
• Promote sleep hygiene and offer support with the Good Sleep Guide
• If the client has had sleep deprivation present for a few weeks, a short prescription of a hypnotic may help (5-7 days). Advise that it is a short course only and no further prescriptions will be issued (document in clinical notes on GP practice computer!)
• If symptoms continue, referral for relaxation therapy (to either Mental Health Day Hospital or the Community Mental Health Team for a ‘Stress management) may be required.

Case D
A 40 year old man who has a long history of a generalised anxiety disorder (GAD). In the past he has had psychological therapy for traumas suffered in childhood. He has had an admission to the psychiatric unit with Depression and Anxiety in 1997. He has received your letter suggesting reduction of medication and has come in for advice. Currently he takes diazepam 5mgs QDS. What are the options and how do you go about it?

Discussion
MUST DO’S:
• Advise on the long-term effects
• Discuss dependency and addiction
• Advise on alternative & non-drug therapies.

OPTIONS:
• Assess current mental health. Does he require a psychiatric review/out-patient appointment?
• Offer a gradual reduction programme. This could entail regular appointments with the GP for support. Reduction should occur slowly at 2mgs per 2-week period, or at a slower rate eg. 1mg per 2 week
• Support with information leaflets on possible withdrawal effects and how to cope
• Consider further support from counselling or psychological services for the GAD
• If the process fails, or if the patient decides he doesn’t wish to continue, this will require documenting and further reviews on a regular basis
• Consider referral to the Benzodiazepine Nurse.
Case E

A 75 year old man has been taking 5mgs Nitrazepam a day on a regular basis for at least 30 years. He is worried that from your letter you will stop this medication. He has no problems and this keeps his ‘nerves’ at bay. He feels rotten if he doesn’t take it. What are the options here?

Discussion

MUST DO’S:

• Advise on the long term effects
• Discuss dependency and addiction
• Advice on alternative and non-drug therapies (can include here switching the nitrazepam to diazepam, which is considered safer).

SHOULD DO:

• Advise on particular risks for the elderly: cognitive problems, risk of falls
• Encourage to reduce.

OPTIONS:

• If the patient agrees to a reduction, switch to 5mgs diazepam and then taper and reduce as above
• It is often considered reasonable practice for the stable, elderly patient on low doses of hypnotics or benzodiazepines to continue on them, as long as they are monitored and reviewed.

Case F

A 17 year old girl arrives in your surgery late Friday evening demanding an urgent appointment. She says that her Auntie is ill in hospital with cancer and she has come to visit. She is requesting some dihydrocodeine for her back pain and some sleeping pills, because she is unable sleep due to the worry. She cannot remember the name of her GP, but says that her GP is marvellous and always gives her sleepers (but can’t remember the name). It is 6.00pm and the patient appears agitated and continues to embellish the ‘story’. What do you do?

OPTIONS:

• Attempt to contact patient’s GP, if known, to clarify the situation
• You are not duty bound to do what another doctor does
• Suggest that you would want to speak to the patient’s doctor before prescribing such medication and that this is the ‘practice policy’
• Advise that in the short term you are willing to prescribe simple analgesics only
• If the patient becomes threatening, explain that your practice doesn’t tolerate such behaviour and that you are not responsible for their actions
• If you feel it is appropriate to prescribe hypnotics eg. if you were able to contact GP then do daily prescriptions for small amounts (Temazepam 10mg at night for three nights only – Friday, Saturday and Sunday).
14. References


Berman, ME; Jones, GD; and McCloskey, MS (2005). The effects of diazepam on human self-aggressive behaviour. Psychopharmacology (Berl), 2005 February; 178 (1); pp100-106.


Committee Safety of Medicines (1998), Report by Royal College Physicians.


Gustavsen, I; Bramness, JG; Skurtveit, S; Engeland, A; Neutel, I and Morland, J (2008). Road traffic accident risk related to prescriptions of the hypnotics zopiclone, zolpidem, flunitrazepam and nitrazepam, Sleep Medicine, January 26, 2008.


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MeReC Briefing, issue no.17, April 2002. Update on benzodiazepine and non-benzodiazepine hypnotics.


Other Sources

HSCB Benzodiazepine Resource Pack (accessible on HSCB intranet site) http://primarycare.hscni.net/PharmMM_Resources_Clinical%20Resources_Benzos_ZDrugs.htm


PRODIGY: Hypnotic and anxiolytic dependence and insomnia. www.prodigy.nhs.uk


NHS Clinical Knowledge Summaries. Insomnia (July 2009)

