# APPENDIX 4. GUIDES FOR HEALTHCARE PROFESSIONALS

## 4a) Example of secondary care guidelines on the prescribing of anxiolytics and hypnotics

* On admission to hospital, establish if the patient is a regular or occasional user of benzodiazepines or z-drugs. Alternatively, determine whether hypnotic and/or anxiolytic treatment has been newly initiated upon admission.
* Regular users should not have their treatment stopped suddenly.
* Before a hospital patient is prescribed a hypnotic there should be an accurate diagnosis and any treatable causes of insomnia should be addressed first (e.g. pain, urinary frequency, breathing difficulties, depression, mania, substance misuse, etc).
* Discuss with the patient the benefits and principles of good sleep hygiene, avoiding the use of hypnotics and anxiolytics, and the possibility of dosage reduction.
* Review the timing of regular medication (i.e. sedating medication at night, alerting medication in the morning).
* Hospital patients requiring hypnotics should have them prescribed on the ‘as required’ (PRN) side of the prescription chart (unless the patient was admitted on regular doses of night sedation). Ideally the prescriber should specify the earliest time and the maximum number of consecutive nights that a hypnotic should be given, or provide more specific instructions (e.g. every 2nd/3rd night if the patient is not asleep one hour after retiring to bed).
* Any prescription should be for the lowest effective dose and shortest duration possible (no longer than four weeks), and patients should be advised of the short term nature of treatment at initiation.
* If prescribing newly initiated hypnotics for a regular period (increasing the risk of dependence), the consultant should document this in the patient’s medical notes.
* Nurses should use the following guidelines when administering a hypnotic during the patient’s hospital stay:
	+ Administer if the patient has been unable to sleep for one hour after retiring to bed and is requesting it.
	+ Administer after 11.30 pm as long as the patient has had an opportunity to fall asleep, but administer before 1.00 am to prevent hangover effects next morning.
	+ Do not administer for more than two consecutive nights (without seeking medical review).
* Regularly review the progress of hypnotic treatment during the patient’s hospital stay and discontinue as soon as possible.
* Hypnotics and anxiolytics newly initiated in hospital should *not* be prescribed on discharge unless an explicit withdrawal regimen is indicated. Withdrawal regimens may be required if the patient has taken the hypnotic/anxiolytic continuously for more than six weeks as an in-patient.
* In rare cases where newly initiated anxiolytic or hypnotic treatment is continued after discharge, the GP should receive details about why the treatment was initiated, the expected treatment duration, details of any dose reduction regimen and what information has been given to the patient or carer.
* An example of where it may be appropriate to discharge a patient home on hypnotic or anxiolytic treatment includes patients receiving palliative care.
* Any patient prescribed for an ‘as required’ hypnotic should have their prescription cancelled if no dose has been administered in the previous two weeks. Pharmacy staff should have the authority to cancel such prescriptions.
* All ‘as required’ hypnotic prescriptions should be regularly reviewed (e.g. at weekly ward rounds) to assess the frequency and appropriateness of usage.
* If non-recommended long-term use is envisaged (i.e. more than four weeks) consent needs to be obtained regarding the use outside the product licence.

## 4b) Example of a GP practice prescribing policy for benzodiazepines and z-drugs

GPs in this practice will prescribe hypnotics and anxiolytics (benzodiazepines and z- drugs) in line with national and locally developed guidelines:

* First-line treatment should be non-pharmacological measures.
* Where benzodiazepine or z-drug treatment is indicated, first-line options should be:
	+ Anxiolytic: diazepam
	+ Hypnotic: zopiclone
* For patients who have not received these drugs regularly, GPs will only prescribe hypnotics and anxiolytics for a maximum of 14 days and at the lowest effective dose. They will only be prescribed if the GP feels that the condition is severe, disabling and subjecting the patient to extreme distress and/or for those where other interventions have not been successful. The following guidance published by NICE will apply:
	+ The indication for starting a hypnotic or anxiolytic will be documented.
	+ Other possible causes of sleep disturbance will be recorded (e.g. pain, dyspnoea, depression) and treated appropriately.
	+ All patients will receive advice on non-drug therapies for anxiety and insomnia.
	+ Patients will be advised on the potential problems of dependence (i.e. addiction).
	+ A second prescription will not be issued without a follow-up visit to the GP.
	+ Benzodiazepines or z-drugs should *not* be taken for more than 2–4 weeks (including tapering off).
* Patients who are already on a regular benzodiazepine or z-drug prescription will be assessed and, if appropriate, counselled for a withdrawal scheme with the aim to gradually reduce drug dosage to zero.
* Patients who are unable or unwilling to reduce drug dosage via a managed withdrawal scheme (or who use more than one drug of abuse, or who are dependent on alcohol) may be referred to the substance misuse service in their area.
* Prescriptions for hypnotics and anxiolytics should not be routinely available on repeat. However, the practice accepts that there may be a small minority of people who need to be on a small maintenance dose of a benzodiazepine. Examples are people:
	+ with severe mental health problems under care of a psychiatrist;
	+ on benzodiazepines for treatment of epilepsy;
	+ who are seriously or terminally ill.
* Lost prescriptions will not be replaced.
* Patients will be allocated a ‘usual doctor’ and will only deal with this person.
* If a patient takes higher doses than prescribed, and runs out of medication before the next prescription is due, they will not be prescribed extra tablets.
* The practice will undertake a regular review and audit of the prescribing practice of benzodiazepines and z-drugs to ensure compliance with national and local guidelines.
* Temporary residents should note that:
	+ patients not currently on an anxiolytic or hypnotic will be treated according to NICE guidelines and the practice policy
	+ regular users will not receive prescriptions without proof of dosage, frequency and date of last prescription; this can be obtained from the patient’s surgery. If they remain with the practice for more than two weeks, they should enter the reducing scheme and the policy should be followed as for a registered patient.
* Any new patients currently on hypnotics or anxiolytics will be informed that they will be placed on a withdrawal regimen (unless they fall into the exclusion criteria above), when they register with the practice.

## 4c) Example of GP practice guidelines for initiating hypnotics and anxiolytics

* Establish current sleep/anxiety patterns with the help of sleep/anxiety diaries (Appendices 2d and 2e).
* Address any treatable causes of insomnia/anxiety:
	+ Review concomitant drug therapy.
	+ Review the timing of regular medication (e.g. sedating medication at night, alerting medication in the morning).
* Consider non-drug treatment options first:
	+ Give advice (verbally or using patient information leaflets) on non-drug treatments, and record in medical notes whether or not an anxiolytic or hypnotic is prescribed.
* When hypnotics or anxiolytics *must* be used:
	+ use lowest effective dose.
	+ use for a short period only. All prescriptions for hypnotics and anxiolytics issued to new patients should be for a maximum of two weeks.
	+ ensure that no prescriptions for hypnotics or anxiolytics are on repeat.
	+ encourage intermittent use rather than continual use.
	+ note that hypnotics started in hospital should not usually be continued in primary care.
	+ document indication.
* Provide patients with information (Appendices 3e and 3f) and self-help leaflets (Appendices 3a, 3b, 3c and 3d) at the time of initial drug supply. Advise about the potential for dependence (addiction), falls and driving impairment, and document in records.
* Explain that the prescription will not be repeated. Patients will be seen by a GP before a second prescription is issued.
* In elderly patients prescribe with caution and start at a lower dose. Monitor the response as:
	+ unpredictable drug metabolism and interactions may make patients more sensitive to these medicines.
	+ there may be an increased risk of ‘hangover’ effect due to prolonged half-life.
	+ there may be an increased risk of ataxia and confusion, therefore causing an increase in falls.
* Use clinical judgement to assess the risks/benefits of withdrawal for individual patients.