NHS Grampian

Prescribing Guidance For Patients With Benzodiazepine Or Z Drug Dependence In Grampian

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		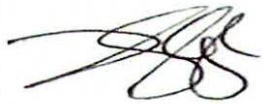

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Policy Statement:
It is the responsibility of all staff to ensure that they are working to the most up to date and relevant guideline, policies, protocols and procedures.

Version 4

Executive Sign-Off

This document has been endorsed by the Director of Pharmacy and Medicines Management

Signature: 

Replaces: NHSG/Guid/BenzoZ/MGPG904, Version 3

Document application: NHS Grampian

Revision History:

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December 2024	Full document review	Throughout

Consultative Group

Special thanks to Sarah O'Beirne, Lead Pharmacist NHS Grampian Medicines Information Centre for undertaking an in depth review of the current evidence base to support development of this document.

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1. Introduction

Benzodiazepines and Z-drugs remain a useful treatment option for licensed indications however they can result in dependence and increase the risk of harms including drug related death. This is particularly the case where potent, non-prescribable or "street" benzodiazepines are concerned. The use and availability of street benzodiazepines in Scotland continues to increase. Most recent (2023) drug death data [NRS] showed that, of the 1172 people in Scotland who lost their lives to a drug related death, 58% had taken "any" type of benzodiazepine, 49% a "street" benzodiazepine and 17% a "prescribable" benzodiazepine. Poly-substance use remains a key cause of drug related death.

The introduction of NICE guidance for medicines associated with dependence or withdrawal symptoms provides further support to healthcare professionals, particularly for prescribed medicines. It advises that dependence can be expected, prevented and managed successfully where patients are given the correct information and support at the time of prescribing and when reducing or ceasing prescribing.

1.1. Objectives

This guidance aims to reduce the risks associated with use of benzodiazepines and Z-drugs (prescribable and non-prescribable) by promoting safe prescribing and managing withdrawal. Non pharmacological support is not fully covered. The MAT Standards Informed Response for Benzodiazepine Harm Reduction provides more in depth advice. This guidance is for all health care professionals in any setting who care for people prescribed or using benzodiazepines or Z-drugs.

1.2. Definitions

Dependence is characterised by both tolerance (the need for increasing doses to maintain the same effect) and withdrawal symptoms. Dependence is a common and well described property of a number of medicines (prescribable or non-prescribable). It is not in itself a contraindication to continued or new prescribing of benzodiazepines or Z-drugs. Dependence becomes clinically important if treatment reduction or cessation is needed.

Dependence is different from **addiction** which features tolerance and withdrawal but has additional factors including impaired control, social problems and risky use. There is considerable debate about these definitions and in practice the terms are often used interchangeably.

The word "**illicit**" is used for simplicity and refers to any benzodiazepine or z-drug use which has not been prescribed to the person taking it. This includes both "street" benzodiazepines outlined above and prescribable benzodiazepines and Z-drugs which have not been prescribed to the person taking them. The route of manufacture may be unregulated, e.g. where tablet presses and raw materials have been acquired. In these circumstances the content, purity and consistency of each tablet produced can vary leading to increased risk of harm and uncertainty over the effects produced. WEDINOS (www.wedinos.org) is a drug checking service in Wales that can check the contents of substances to encourage harm reduction.

1.3. Clinical Situations

Provision of treatment and support to people with suspected dependence to or reporting problematic or harmful use of benzodiazepines or Z-drugs.

1.4. Patient Groups To Which This Document Applies

Adults 18 years and above

1.5. Patient Groups To Which This Document Does Not Apply

People under 18 years or with no confirmed dependence to benzodiazepines or Z-drugs.

2. Evidence Base For Prescribing Benzodiazepines

There remains no definitive evidence base for long-term prescribing of benzodiazepines. In 2021 the Drug Death Taskforce for Scotland produced the MAT Standards Informed Response for Benzodiazepine Harm Reduction to provide guidance for clinicians supporting patients experiencing problematic benzodiazepine use. This MAT response provides practical advice and tools for a holistic, biopsychosocial approach and its use is recommended alongside this document.

In 2024 the Advisory Council on Misuse of Drugs (ACMD) recommended control of a further 15 uncontrolled novel benzodiazepines and related compounds. It highlighted "important health harms including drowsiness, psychomotor impairment, unsteadiness, with high doses potentially causing loss of consciousness and respiratory depression, especially if used in combination with alcohol or other sedatives. Regular use may be associated with tolerance and dependence."

In 2020 the MHRA released a reminder on the risk of potentially fatal respiratory depression when benzodiazepines are co-prescribed with opioids.

National clinical guidance (NICE, BAP) has been developed which covers the reduction and discontinuation of benzodiazepines following long term prescribing or use in suitable patients to minimise psychological and physical symptoms of withdrawal.

3. Process Document Main Components and Recommendations

3.1. Pharmacology of Benzodiazepines and Z-Drugs – Key points

There are a large number of benzodiazepines available with similar properties. Their potency and half-lives (the time it takes for the amount of a drug's active substance in the body to reduce by half) vary. See Appendix 3.

- The majority of benzodiazepines exhibit peak effects within a half-hour to 2 hours of taking orally.
- Half-lives vary widely. Individual variation, daily dose taken and how long the person has been taking it are some of the factors which affect this. Effects may last longer, and withdrawal may take longer to appear than some may expect.
- Those with long half-lives such as diazepam and nitrazepam are more likely to produce residual effects such as sedation and falls the next day.

- Benzodiazepines and Z-drugs enhance the activity of the inhibitory neurotransmitter gamma aminobutyric acid (GABA) which affects almost every part of brain function unselectively. This “inhibitory” effect is responsible for the characteristic effects of sedation, amnesia and difficulties with coordination.

3.2. Problems associated with long-term use

Benzodiazepines and Z-drugs carry a risk of dependence, tolerance and can cause symptoms of withdrawal if/when stopped. These typically occur after only a few weeks of regular use making them less effective for the management of the prescribed indication after this time. Disadvantages and problems associated with long-term use include:

- Cognitive impairment including memory impairment, emotional blunting, weakening of coping skills and amnesia. Patients may struggle to remember recent events, the circumstances in which they occurred, and sequence in time. This may impact efficacy of psychological interventions and recollection of consultations may be poor.
- Precipitating or aggravating depression including suicidal tendencies.
- Paradoxical excitement with increased anxiety, insomnia, nightmares and hallucinations at the onset of sleep, irritability, hyperactivity or aggressive behaviour. The extent of these effects will vary between individuals and depend on dose and duration of use. They will gradually reduce in most people but can last for 6-12 months after stopping the drug.
- Dependence on even small doses of benzodiazepines/Z-drugs can result in anxiety, insomnia and other distressing withdrawal symptoms if the drug is stopped abruptly. **Gradual dose reduction is preferable to abrupt discontinuation.** Symptoms may initially appear to worsen following dose reduction, however with slow withdrawal and psychological support, symptoms will often improve.

3.3. Assessment of Benzodiazepine or Z-Drug dependence

A needs based approach to assessment is recommended. The MAT response should be accessed for more in depth guidance. Areas to consider include:

a. Presenting Issues: What are the immediate concerns – is current benzodiazepine use placing the person at risk of harm? Crew 2000 have developed a benzodiazepine harm reduction resource which can support discussion.
b. Predisposing Factors: Why this person? What has happened in this person’s life that has made them vulnerable to developing these problems?
c. Precipitating Factors: Why now – what are the triggers for use?
d. Perpetuating Factors: How are the presenting problems being maintained?
e. Protective factors: What strengths, skills and resources does the person have? What existing supports are in place?

The following information may help assessment of benzodiazepine or z-drug dependence and if prescribing is appropriate.

a. Take a full drug history (including prescribed or over the counter medication and alcohol). Estimate quantity taken or daily dose, timing of doses, frequency of use and length of time it’s been taken for.
b. Is the benzodiazepine or z-drug being prescribed and taken as prescribed or not?
c. Indication if prescribed.
d. Patient goals and expectations. What do they hope to achieve? Are they feeling motivated to stop or reduce?

e. History of previous withdrawal symptoms, including history of seizures and severity or post-withdrawal reaction.
f. Other medical or psychiatric illnesses.
g. Patient's presentation – drowsiness, disinhibition, dilation of pupils, and the frequency or consistency of presentation over a period of time.
h. Consider use of dependency questionnaires and drug diary sheets to assess the patient's pattern of use and level of dependence. This process may help patients to reduce intake without the need for a prescription and help those patients already in receipt of a prescription to identify triggers or reasons why they use benzodiazepines or Z-drugs (see Appendix 1, 2 and 3 respectively for self-report BDEPQ questionnaire, scoring sheet and drug diary). Binge episodes of heavy benzodiazepine or Z-drug use should not be confused with dependence.
i. Undertake urine drug testing to support diagnosis. The request for a urine drug screen should clearly indicate "benzodiazepine testing" and highlight any prescribed and any known non-prescribed medications reported. These can be used to support risk assessment. Full guidance on the use of drug testing can be accessed in Drug Misuse and Dependence: UK guidance on clinical management. Please note: novel benzodiazepines may not always show on a urine drug screen.

4. Prescribing Options for Patients with Benzodiazepine or Z-Drug Dependence

4.1. Initiating a Benzodiazepine

Clear and realistic goals should be agreed before starting a benzodiazepine prescription. The NICE decision aid "Before starting medicines associated with dependence or withdrawal symptoms" can support discussion. In addition, Choice and Medication has printable patient information leaflets for specific mental health related medications including diazepam, other benzodiazepines and Z-drugs. A collaborative approach is recommended.

Prescribers should consider the potential risks and benefits of prescribing benzodiazepines and the harms of patient's continuing use of non-prescribed benzodiazepines.

- A single benzodiazepine is considered safer than prescribing multiple benzodiazepines.
- Diazepam is recommended for most patients due to its relatively long half-life and range of tablet strengths. This includes those dependent on Z-drugs.
- The maximum licenced diazepam daily dose of 30mg is preferred in most cases as it is associated with less likelihood of adverse effects. Clinical rationale for prescribing higher doses should be clearly documented and discussion within the specialist multi-disciplinary team is advised prior to initiation.
- Where risks are particularly high, a lower starting dose of 10 or 20mg daily and titration upwards may be safer than starting at a higher daily dose
- Where there is risk of over use or diversion, instalment dispensing should be considered. If the patient already has an instalment dispensing arrangement for another prescription, it may be helpful to mirror this existing dispensing arrangement.

The prescriber and the patient should agree and have a clear understanding of what the prescription aims to achieve along with the circumstances a prescription will be stopped or reduced if it is not achieving the intended goals. Ensure the patient understands the effects and adverse effects of the medication.

4.2. Maintaining, Reducing and Stopping Benzodiazepines

NICE has produced a useful decision aid to help discuss pros and cons of continuing, reducing or stopping benzodiazepine prescribing. Deprescribing.org has also produced a useful algorithm for those prescribed benzodiazepines. Evidence suggests changes are more likely when the person is motivated. Focus on the positive changes the individual hopes to achieve by stabilising or reducing benzodiazepine use, this may be more beneficial than regular focus on the harms associated with ongoing use. These could include improvements in physical and mental health, relationships, performance at work or in education and feeling of increased personal control over aspects of their life. Where dose reduction is agreed.

a. A gradual, withdrawal schedule (dose tapering) should be negotiated. This is a flexible process which can be slowed or paused if needed. The person should guide adjustments so that they remain comfortable with the withdrawal. As a rule of thumb, at higher doses patients may initially tolerate reductions in the daily dose of around 10-15%. Dose reductions may become smaller as the reduction progresses.
b. Ensure the patient understands what symptoms of withdrawal they may experience and what to do if they occur.
c. Reviews should be frequent to detect and manage problems early and to provide advice and encouragement during and after the drug withdrawal, as a minimum before each dose reduction. Be mindful of changes to mental health during dose reductions.
d. If the patient is struggling with symptoms of withdrawal, pause the reduction and maintain the current dose until symptoms improve. Increases in dose are to be discouraged. Examples of reducing scale can be found in Appendix 6.
e. Check that other substances or alcohol are not being added in or increased to cope with the benzodiazepine reduction.
f. The time needed for complete withdrawal may vary and can take a year or more for those who have been taking high doses for extended periods.
g. Automated repeat prescriptions are not recommended. Patients should be reviewed for ongoing assessment and support. Where appropriate, review may be by phone but face to face appointments are encouraged as they allow better assessment of mental health.
h. Document updates to the care plan in the patient notes.
i. Patients with diagnosed or suspected co-occurring psychiatric illness may need additional psychological support when adjusting benzodiazepine use.

4.3. Patients with Co-Occurring Alcohol Dependence

Where patients exhibit a co-dependency on alcohol, the local specialist alcohol team should be consulted for advice prior to initiating a benzodiazepine for dependence.

Area	Name of Alcohol Service	Telephone	Email
Aberdeen City	Integrated Alcohol Service	01224 557845	gram.macrappointment@nhs.scot
Central/South Aberdeenshire	Aberdeenshire Drug and Alcohol Service	01467 532833	gram.southcentralsms@nhs.scot
North Aberdeenshire	Aberdeenshire Drug and Alcohol Service	01346 585160	gram.kessockclinic@nhs.scot
Moray	Moray Integrated Drug and Alcohol Service	01343 552211	gram.midasadministration@nhs.scot

4.4. Patients with Co-Occurring Opioid Dependence

Withdrawal from both medications opioid substitution therapy (OST and benzodiazepine) at the same time is not recommended in community settings. It is recommended to reduce one medication at a time.

People who present with co-occurring opioid dependence can be offered same day prescribing of OST where clinically appropriate. Benzodiazepine dependence should be assessed as per this guidance. The additional risks should be discussed and harm reduction covered. Where possible the OST prescription should be stabilised prior to adjustment of benzodiazepine dosage.

4.5. Pregnancy

The Essential Guide to Problem Substance use During Pregnancy states:

"There is no conclusive evidence that benzodiazepines cause congenital birth defects or other serious adverse effects on the developing fetus. However, an increased risk of low birth weight and preterm delivery has been reported and most studies have investigated low dose use, whereas many drug users report high dose intake. Whilst there have been some reports of facial abnormalities (i.e. cleft lip and palate) following high dose benzodiazepine use in early pregnancy, these findings have not been reliably reproduced.

Maternal use of benzodiazepines near term can also result in "floppy baby syndrome" where the newborn baby is lethargic, has reduced muscle tone and respiratory depression. Dependent benzodiazepine use by the mother is clearly associated with withdrawal symptoms in the newborn baby. Neonatal Abstinence Syndrome can be more severe and prolonged with benzodiazepines and the onset of withdrawal symptoms can be delayed, secondary to maternal opioid use".

It is generally recommended that use of benzodiazepines is avoided in pregnancy unless there is a clear indication. However to reduce the risk of illicit use, those women who are dependent on benzodiazepines or Z-drugs should be stabilised on diazepam and where this can be tolerated without restarting illicit use, the dose reduced.
www.nhs.uk/medicines/diazepam/pregnancy-breastfeeding-and-fertility-while-taking-diazepam/

Recommended management for benzodiazepine use in pregnancy:

- **Outpatient:** General Practitioners should liaise closely with the obstetrician involved with the care of the patient who is benzodiazepine dependent in order to determine individual management. Follow this policy, speeding up reduction if possible by reducing the interval of reductions to weekly.

- **In-Patient:** In Aberdeen Maternity Hospital care will be jointly delivered by the consultant obstetrician and the specialist antenatal clinic.

5. Reference

Previous Guidance References

1) MHRA, 2020. Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory. Drug Safety Update volume 13, issue 8: March 2020: 5. Available from www.gov.uk/drug-safety-update/benzodiazepines-and-opioids-reminder-of-risk-of-potentially-fatal-respiratory-depression
2) Public Health Scotland, 2023. MAT standards informed response to benzodiazepine harm reduction guidance. Available from: https://drugstaskforce.knowthescore.info/archive/?_sf_s=benzo%20
3) Department of Health England, 2017. *Drug Misuse and Dependence: UK guidelines on clinical management*. [online] Available from: www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management.
4) Baillie, A.J., Mattick, R.P., 1996. *The benzodiazepine dependence questionnaire: development, reliability and validity*.Br J Psychiatry. 1996 Sep;169(3):276-81
5) Ashton, H. Benzodiazepines: How the work and how to withdraw (The Ashton Manual). [online]. Newcastle: University of Newcastle. Available from: www.benzo.org.uk
6) Whittaker, A. 2011. The Essential Guide to Problem Substance Use During Pregnancy. A Resource Book for Professionals. London: DrugScope. 2011 Edition
7) DVLA, 2024. Assessing fitness to drive – a guide for medical professionals [online]. DVLA. Available from: www.gov.uk/dvla/fitnesstodrive
8) NICE, 2022. Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults [online]. Available from: www.nice.org.uk/guidance/ng215/resources/medicines-associated-with-dependence-or-withdrawal-symptoms-safe-prescribing-and-withdrawal-management-for-adults-pdf-66143776880581
9) McCarthy, L., Thompson, W., Farrell. B., 2019. Benzodiazepine and Z-drug Deprescribing Algorithm [online]. Available from: https://deprescribing.org/wp-content/uploads/2019/03/deprescribing_algorithms2019_BZRA_vf-locked.pdf
10) McAuley A., Palmateer N., Goldberg D.J. et al, 2023. Increased risk of non-fatal overdose associated with non-prescribed benzodiazepine use in Scotland, UK.
11) McAuley A., Matheson C., Robertson J.R., 2022 from the clinic to the street: the changing role of benzodiazepines in the Scottish overdose epidemic. International Journal of Drug Policy. 100.
12) Dyer A.H., Laird E., Hoey L. et al, 2021. Long-term anticholinergic, benzodiazepine and Z-drug use in community-dwelling older adults: What is the impact on cognitive and neuropsychological performance? International Journal of Geriatric Psychiatry. 36(11) (pp 1767-1777).
13) Liu L., Jian L., Jian P. et al, 2020. The Effects of Benzodiazepine Use and Abuse on Cognition in the Elders: A Systematic Review and Meta-Analysis of Comparative Studies. Frontiers in Psychiatry. 11.
14) Javelot H., Marquis A., Antoine-Bernard E. et al, 2018. Benzodiazepines withdrawal: Initial outcomes and long-term impact on falls in a French nursing home. Pharmacy. 6(2) (no pagination)
15) May T., Holloway K., Buhociu M., Hills R., 2020. Not what the doctor ordered: Motivations for nonmedical prescription drug use among people who use illegal drugs. International Journal of Drug Policy. 82(no pagination).
16) Peng L, Morford KL, Levander XA, 2022. Benzodiazepines and related sedatives. Med Clin North Am. 2022; 106(1):113–129
17) Acute and persistent withdrawal syndromes following discontinuation of psychotropic medications. Cosci F., Chouinard G. Psychother Psychosom 2020; 89: pp. 283-306

6. Responsibilities For Implementation

Organisational:	Chief Executive and Management Teams
Corporate:	Senior Managers
Departmental:	Heads of Service/Clinical Leads
Area:	Line Managers
Hospital/Interface services:	Group Clinical Directors
Operational Management Unit:	Unit Operational Managers

Appendix 1 - NHSG Benzodiazepine Dependence Questionnaire (BDEPQ)

In the questions that follows you will be asked about your experience using medications known as sleeping pills, sedatives, hypnotics, 'benzos' or tranquillisers. These medications are also known by their trade names: valium, temazepam, nitrazepam (or mogadon), chlordiazepoxide (Librium); or by their nicknames such as 'blues', 'moggies', 'tems', 'downers'.

When answering the questions please think only about your experiences **over the last month**. Circle the answer that best suits your experience in the last month.

1. In the last month, have you taken another sedative or tranquilliser as soon as the effects of the previous one began to wear off?

NEVER SOMETIMES OFTEN ALWAYS

2. Have you taken sedatives, tranquillisers or sleeping pills in the last month because you like the way they make you feel?

NEVER SOMETIMES OFTEN ALWAYS

3. In the last month, have you felt that you cannot face anything out of the ordinary without a sedative or tranquilliser?

NEVER SOMETIMES OFTEN ALWAYS

4. Do you feel that you cannot get through the day without the help of your sedatives or tranquillisers?

NEVER SOMETIMES OFTEN ALWAYS

5. Do you need to carry your sedatives or tranquillisers with you?

NEVER SOMETIMES OFTEN ALWAYS

6. Have you tried to reduce the number of sedatives, tranquillisers or sleeping pills you take because they interfered with your life?

A GREAT DEAL SOMEWHAT A LITTLE NO

7. Have you found that you needed to take more tranquillisers, sedatives or sleeping pills to get the same effect in the last month compared to when you first took them?

NEVER SOMETIMES OFTEN ALWAYS

8. Do you need to take sedatives, tranquillisers or sleeping pills to deal with the problems in your life?

NEVER SOMETIMES OFTEN EVERY DAY

9. Do you feel terrible if you do not take a sedative, tranquilliser or sleeping pill?

EVERY DAY OFTEN SOMETIMES NEVER

10a. In the last month, have you been worried that your doctor might not continue to prescribe the sedatives, tranquillisers or sleeping pills you are taking?

NEVER SOMETIMES OFTEN A LOT

10b. How strong has this worry been?

MILD MODERATE SEVERE

11. Could you stop taking sedatives, tranquillisers or sleeping pills tomorrow without any difficulties?

No, it would be impossible
Perhaps, with a lot of difficulty
Yes, with some difficulty
Yes, without difficulty

12. Do you count down the time until you can take your next sedative, tranquilliser or sleeping pill?

ALWAYS OFTEN SOMETIMES NEVER

13a. Have you experienced relief when you have taken sedatives, tranquillisers or sleeping pills in the last month?

NEVER SOMETIMES OFTEN ALWAYS

13b. How strong is that relief?

MILD MODERATE INTENSE

14a. In the last month, have you felt bad or sick as the effects of sedatives, tranquillisers or sleeping pills wore off?

Yes – Answer the next question
No – Skip to question 15

14b. Have you taken another sedative, tranquilliser or sleeping pill to reduce these unpleasant after-effects?

NEVER SOMETIMES OFTEN ALWAYS

15. In the last month, have you taken sedatives, tranquillisers or sleeping pills against the doctor's advice or more frequently than recommended?

NEVER OCCASIONALLY SOMETIMES OFTEN

16. Are you concerned about the number of sedatives, tranquillisers or sleeping pills you have taken in the last month?

A GREAT DEAL A LOT A LITTLE NOT AT ALL

17. Have you taken more sedatives, tranquillisers or sleeping pills in one day than you planned to?

EVERY DAY OFTEN SOMETIMES NEVER

18a Have you found the effects of sedatives, tranquillisers or sleeping pills pleasant?

NEVER SOMETIMES OFTEN ALWAYS

18b. How strong is the pleasant feeling?

MILD MODERATE INTENSE

19. Have you taken sedatives, tranquillisers or sleeping pills for a longer period than you intended when you started?

NEVER SOMETIMES OFTEN A LOT

20a. Have you felt tense or anxious as your prescription for sedatives, tranquillisers or sleeping pills began to run out?

NEVER SOMETIMES OFTEN EVERY TIME

20b. How strong have these feelings been?

MILD MODERATE SEVERE

21a. Have you felt an urge or desire to take sedatives, tranquillisers or sleeping pills in the last month?

NEVER SOMETIMES OFTEN EVERY DAY

21b. How strong is that urge or desire?

MILD MODERATE INTENSE

22. Have you taken sedatives, tranquillisers or sleeping pills in the last month when you did not really need them?

NEVER SOMETIMES OFTEN EVERY DAY

Instructions: In the next set of questions please tick the box below next to the answer that matches what you think.

23. I feel powerless to prevent myself taking a sedative or tranquilliser when I am anxious, uptight or unhappy.

STRONGLY DISAGREE
SOMEWHAT DISAGREE
SOMEWHAT AGREE
STRONGLY AGREE

24. I would not be able to handle my problems unless I take a sedative or tranquilliser.

STRONGLY AGREE
SOMEWHAT AGREE
SOMEWHAT DISAGREE
STRONGLY DISAGREE

25. I get so upset over small arguments, that I need to take a sedative or tranquilliser.

STRONGLY AGREE
SOMEWHAT AGREE
SOMEWHAT DISAGREE
STRONGLY DISAGREE

THANK YOU

Appendix 2 - Scoring The BDEPQ

SCORING INSTRUCTIONS:

Scoring the BDEPQ requires no more than basic clerical skills. The following steps describe how to calculate a total score and scores on the three subscales.

1. Score the items as follows:

    a. Score most items as 0 1 2 3
    b. Except items 2, 5, 6,9,12,16,17,24, and 25 which are reversed. Score these as 3 2 1 0.
    c. Score the second part (b) of 2-part items as 0 if the first part (a) is scored 0.
    d. Ignore item 14a
    e. Score item 11 as
        3. No, it would be impossible
        2. Perhaps, but with a lot of difficulty
        1. Yes, with some difficulty
        1. Yes, without difficulty

2. Sum the items to give a total score.

3. Optionally calculate subscale scores as follows

    a. GENERAL DEPENDENCE SUBSCALE: Sum items 1, 6, 7, 10a, 14b, 15, 16, 17, 19, 20a, 20b, 21a, and 22
    b. PLEASANT EFFECTS SUBSCALE: Sum items 2, 13a, 13b, 18a, 18b,and 21b
    c. PERCEIVED NEED SUBSCALE: Sum items 3, 4, 5, 8, 9, 11, 12, 23, 24,and 25

INTERPRETATION

In general higher scores are associated with greater risk of future withdrawal symptoms, of continued benzodiazepine use, and are more likely to be associated with ICD-11 diagnosis of benzodiazepine dependence. **SCORING SHEET**

1	0	1	2	3
2	3	2	1	0
3	0	1	2	3
4	0	1	2	3
5	3	2	1	0
6	3	2	1	0
7	0	1	2	3
8	0	1	2	3
9	3	2	1	0
10a	0	1	2	3
10b	0	1	2	3
11	3	2	1	0
12	3	2	1	0
13a	0	1	2	3
13b	0	1	2	3

14a	Ignore			
14b	0	1	2	3
15	0	1	2	3
16	3	2	1	0
17	3	2	1	0
18a	0	1	2	3
18b	0	1	2	3
19	0	1	2	3
20a	0	1	2	3
20b	0	1	2	3
21a	0	1	2	3
21b	0	1	2	3
22	0	1	2	3
23	0	1	2	3
24	3	2	1	0
25	3	2	1	0
TOTAL				
			TOTAL SCORE	

SUBSCALES:

GENERAL DEPENDENCE

Q	1	6	7	10a	10b	14b	15	16	17	19	20a	20b	21a	22
Score														
										TOTAL				

PLEASANT EFFECTS

QUESTION	*2*	*13a*	*13b*	*18a*	*18b*	*21b*
SCORE						
					TOTAL	

PERCEIVED NEED

Q	3	4	5	8	9	11	12	23	24	25
1. S										
							TOTAL			

Appendix 3 – NHS Grampian Drug Diary

Date and time	What did I use and how much?	What triggered me to use?	How was I feeling before I used?	Any consequences of taking drug? (good or bad)

Appendix 4 - Diazepam Equivalent Table

All Doses approximately equivalent To Diazepam 10mg -**Table adapted from Heather Ashton**

*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.

Benzodiazepines[5]	Half-life (hrs)* [active metabolite]	Approximately Equivalent Oral Dosages (milligrams)
Alprazolam	6-12	0.5
Chlordiazepoxide	5-30 [36-200]	25
Clobazam	12-60	20
Clonazepam	18-50	0.5
Clorazepate	[36-200]	15
Diazepam	**20-100 [36-200]**	**10**
Flunitrazepam	18-26 [36-200]	1
Flurazepam	[40-250]	15-30
Loprazolam	6-12	1-2
Lorazepam	10-20	1
Lormetazepam	10-12	1-2
Nitrazepam	15-38	10
Oxazepam	4-15	20
Temazepam	8-22	20
Non-benzodiazepines with similar effects		
Zaleplon	2	20
Zolpidem	2	20
Zopiclone	5-6	15

Appendix 5 - Sample Reducing Regimen

Notes: Stages 1-5 might be manageable with one week between reductions, but the later stages are better taken over 2 weeks.

A mixture of 5mg and 2mg tablets will be required. If intermediate reductions of 1mg are required, halve the 2mg (scored) tablets. Do not prescribe in 10mg tablets.

DIAZEPAM REDUCING REGIMEN : STARTING AT 30MG DAILY						
		MORNING	**AFTER-NOON**	**NIGHT**	TOTAL FOR DAY	GP USE: TABS PER WEEK
STARTING DOSE		**10mg**	**10mg**	**10mg**	30mg	42 x 5mg
STAGE 1	2 WEEKS	**8mg**	**8mg**	**8mg**	24mg	84 X 2mg
2	2 WEEKS	**6mg**	**6mg**	**8mg**	20mg	70 X 2mg
3	2 WEEKS	**6mg**	**6mg**	**6mg**	18mg	63 x 2mg
4	2 WEEKS	**4mg**	**6mg**	**6mg**	16mg	56 x 2mg
5	2 WEEKS	**4mg**	**4mg**	**6mg**	14mg	49 x 2mg
6	2 WEEKS	**4mg**	**4mg**	**4mg**	12mg	42 x 2mg
7	2 WEEKS	**2mg**	**4mg**	**4mg**	10mg	35 x 2mg
8	2 WEEKS	**2mg**	**2mg**	**4mg**	8mg	28 x 2mg
9	2 WEEKS	**2mg**	**2mg**	**2mg**	6mg	21 x 2mg
10	2 WEEKS	**2mg**	**0**	**2mg**	4mg	14 x 2mg
11	2 WEEKS	**0**	**0**	**2mg**	2mg	7 x 2mg
SOME GROUND RULES						
This is intended to be a slow process. Do not try to rush it.						
If struggling take an extra week or two to complete a stage rather than going backwards by increasing the dose.						
Tell a friend or partner what you are aiming for so that they can support/encourage you.						
Consult your GP regularly, especially if you experience any fainting, fits, and depression or panic attacks.						

WITHDRAWAL FROM **Zopiclone 15mg** with diazepam substitution
(15mg Zopiclone is approx. equivalent to 10mg diazepam)

	Night Time	Equivalent diazepam dose
Starting dose	Zopiclone 15mg	10mg
Stage 1 (1 week)	Zopiclone 7.5mg Diazepam 5mg	10mg
Stage 2 (1 week)	Stop Zopiclone Diazepam 10mg	10mg
Stage 3 (1-2 weeks)	Diazepam 9mg	9mg
Stage 4 (1-2 weeks)	Diazepam 8mg	8mg
Then continue reducing diazepam by 1mg every 1-2 weeks		

Appendix 6 – Blank Sample Reducing Regimen

Notes: Stages 1-5 might be manageable with one week between reductions, but the later stages are better taken over 2 weeks.

A mixture of 5mg and 2mg tablets will be required. If intermediate reductions of 1mg are required, halve the 2mg (scored) tablets. Do not prescribe in 10mg tablets.

DIAZEPAM REDUCING REGIMEN							
Date			**MORNING**	**AFTER-NOON**	**NIGHT**	TOTAL FOR DAY	GP USE: TABS PER WEEK
	STARTING DOSE						
	STAGE 1	2 WEEKS					
	2	2 WEEKS					
	3	2 WEEKS					
	4	2 WEEKS					
	5	2 WEEKS					
	6	2 WEEKS					
	7	2 WEEKS					
	8	2 WEEKS					
	9	2 WEEKS					
	10	2 WEEKS					
	11	2 WEEKS					
SOME GROUND RULES							
This is intended to be a slow process. Do not try to rush it.							
If struggling take an extra week or two to complete a stage rather than going backwards by increasing the dose.							
Tell a friend or partner what you are aiming for so that they can support/encourage you.							
Consult your GP regularly, especially if you experience any fainting, fits, and depression or panic attacks.							