

## PRESCRIBING GUIDELINES FOR BENZODIAZEPINES in ADULTS

### Background

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

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

### GENERAL GUIDANCE

- Benzodiazepines should be used at the lowest effective dose for as short a duration as possible
- Consideration of alternatives to benzodiazepines should include a balanced appraisal of the relative benefits and risks of the range of options, in acute and longer-term treatment. Non-pharmacological interventions should always be considered as alternatives or additions to pharmacological treatment.
- Dependence is recognized as a significant risk in some patients receiving treatment for longer than one month, and health professionals should be conscious of this when considering the relative benefits and risks of treatment. The potential risks of long-term treatment need to be considered prior to starting short-term treatment.

### COMMON INDICATIONS

#### Treatment of anxiety disorders

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

#### For severe anxiety

Diazepam initially 1-2 mg TDS (titrating to maximum of 5-10mg TDS) OR

In hepatic impairment / elderly - lorazepam 500 micrograms – 1 mg daily in divided doses (max 2-4mg daily in divided doses)

#### For severe anxiety AND insomnia:

Diazepam initially 2.5mg – 5mg ON (titrate up to 5mg– 15mg ON)

For panic disorder [unlicensed indication]

Lorazepam 3-5 mg daily in divided doses OR Clonazepam 1-2 mg daily in divided doses

### Induction of sleep

- NICE guidance recommends that hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, after consideration of non-drug measures. Hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications.
- Z drugs (e.g. zopiclone, zolpidem), as per BNF
- Where benzodiazepine treatment is required, the following regimes are recommended -  
Temazepam 10 – 20 mg ON for 2 – 4 weeks (review after 2 weeks)

### Other psychiatric uses

#### Alcohol withdrawal:

- Benzodiazepines are used for medically assisted detoxification from alcohol with specialist supervision or under shared care arrangement in primary care setting in conjunction with psychosocial intervention as per [NICE CG115](#).
- Recommended treatments are
  - Chlordiazepoxide or Diazepam
  - The dose required is determined by the use of tools such as SADQ and or daily units of consumption. See [NICE CG115](#) for details.

#### Muscle relaxant effects

- Diazepam is recommended for use in acute pain associated with muscle spasm
- Recommended regimes include

Acute back pain 2-5mg up to three times a day for 2-5 days

Temperomandibular disorders 2- 5mg three times a day for 2 weeks

#### Anticonvulsant effects (see BNF for dosage regimes)

- Clonazepam, diazepam, lorazepam and [buccal midazolam](#) are recommended for treatment of seizures; clonazepam is also given as short term treatment (e.g. 7 days following seizure) where longer term treatment is being initiated or changed
- Clobazam and clonazepam may also be used for long term treatment of epilepsy

### WITHDRAWING BENZODIAZEPINES

In general, benzodiazepines should be prescribed in as low a dose as possible to afford adequate symptom relief. In general compounds with higher potency and shorter half-life are

associated with a greater likelihood of developing dependence. Unless there are clear risks of more severe problems if the drug is stopped, patients should be encouraged to **withdraw gradually after long-term use** under close supervision

Guidance on managing withdrawal can be found <https://cks.nice.org.uk/topics/benzodiazepine-z-drug-withdrawal/management/benzodiazepine-z-drug-withdrawal/>  
Information on prescribing, including switching to diazepam can also be found at <https://bnf.nice.org.uk/>

Patients should be referred to a specialist in the following circumstances:

Slow tapering is recommended for these individuals

- History of alcohol or other drug use or dependence.
- Concurrent, severe medical or psychiatric disorder or personality disorder.
- A history of drug withdrawal seizures — these generally occur in people who suddenly stop high doses of the drugs.
- Hepatic impairment – for advice on prescribing regime
- Prolonged periods of prescribing with or without signs of drug seeking behaviour

When patients are discharged from secondary care and benzodiazepines have been prescribed then the discharge information should include a review date for the current dose and the long term plan ie reduction and discontinuation if considered appropriate. If this has been agreed with the patient then this information should also be recorded on the IDL with the proposed timescales

## References for Further Information

British National Formulary (2014) <https://bnf.nice.org.uk/>

Baldwin et al (2013) Benzodiazepines: Risks and benefits. A reconsideration. *J. Psychopharmacol*: 27 (11) 867-871

Lingford-Hughes et al (2012) BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *J. Psychopharmacol*: 0(0) 1 –54

NICE (2011) CG 115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence <http://www.nice.org.uk/guidance/CG115>

NICE Clinical Knowledge Summaries [accessed July 2014] Back pain - low (without radiculopathy) <http://cks.nice.org.uk/back-pain-low-without-radiculopathy#azTab>

NICE Clinical Knowledge Summaries [accessed August 2021] Benzodiazepine and z-drug withdrawal <https://cks.nice.org.uk/topics/benzodiazepine-z-drug-withdrawal/management/benzodiazepine-z-drug-withdrawal/>

NICE Clinical Knowledge Summaries [accessed July 2014] TMJ disorders <http://cks.nice.org.uk/tmj-disorders#azTab>

NICE (2004) Guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia <https://www.nice.org.uk/guidance/ta77/chapter/1-Guidance>

## APPROVAL PROCESS

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