Northamptonshire Healthcare
NHS Foundation Trust

HMP BEDFORD
GUIDANCE FOR PRESCRIBING AND MANAGEMENT OF BENZODIAZEPINE WITHDRAWAL

Policy Details	
NHFT document reference	MMG026/HMP
Version	1
Date Ratified	7th April 2017
Ratified by	HMP Bedford Drugs and Therapeutics Committee
Implementation Date	April 2017
Responsible Director	Medical Director
Review Date	April 2019
Related Policies & other documents	MMP-001 Control of Medicines Policy
Freedom of Information category	Guidance

TABLE OF CONTENTS

1. DOCUMENT CONTROL SUMMARY

Document Title	HMP Bedford Guidance for Prescribing and Management of Benzodiazepine withdrawal
Document Purpose (executive brief)	To provide guidance on the prescribing of benzodiazepines and the management of prisoners at HMP Bedford undergoing withdrawal
Status: - New / Update/ Review	New
Areas affected by the policy	HMP Bedford
Policy originators/authors	Dr Konstantinos Stagias Janice Jones Dr Caroline Watson
Consultation and Communication with Stakeholders including public and patient group involvement	HMP Bedford Drugs and Therapeutics Committee members
Archiving Arrangements and register of documents	The Risk Management Team is responsible for the archiving of this policy and will hold archived copies on a central register
Equality Analysis (including Mental Capacity Act 2007)	See Control of Medicines Policy
Training Needs Analysis	See section 7
Monitoring Compliance and Effectiveness	See section 8
Meets national criteria with regard to	
NHSLA	
NICE	
NSF	
Mental Health Act	
CQC	
Other	Clinical Management of Drug Dependence in the Adult Prison Setting
Further comments to be considered at the time of ratification for this policy (i.e. national policy, commissioning requirements, legislation)	
If this policy requires Trust Board ratification please provide specific details of requirements	N/A

2. INTRODUCTION

Benzodiazepines are licensed for the following indications:

- Short term (2 to 4 weeks) relief of anxiety that is severe, disabling or causing the patient unacceptable distress, occurring alone or in association with insomnia or short term psychosomatic, organic or psychotic illness.
- To treat insomnia only when it is severe, disabling or causing the patient extreme distress.

Clobazam and clonazepam may be used individually, as adjunctive therapies in the treatment of generalised tonic-clonic and refractory focal seizures. They may be prescribed under the care of a specialist for refractory absence and myoclonic seizures.

Benzodiazepines are also used in palliative care and for the treatment of status epilepticus.

3. PURPOSE

Benzodiazepines are potentially addictive drugs. Both physical and psychological dependence may occur and tolerance may develop. This may lead to difficulty in withdrawing the drug and to requests for incremental dose increases after the patient has been taking a benzodiazepine regularly for more than a few weeks.

Benzodiazepines are increasingly used in conjunction with other substances of abuse. They are used in this context to increase the “kick” obtained from the opiates and to alleviate the withdrawal symptoms of other drugs of abuse such as cocaine, amphetamines and alcohol.

This guidance governs the safe prescribing and management of patients prescribed benzodiazepines who come under the care of the prison IDTS service in HMP Bedford. Prescribing of benzodiazepines for a physical or mental health condition (epilepsy, psychosis or severe anxiety) is not covered by this guidance, however the principles within can be applied if a decision is taken by primary or secondary care teams to gradually discontinue prescribing.

This document is by no means exhaustive and does not attempt to cover every eventuality. It is the duty of all employees (in line with health and safety policies and procedures of Northamptonshire Healthcare Foundation Trust) to report any unusual or unforeseen situations with regard to any procedure to their line manager.

4. DEFINITIONS

NHFT - Northamptonshire Healthcare NHS Foundation Trust
CJIT- Criminal Justice Integrated Teams
SORTT- Supporting Offenders in Rehabilitation and Treatment Team
Benzodiazepine- commonly used anxiolytic and hypnotic drugs
Z drugs- (zopiclone, zolpidem and zalepon) drugs which are non benzodiazepine hypnotics which act on benzodiazepine receptors.

5. DUTIES

Relevant experienced medical and pharmacy staff are responsible for amending and updating this document in line with local and national guidance.

It is the responsibility of all registered clinicians employed or contracted by NHFT and working within HMP Bedford to provide care for benzodiazepine misuse problems.

Prescribing is the responsibility of the professional signing the prescription. The responsibility cannot be delegated. Reducing doses of medication should not be prescribed in isolation; a multidisciplinary approach to dependency treatment is essential.

The registered professional who administers the medication has a responsibility to ensure that the correct patient receives the correct dose and that appropriate efforts are taken to ensure that the drug is used safely, appropriately and not diverted.

The registered prescribing professional should liaise regularly with the dispensing pharmacist/ technician about the specific patient and the prescribing regime.

The doctor completing any discharge/ transfer documentation should provide clear details of dose/ treatment reductions undertaken at HMP Bedford to other health care providers, including General Practitioners, when the prisoner is transferred or released.

6. PROCESS

6.1. General Principles

Early detection of dependence and initiation of intervention are important factors in successful outcomes. A diagnosis of dependence should only be made in the presence of a history of regular benzodiazepine use for over 3 weeks, the presence of physical withdrawals and a urine drugs screen positive for benzodiazepines.

Benzodiazepine withdrawal syndrome:

- Benzodiazepine doses should be reduced slowly to minimise the likelihood of withdrawal
- Withdrawal may develop any time up to 3 weeks after stopping long acting benzodiazepines or within a day in short-acting ones.
- Characterised by insomnia, anxiety, loss of appetite, weight loss, tremor, perspiration, tinnitus and perceptual disturbances.
- Severe effects of abrupt withdrawal: Confusion, toxic psychosis, convulsions, a condition resembling delirium tremens
- Some symptoms may continue for weeks or months after stopping benzodiazepines.

Benzodiazepine Diversion:

- To reduce the risk of diversion all benzodiazepines should be prescribed for supervised consumption only.
- Where there are concerns that a patient may be diverting prescribed diazepam tablets, clinicians should consider the use of liquid formulation and a more rapid detoxification if clinically justified.

6.2. Benzodiazepine half life

The effects of most benzodiazepines wear off within a few hours. However the half-life of the drug is important as the drug will continue to exert subtle effects as long as it is in the body. Short acting benzodiazepines e.g lorazepam are eliminated quickly, causing peaks and troughs of concentration. They are therefore unsuitable for managing withdrawal and are highly addictive.

Clients presenting with a history of regular illicit diazepam use, withdrawal and a positive urine screen generally start benzodiazepine detoxification treatment at 10mg diazepam with ongoing monitoring of withdrawal symptoms. The dose is then reduced by 2mg each week.

If clients have been on a script of diazepam or another benzodiazepine from their community GP, they should be converted to the estimated equivalent dose of diazepam. Conversion should also include ALL illicit benzodiazepine- type medication including Z drugs. In the majority of cases, an initial dose of between 10mg and 20 mg diazepam daily, with ongoing monitoring of withdrawal symptoms should be sufficient

In very high dose benzodiazepine users, 30 mg diazepam is sufficient to prevent benzodiazepine withdrawal symptoms including withdrawal seizures. Greater doses are rarely required and, where requested or appear necessary, advice from a specialist consultant should be requested.

For doses of benzodiazepines in conjunction with alcohol withdrawal see below.

For equivalent doses of benzodiazepines see Appendix 1.

6.2.1. Management of polydrug dependence e.g. opiates, cocaine and benzodiazepines.

Opiates (including methadone and buprenorphine), alcohol and other sedative drugs combined with benzodiazepines will greatly increase the risk of respiratory depression and suppression of the gag reflex. This is a major factor in drug related death.

A six day stabilisation of methadone administration should be initiated in any patient presenting with both opiate and benzodiazepine use before commencing a benzodiazepine reduction. This regimen reduces the risk of overdose and increases the likelihood of a successful outcome.

In cases of co-dependency on any combination of alcohol, opiates and benzodiazepines, clinical guidelines vary in their recommendations with NICE recommending one benzodiazepine to be used, taking into account the dose required for alcohol and benzodiazepine use. Clinical Guidelines for prisons recommends separate benzodiazepines are used for each drug use.

At HMP Bedford patients are commenced on an alcohol withdrawal regimen with a minimum dose of 40mg chlordiazepoxide twice daily (equivalent to 30 mg diazepam daily) is used to treat patients with dual dependency. Patients are observed for signs of withdrawal from either substance. Observations should be made twice a day for the first 24 hours and then daily for the subsequent 4 days unless clinical signs indicate more frequent observations are necessary. Patients showing signs of withdrawal are reviewed and commenced on a higher dose of chlordiazepoxide where clinically indicated.

Following alcohol detoxification patients with a history of dual (benzodiazepine and alcohol) dependency should be observed for three days for signs of benzodiazepine withdrawal. If clinically indicated a benzodiazepine detoxification can then be introduced commencing at 10mg diazepam daily

6.2.2. Assessment of client

6.2.2.1 Check for evidence of benzodiazepine dependence

- Note patient's physical presentation: drowsiness, disinhibition, dilation of the pupils, (Appendix 2)

6.2.2.2 Try to establish the pattern of benzodiazepine use

- Self-reported history
- Confirmed prescribing history (where applicable)
- Withdrawal monitoring
- Drug testing

A negative drug test should not automatically preclude the prescribing of a benzodiazepine detoxification regimen as benzodiazepine withdrawal may take up to 72 hours to set in. Patients should be observed daily for three days for signs or symptoms of benzodiazepine withdrawal

6.2.3. Detoxification

- Withdrawal prescribing should be initiated where clinical assessment indicates a previous history of regular benzodiazepine use (either prescription or street) sufficient in dose and duration (more than three weeks) to suggest dependency.
- Withdrawal prescribing should be initiated on the day of admission where there is a history of benzodiazepine dependence, evidence of withdrawal and a positive urine.
- 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.
- If there is no evidence of benzodiazepine withdrawal in Reception but a positive urine, the client should be carefully monitored and a detoxification regimen initiated if subsequently indicated by the emergence of withdrawal symptoms.
- If there is evidence of withdrawal in reception a MAXIMUM dose of 10mg diazepam should be administered and the prisoner placed on observations for a minimum of three days.
- UK guidelines state that withdrawal should be slow with the dose titrated according to severity of withdrawal symptoms and dose reductions of 5-10% every 1-2 weeks with a slower reduction at lower doses.
- In practice at HMP Bedford, most diazepam detoxifications start at a maximum dose of 20mg and reduce by 2mg per week. If the starting dose is higher than 20mg, then initial reductions will be greater (eg 5mg dose reduction per week from 30mg until 20mg is reached.)
- To reduce the risk of over sedation diazepam should be prescribed twice daily until a dose of less than 20mg is attained.

- Where a patient has been prescribed a benzodiazepine withdrawal regimen is found not to be dependent the prescription should be reviewed by a prescriber with experience in substance misuse in the secure environment setting.
- Patients who are sedated or showing signs of withdrawal whilst undertaking a benzodiazepine withdrawal regimen should be reviewed as soon as possible by a prescriber with IDTS experience after a team discussion.
- Where a client is found to be concealing/diverting diazepam, the prescription should be converted to diazepam liquid and where necessary making the detoxification more rapid (2mg reduction every 5 days.)
- Where opiate substitution therapy is being prescribed benzodiazepine withdrawal can be prescribed as above. Where concurrent detoxification is being undertaken a more cautious approach should be maintained.

There is no evidence to suggest that long-term substitute prescribing of benzodiazepines reduces the harm associated with benzodiazepine use and there is increasing evidence that long-term prescribing of more than 30 mg per day may cause harm.

Doctors should be reluctant to initiate maintenance prescribing of substitute benzodiazepines and should gradually reduce the doses of those already on a maintenance script for more than 30mg per day.

6.2.4. Nursing/Pharmacy Technician/ Pharmacist Observations

- Staff should supervise the administration of every dose of benzodiazepine
- Patients should be observed for signs and symptoms of benzodiazepine withdrawal and advice given for non-drug treatments of symptoms.

6.2.5. Other Clinical Indications

Patients prescribed regular benzodiazepines for confirmed physical or mental health conditions remain the responsibility of the General Healthcare/ Mental Health teams. Decisions to withdraw medication remain with them, however, this guidance will be available for their use and may be employed to facilitate management.

6.2.6. Clients identified as using illicitly from within the establishment or who relapse.

Some clients may present from within the existent population as having a drug problem. This may happen when they have been using illicitly within the establishment and may not have previously been identified or who have relapsed back to illicit use following successful reduction, or abstinence.

- If clinical staff are made aware of a client with a new/recurrent presentation of illicit drugs, the nurse will take a full history and a urine drug screen. The case will then be presented to the doctor/ IDTS non-medical prescriber and after a team discussion a management plan to be in place.

- All clients should be brought to the IDTS wing for assessment, treatment and clinical observation, as soon as possible.

- If there is evidence of benzodiazepine withdrawal and a urine test is positive for benzodiazepines (providing any diazepam detoxification finished more than 2 weeks previously) a rapid, low dose diazepam detoxification may be considered. A 'one off' opportunity for detoxification with minimised withdrawal over a 25 day period will be offered. Initiation onto treatment should be commenced at 10mg diazepam and reduced by 2mg every 5 days until stopping. Daily observations should be made to ensure withdrawal symptoms are controlled.

- If there has been any evidence of concealing of any medication while in custody, diazepam should be prescribed in liquid form.

7. TRAINING

7.1. Specific Training not covered by Mandatory Training

Ad hoc training sessions based on an individual's training needs as defined within their annual appraisal or job description.

8. MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trusts' monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Method of monitoring	Individual responsible for the monitoring	Monitoring frequency	Group or committee who receive the findings or report	Group or committee or individual responsible for completing any actions
Duties	To be addressed by the monitoring activities below.				
	Monitoring of incidents	Prison senior nurse	Ongoing	Drugs and Therapeutics Committee	Prison senior nurse
	Audit of patient records	Prison senior nurse	Annually	Drugs and Therapeutics Committee	Prison senior nurse
Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.					

9. REFERENCES AND BIBLIOGRAPHY,

Clinical Management of Drug Dependence in the Adult Prison Setting 2006, Updated March 2010 (DH)

Clinical Knowledge Summaries Benzodiazepine and Z drug withdrawal accessed on line Nov 2014

NHS Grampian: Guidance for the Prescribing and Withdrawal of Benzodiazepines and Hypnotics in General Practice Oct 2008

Ashton, C.H. (2002c) *Slow withdrawal schedules.* The Ashton Manual..*University of Newcastle*.www.benzo.org.uk

British Association of Psychopharmacology 2012 updated Guidelines on Substance Misuse. Journal of Psychopharmacology 1-54

BNF 68 September 2014 to March 2015

10. RELATED TRUST POLICY

MMP001 Control of Medicines Policy

HMP Bedford: Procedure for the Transfer of Prisoners Participating in the Integrated Drug Treatment System (IDTS)

Controlled Drug Procedure for HMP Bedford (IDTS)

APPENDIX 1- EQUIVALENT DOSES OF DIAZEPAM

The following are **approximately** equivalent to diazepam 5mg[1]:

Alprazolam 250mcg
Chlordiazepoxide 12.5mg
Clobazam 10mg
Clonazepam 0.25mg
Flurazepam 7.5mg to 15mg
Loprazolam 0.5mg to 1mg
Lorazepam 500mcg
Lormetazepam 0.5mg to 1mg
Nitrazepam 5mg
Oxazepam 10mg
Temazepam 10mg
Zaleplon 10mg[2]
Zopiclone 7.5mg[2]
Zolpidem 10mg[2]

[1] BNF 68 September 2014 to March 2015
[2] CKS Benzodiazepine and Z drug withdrawal

APPENDIX 2- BENZODIAZEPINE WITHDRAWAL SCALE

For each of the following items, please circle the number which best describes the severity of each symptom or sign

1	Observe behaviour for restlessness and agitation	0 Normal activity	1	2 Restless	3	4 Paces back and forth, unable to sit still
2	Ask patient to extend arms with fingers apart, observe tremor	0 No tremor	1 Not visible, can be felt in fingers	2 Visible but mild	3 Moderate with areas extended	4 Severe, with arms not extended
3	Observe for sweating, feel palms	0 No sweating visible	1 Barely perceptible sweating, palms moist	2 Palms and forehead moist, reports armpit sweating	3 Beads of sweat on forehead	4 Severe drenching sweats

For each of the following items, ask the patient to circle the number which best describes how he/she feels

4	Do you feel irritable?	1 Not at all	2	3	4 Very much so
5	Do you feel fatigued?	1 Not at all	2	3	4 Severely
6	Do you feel tense?	1 Not at all	2	3	4 Very much so
7	Do you have any difficulties concentrating?	1 No difficulty	2	3	4 Cannot concentrate
8	Do you have any loss of appetite?	1 No loss	2	3	4 No appetite
9	Have you any numbness or burning sensation in your hands feet or face?	1 No	2	3	4 Severe

10	Do you feel your heart racing?	1 No	2	3	4 Constantly
11	Does your head feel full or achy?	1 No	2	3	4 Severe
12	Do you feel muscle aches or stiffness?	1 No	2	3	4 Severe
13	Do you feel anxious, nervous or jittery?	1 Not at all	2	3	4 Very much so
14	Do you feel upset?	1 Not at all	2	3	4 Very much so
15	How restful was your sleep last night?	1 Very restful	2	3	4 Not at all
16	Do you feel weak?	1 Not at all	2	3	4 Very much so
17	Do you think you didn't have enough sleep last night?	1 No	2	3	4 Not nearly enough
18	Do you have any visual disturbances (sensitivity to light, blurred vision)?	1 Not at all	2	3	4 Extreme
19	Are you fearful?	1 Not at all	2	3	4 Very much so
20	Have you been worrying about possible misfortunes recently?	1 Not at all	2	3	4 Very much so

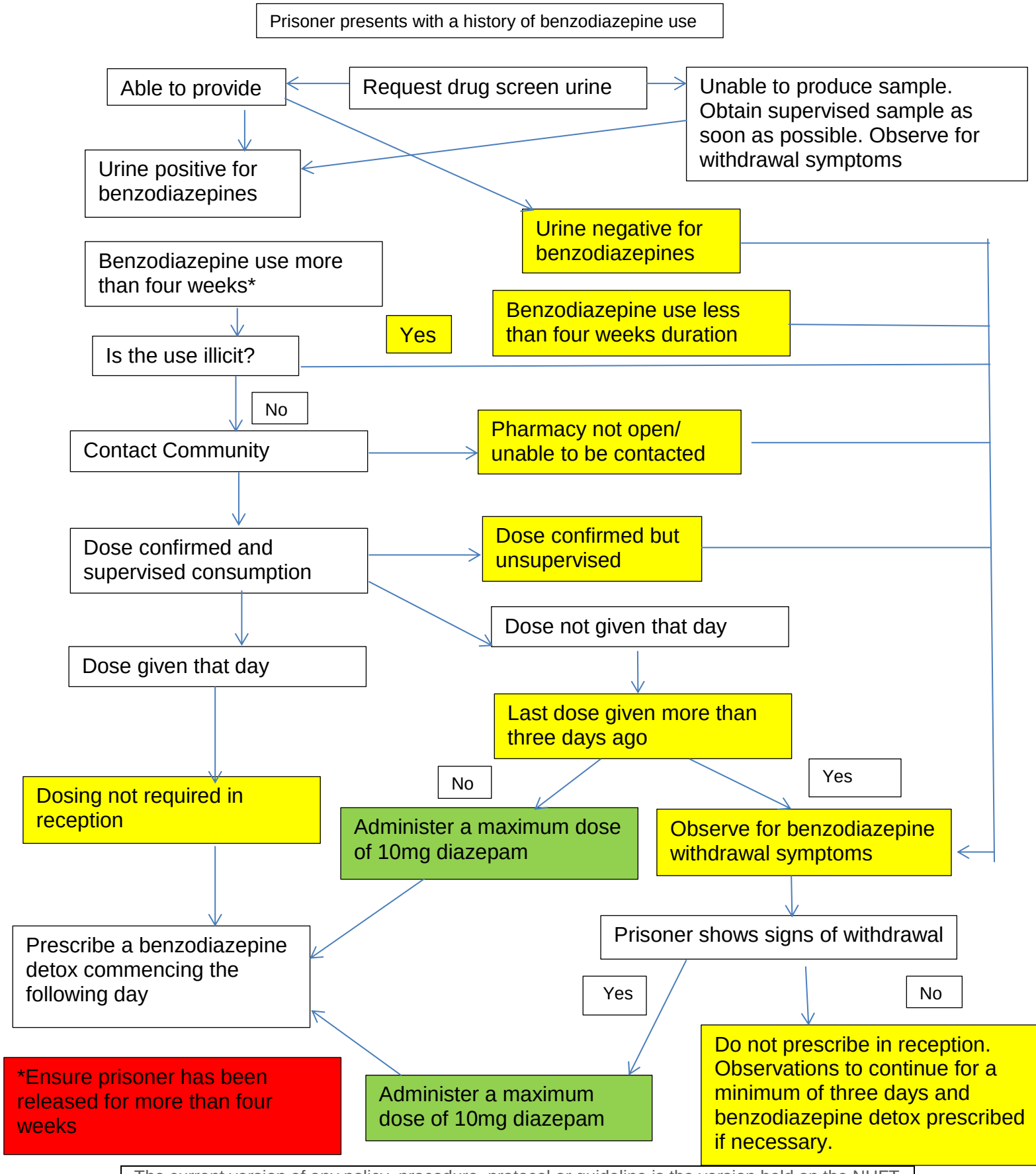
Total score
(Total of items 1-20)…….

Assessors initials……

Interpretation of scores:
1–20 = mild withdrawal
21–40 =moderate withdrawal
41–60 = severe withdrawal
61–80 = very severe withdrawal.

Use this score to monitor trends in the patient's condition

APPENDIX 3-PRESCRIBING IN RECEPTION FOR BENZODIAZEPINE USE



APPENDIX 4: STAFF SIGNATURE SHEET

I confirm that I have read and understood the Guidance for Prescribing and Management of Benzodiazepine Withdrawal:

Date	Print Name	Sign