

bat

battle against tranquillisers

Benzodiazepine Guidance

South Gloucestershire Benzodiazepine Guidance

Executive summary

- 1) As a general rule ‘Benzos are unsuitable for long term use and should be prescribed for periods of 2-4 weeks ONLY’ (Committee on Safety of Medicines & Royal College of Psychiatrists – 1988 & 1992).**
- 2) If a patient/client presents with use above 30mg diazepam/ equivalent per day, the reduction down to 30mg may be able to happen more quickly than if they were taking 30 mg or less, but this must be very carefully monitored. This careful monitoring should continue throughout the patient’s reduction and from this point onwards the reduction, should follow the NHS Clinical Knowledge Summary (Appendix iii).**
- 3) It is better to reduce too slowly than too quickly (BNF).**
- 4) Where patients have knowledge about their own condition, they should be included in decisions about their treatment.**
- 5) The South Gloucestershire Drug and Alcohol Service is available through the single point of contact on 01454 868750 and can support patients who are having their medication reduced.**

Policy for the delivery of services for both prescribed and unprescribed use of Benzodiazepine / ‘Z’ drugs in South Gloucestershire.

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Purpose

This document is intended for prescribing staff

Overview

Ensure that:-

- Benzos and Z Drugs are prescribed within guidelines and that there are systems in place to ensure that this is happening.
- The patient / service user is an intrinsic part of planning and decision making in his / her withdrawal. S/he should be given clear accurate and useful information about the task ahead. This should be available both orally and via written information.

Patients with more complex problems, who are more difficult to engage with primary care, should be referred to South Gloucestershire Drug and Alcohol Services (SGDAS)- 01454 868750. This is a single point of contact and clients/patients will be referred to the relevant agency.

Patients should have access to relaxation, anxiety management and Benzo specific services; for example Battle Against Tranquillisers (BAT). They will need constant reassurance that what they experience in withdrawal is to be expected, but will go in time.

Service user comments

“

Am I ever going to be well?

Will I ever not feel scared?

Why do I feel like this? I never used to.

”

This policy document is intended to:-

- Ensure that best practice is promoted and used in both prescribed and unprescribed Benzodiazepine and 'Z' drug user populations.
- Be a useful and deliverable resource for prescribers and all those who are part of delivering services and supporting clients / patients who use Benzodiazepines / 'Z' drugs.
- Lead to better outcomes for service users / patients.
- Promote Recovery for service users / patients through becoming Benzodiazepine free.

- Provide details of useful organisations to prescribers / service users.
- Provide resources for use for both prescribers and patients / service users.

South Gloucestershire Drug and Alcohol Services is the umbrella term given to all service providers working with clients who are engaging with treatment to address their drug and/or alcohol issues.



BAT - AWP (Avon and Wiltshire Partnership) including community and custodial - Developing Health and Independence (DHI).
DHI are the Single Point of Contact.

Introduction and context

This document has been designed to address both prescribed and unprescribed use of Benzodiazepines and Z drugs (jointly referred to in this policy document as 'Benzos'), in line with new government directives, which have been put in place following the All-Party Parliamentary Drugs Misuse Group Report on Physical Dependence and Addiction to Prescription and Over the Counter Medication (2009).

This policy is firmly rooted in the Department Of Health's 'Liberating the NHS: Greater Choice and Control' and elaborates on the statement 'No decision about me, without me' which is contained within the publication title. The Notification of drug misusers from the BNF 61 (appendix ix) states that notification to the regional National Drug Treatment Monitoring System (NDTMS) or national centre should be made when a patient starts treatment for drug misuse. All types of problem drug misuse should be reported including opioid, **Benzodiazepine**, and CNS

stimulant. Whilst the principles of both prescribing and reduction are the same in both client populations, some details differ in practice. The leaflets 'Harm Reduction' (appendix xi) and 'General information' (appendix x) and other information are available from BAT on request.

Why include 'Z' Drugs?

NICE have concluded that given the lack of compelling evidence on any clinically useful differences between 'Z' hypnotics and the shorter acting Benzodiazepine hypnotics, unless a patient experiences adverse effects considered to be due to a specific hypnotic:-

“ **The drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be used in preference to more expensive alternatives.**

Switching between different hypnotics is not recommended.

Hypnotics should not be prescribed above British National Formulary (BNF) recommended doses in line with the Drug misuse and Dependence: UK guidelines on clinical management 2007.

When prescribing hypnotics a discussion should take place highlighting the potential risks of sedation and decreased concentration on ability to drive safely.

Advice should also be given regarding the potential for dependency. It is good practice to record that this advice has been given in the case notes. „²

Service user comments



If I'd had all the information I needed when I first tried to come off Benzos, I'd have been off for over 10 years now, instead of just one.



Background

Evidence shows increasing understanding of the harms caused by Benzos.

“ These medicines have their own potential for misuse and dependence, and are often taken in combination with opiates or stimulants. Many drug misusers misuse Benzos but the majority do not require long term replacement prescribing, or high doses. For those who are Benzo dependant, sudden cessation in their use can lead to a recognised withdrawal state. Good assessment and care planning and adherence to local protocols are prerequisites for considering prescribing Benzos... „

Service user comments



I don't mind reducing my methadone or stopping drinking, but don't touch my Benzos...

Stopping using Heroin was a piece of cake compared to stopping using Benzos...



¹ http://www.dh.gov.uk/en/consultation/liveconsultations/DH_134221

² NICE technology appraisal 77 – Guidance on the use of Zaleplon, Zopiclone and Zopiclone for the short term management of insomnia – April 2004

Evidence suggests that long term use of Benzos can result in a range of unwanted effects (see appendix i – DSM iv Diagnostic Statistical Manual 1994) and patient information leaflet (appendix vii). These include (but are not restricted to) depression; increasing anxiety; poor memory and cognition; emotional blunting; physical symptoms (e.g. tremor, Irritable Bowel Syndrome, joint and muscle pain). Benzos do not work when they have been taken for more than a few weeks or months of regular use. This is because tolerance develops and withdrawal symptoms can appear even though the drug is still being taken i.e. a mixture of adverse effects of the drugs and withdrawal effects due to tolerance.

The above can affect both prescribed and unprescribed populations.

“ Benzos are frequently used by drug misusers as a secondary drug, either to enhance the effect of the primary drug or to ameliorate withdrawal effects. They have strong addictive potential, the withdrawal syndrome can be dangerous, and they are known to be a major contributor to deaths from drug misuse. Whilst there is no evidence to support their use for maintenance treatment, in view of the major role which they occupy in the field of drug misuse, services must be able to accommodate and treat Benzo use and to prescribe Benzos where appropriate, and within their licence. In general this will mean using Benzos primarily for people withdrawing from Benzo dependence. ” ³

As a general rule ‘Benzos are unsuitable for long term use and should be prescribed for periods of 2-4 weeks ONLY. (Committee on Safety of Medicines & Royal College of Psychiatrists – 1988 & 1992)’. If longer term prescribing is being considered, the goal of prescribing should be clear and should be discussed with the patient and recorded for future reference.

³ Drug misuse and dependence: UK guidelines on clinical management 2007

Principles and Practice of Prescribing

Prescribing regimen

The dispensing pharmacists should be kept aware of the tapering process for the reduction of Benzodiazepines prescribing and withdrawal processes as well as any new patients / clients with whom the process is being discussed. Nursing staff need to have a basic awareness of the problems caused by Benzodiazepine ingestion and withdrawal – some of the symptoms of both are described in appendix vi.

Unprescribed:

“ There is little evidence to suggest that long term substitute prescribing of Benzos reduces the harm associated with Benzo misuse. And there is increasing evidence that long term prescribing, especially of more than 30mg (equivalent Diazepam per day), may cause harm...

...to prevent symptoms of Benzo withdrawal the clinician should continue the prescription but the dose should be gradually reduced to zero. Only very rarely should doses of more than 30mg (equivalent Diazepam per day) be prescribed. Prescribing to assist withdrawal should only be initiated where there is clear evidence of Benzo dependency from a patient's history, observed

symptoms, and drug testing. The aim should be to prescribe a reducing regimen for a limited period of time....

Service user comments

“

Why was I pushed into psychiatry for my Benzodiazepine addiction?

Why was I referred to psychology services for my Benzodiazepine addiction/withdrawal?

”

...if the patient is also receiving a long term prescription of methadone for concomitant opioid dependency the methadone dose should be kept stable throughout the Benzo reduction period. Concurrent detoxification from both medications is not recommended in a community setting...

Prescribed and unprescribed

Local evidence points to the occurrence of dependence even with ‘alternate day’ regimes ... “there is no evidence that intermittent, ‘pulse’ regimens (such as one week on and one week off) prevent dependence, and these should be avoided.” ⁴

“ Prescribing of these drugs is widespread but dependence (both physical and psychological) and tolerance occur... should therefore be reserved for short courses to alleviate acute conditions, after cause or factors have been established.

Tolerance to their effects develops within 3 – 14 days after continuous use.

Benzodiazepines are indicated for the short term relief (2-4 weeks only) 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.

The use of Benzodiazepines to treat short term (mild) anxiety is not recommended.

Benzodiazepines should be used to treat insomnia only when it is severe, disabling or causes the patient extreme distress.

Hypnotics should not be prescribed indiscriminately and routine prescribing is undesirable. They should be reserved for short courses in the acutely distressed.

Tolerance to their effects develops within 3-14 days of continuous use, and long term efficacy cannot be assured. A major drawback of long term use is that withdrawal can cause rebound insomnia and a withdrawal syndrome.

Ensure that Benzodiazepine prescribing follows guidelines, and that regular reviews are in place.

Take note of ‘consent to treatment directive’ and check that the patient understands.

Initiation of Benzos in pregnant women / women intending to become pregnant, to be avoided.

Service user comments

“

Why wasn't my consent ever obtained for Benzodiazepine treatment?

”

Aim for the smallest dose for the shortest time „ ⁵

⁴ Drug misuse and dependence: UK guidelines on clinical management 2007

⁵ <http://www.bnf.org/bnf/index.htm>

“ Do not take Diazepam if you are:-

- Allergic to Diazepam or Benzodiazepines or any of the other ingredients of this medicine.
- Have long term or severe liver problems.
- Suffer from severe breathing problems.
- Suffer from sleep apnoea (difficulty breathing while asleep).
- Suffer from Myasthenia Gravis (a disorder where muscles become weak and tire easily).
- Suffer from mental illness such as phobias or obsessions.

Tell your doctor immediately if you suffer from:-

- Behavioural changes, such as restlessness, agitation, irritability, aggressiveness, delusions, rages, nightmares, hallucinations, psychiatric disorders or inappropriate behaviour „⁶

Consider using the Pompidou Benzodiazepine group in Europe suggestion that:-

“ For every new Benzodiazepine prescription there should be a built in exit strategy. „⁷

(In the way that Chlordiazepoxide is used in alcohol detox)

Transfer of Benzo and ‘Z’ hypnotic prescribing from secondary care.

When prescribing is to be transferred from secondary care to primary care the following information should be relayed to the GP:-

- Indication for use
- Expected length of treatment
- When the treatment will be reviewed, and by whom
- Advice about withdrawal if indicated. ⁸

NB: 5 days supply of Benzodiazepines can be supplied by a pharmacy under certain conditions (please see appendix xii for further details).

⁶ TEVA UK Ltd - Patient information leaflet for Diazepam

⁷ http://www.coe.int/T/DG3/Pompidou/default_en.asp

⁸ NICE technology appraisal 77 – Guidance on the use of Zaleplon, Zopiclone and Zopiclone for the short term management of insomnia – April 2004

Symptoms

INFORMATION FROM THE ROYAL COLLEGE OF PSYCHIATRISTS (BELOW) MAY PROVE USEFUL TO BE GIVEN TO PATIENTS AND IS ALSO INCLUDED AS APPENDIX V.

“How do I know if I’m becoming dependent on tranquilisers?”

You should suspect you might be becoming dependent if:-

- You find the dose you are taking does not seem to work as well as when it was first prescribed.
- You may find that you seem to need more and more of the drug to get the same effect. This will be the same whether the drug was prescribed for anxiety or as a sleeping tablet.
- You may also notice that when you stop taking the drug for any reason you become more nervous and panicky, or get more unusual symptoms. These include intense itching, becoming very sensitive to light or noise or tingling in the hands and feet. ⁹

“Symptoms include anxiety, tremor, confusion, insomnia, sexual disorders, fits, depression, gastro-intestinal and other somatic symptoms. These may sometimes be difficult to

distinguish from the symptoms of the original illness.

It is important to note that symptoms can occur with Benzos following therapeutic doses given for short periods of time. ” ¹⁰

Service user comments

“Why was ‘anxiety’ put on my sick notes for several years, instead of benzodiazepine addiction?”

⁹ See appendix 5

¹⁰ Committee on Safety of Medicines January 1988. Current problems number 21:1-2. Benzo dependence and withdrawal symptoms

Principles and practice of withdrawal

“Withdrawal effects usually appear shortly after stopping a Benzo with a short half-life, or up to several days after stopping one with a long half-life. Symptoms may continue for weeks or months. No epidemiological evidence is available to suggest that one Benzo is more responsible for the development of dependency and / or withdrawal symptoms than any other ” ¹¹

“It is better to reduce too slowly rather than too quickly ” ¹²

Service user comments

“Why were my benzodiazepines stopped abruptly on numerous occasions?”

“The suggested rate of withdrawal is in steps of between 5% and 10% of their current daily dose. The decrease in dosage therefore becomes smaller as the overall dose decreases ” ¹³

The withdrawal process

The decision to withdraw an individual from Benzos should be made jointly between the patient and the prescriber so that it is in line with the NHS Constitution and with General Medical Council guidance.

Guidance for patients

“you have the right* to be given information about your proposed treatment in advance...

...you have the right* to make choices about your NHS care and to information to support these choices...

...You have the right* to be involved in discussions and decisions about your healthcare and to be given information to enable you to do this ” ¹⁴

*NB – “The right” means that it is a legal requirement.

11 <http://benzo.org.uk/commit.htm> CSM UK Government Bulletin to Prescribing Doctors January 1988

12 <http://www.bnf.org/bnf/index.htm>

13 See appendix viii - extract from The NHS Clinical Knowledge Summaries (CKS)

14 NHS Constitution for England – January 2009

General Medical Council for prescribers

“Respect patients’ right to reach decisions with you about their treatment and care. You must encourage patients who have knowledge about their condition to use this when they are making decisions about their care...

...Satisfy yourself that your patient has been given appropriate information in a way they can understand about any common adverse side effects; potentially serious side effects; what to do in the event of a side effect; interactions with other medicines and the dosage and administration of the medicines. ” ¹⁵

(For interactions with other medicines see appendix ii – “Drugs which should be avoided on Benzos/in withdrawal/other useful facts).

Tapering regimes

Tapering regimes (how to reduce and come off Benzos) should be both jointly agreed upon and be flexible. Conversion to Diazepam from shorter acting Benzos is recommended (BNF).

“Benzos should be withdrawn slowly. The length of the period of withdrawal is dependent on the dose of the Benzo that is being withdrawn and the patient response to the withdrawal process. The withdrawal should be a collaborative treatment between patient and health professional. Withdrawal symptoms may start within about 2-3 days of stopping a short acting Benzo, and about 7 days of stopping a long acting preparation. ” ¹⁶

Service user comments

“Can you get delayed symptoms? How long could it take for symptoms to present themselves?”

“The rate of withdrawal is often determined by an individual’s capacity to tolerate symptoms...if withdrawal symptoms occur then the dose can be maintained until symptoms improve ” ¹⁷

¹⁵ General Medical Council (September 2008) – supplementary ethical guidance for doctors on prescribing medicines to patients “good practice in prescribing medication – guidance for doctors”

¹⁶ GP Notebook: <http://www.gpnotebook.co.uk/simplepage.cfm?ID=1328873474>

¹⁷ Drug misuse and dependence: UK guidelines on clinical management 2007 – chapter 5 Pharmacological Interventions

| Generic Name | Brand Name | Dosage | Half Life (hours) | Active Metabolite (hours) |
|------------------|------------|---------|-------------------|---------------------------|
| Alprazolam | Xanax | 0.5 mg | 6-12 | |
| Bromazepam | Lexotan | 6.0 mg | 10-20 | |
| Chlordiazepoxide | Librium | 10.0 mg | 5-30 | 36-200 |
| Clobazam | Frisium | 5.0 mg | 12-60 | |
| Clorazepate | Tranxene | 2.5 mg | | 36-200 |
| Flunitrazepam | Rohypnol | 0.5 mg | 20-30 | 36-200 |
| Flurazepam | Dalmane | 15.0 mg | | 40-250 |
| Ketazolam | Anxon | 6.0 mg | 2 | |
| Loprazolam | Dormonoc | 0.5 mg | 6-12 | |
| Lorazepam | Ativan | 0.5 mg | 10-20 | |
| Lormetazepam | | 0.5 mg | 10-12 | |
| Medazepam | Nobrium | 4.0 mg | | 36-200 |
| Nitrazepam | Mogadon | 5.0 mg | 15-38 | |
| Oxazepam | Oxanid | 15.0 mg | 4-15 | |
| Temazepam | Normison | 10.0 mg | 8-22 | |
| Triazolam | Halcion | 0.25 mg | 2 | |
| Zaleplon | Sonata | 10 mg | 1 | |
| Zolpidem | Stilnoct | 10 mg | 2 | |
| Zopiclone | Zimovane | 7.5 mg | 5-6 | |

Equivalent doses to 5mg Diazepam (Valium) - half-life 20-200 hours

Service user comments



I was told to take Benzos 'as required only, to prevent addiction' but it wasn't long before they very quickly BECAME required every day



Appendices

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Appendix i

From the DSM iv – Diagnostic Statistical Manual 1994

Sedative, Hypnotic or Anxiolytic Use Disorders

304.10

Sedative, Hypnotic or Anxiolytic Dependence (see p.285)

304.50

Sedative, Hypnotic or Anxiolytic Abuse (see p. 286)

Sedative, Hypnotic or Anxiolytic Induced Disorders

292.89

Sedative, Hypnotic or Anxiolytic Intoxication (see p.286)

292.0

Sedative, Hypnotic or Anxiolytic Withdrawal (see p.287)
(Specify if: with perceptual disturbances)

292.81

Sedative, Hypnotic or Anxiolytic Delirium (see p.143)

292.81

Sedative, Hypnotic or Anxiolytic Withdrawal Delirium (see p.143)

292.82

Sedative, Hypnotic or Anxiolytic-Induced Persisting Dementia (see p.186)

292.83

Sedative, Hypnotic or Anxiolytic-Induced Persisting Amnesiac Disorder (see p.177)

292.11

Sedative, Hypnotic or Anxiolytic-Induced Psychotic Disorder, with

Delusions (see p.388)

(Specify if: with onset during intoxication/with onset during withdrawal)

292.12

Sedative, Hypnotic or Anxiolytic-Induced Psychotic Disorder with Hallucinations (see p.388)
(Specify if: with onset during intoxication/with onset during withdrawal)

292.84

Sedative, Hypnotic or Anxiolytic-Induced Mood Disorder (see p.405)
(Specify if: with onset during intoxication/with onset during withdrawal)

292.89

Sedative, Hypnotic or Anxiolytic-Induced Anxiety Disorder
(Specify if: with onset during withdrawal)

292.89

Sedative, Hypnotic or Anxiolytic-Induced Sexual Dysfunction (see p.652)
(Specify if: with onset during withdrawal)

292.89

Sedative, Hypnotic or Anxiolytic-Induced Sleep Disorder (see p.655)
(Specify if: with onset during intoxication/with onset during withdrawal)

292.9

Sedative, Hypnotic or Anxiolytic-Induced Not otherwise Specified (see p.293)

Appendix ii

Drugs which should be avoided on benzos/in withdrawal/other useful facts

Anti-psychotics The BNF (British National Formulary), which is the book that doctors refer to when they prescribe medication, says 'avoid psychotics, which may aggravate withdrawal symptoms.' There is research to show that anti-psychotics lower the seizure threshold and since seizures are a risk in withdrawal (particularly rapid withdrawal), then anti-psychotics should be avoided.

Anti-depressants The BNF says 'should be prescribed ONLY for clinical depression or for panic disorder'. Since both panic and depression are withdrawal symptoms of Benzodiazepine withdrawal, you might want to point this out to clients and get them to consider whether they want to take anti-depressants. Sometimes clients have to find out for themselves, by trying an anti-depressant, or even an anti-psychotic, whether these are helpful. The danger is that a lifting of symptoms which coincides with taking a new drug, will lead people to think that the added drug was useful.

Beta Blockers The BNF says 'should only be tried if other measures fail'.

Sleep disorder The BNF says 'Chronic insomnia is rarely benefited by hypnotics and is more often due to mild dependence, due to injudicious prescribing.' And 'tolerance occurs within 3-14 days'.

Avoid in pregnancy(BNF) Can cause neo-natal withdrawals. Only tell pregnant women this if they have not yet taken a benzo. If they are already on them, tell them that they need to take a stable dose and withdraw slowly if they wish, but must not stop suddenly as this may cause acute distress to the foetus as well as being dangerous to the woman.

ACE inhibitors 'produce enhanced hypotensive effects with Benzos' (BNF).

Adrenergic Neurone Blockers 'enhanced hypotensive effect' (BNF).

Alpha Blockers 'enhanced hypotensive and sedative effects' (BNF).

Analgesics 'increased sedative effect' (BNF).

Angiotensin -11 Receptor antagonists 'enhanced hypotensive effects' (BNF).

Antibiotics/quinolones/ fluoroquinolones. 'found to inhibit Benzodiazepine receptor binding' (British Journal of General Practice)

- Clarythromycin
- Erythromycin
- Quinopristin
- Dalpropistin
- Telithromycin (increased sedation).

'Metabolism' accelerated by:

- Rifampicin
- Isoniazid (BNF)

Phenytoin 'increases or decreases the plasma concentration. Often lowers plasma concentration of clonazepam' (BNF).

Anti- Fungals 'Flucomazole, Itraconazole, metabolism changed in some cases' (BNF).

Anti-histamines 'increased sedation' (BNF).

Anti-virals

- Amprenavir
- Efavirenz
- Indinavir
- Nelfinavir 'concentration possibly increased. Varying sedation effects' (BNF).
- Ritonavir 'Extreme sedation'.

Calcium Channel Blockers

'Hyposensitive effects and sedation' (BNF).

Cardiac Glycosides 'risk of toxicity' (BNF).

Diuretics 'increased hypotension' (BNF).

Muscle relaxants eg: Baclofen

'increased sedative effects' (BNF)

Theophiline: 'Benzo effects may be reduced' (BNF).

Ulcer-healing drugs; Proton Pump inhibitors. Omeprazole and Esomeprazole 'Increased plasma concentration. Metabolism inhibited' (BNF).

Cimetidine 'metabolism of benzodiazepines inhibited' (BNF).

Vasodilator Anti-hypertensives hydralazine, minoxidil, nitroprusside, 'Enhanced hypotensive effect' (BNF).

Carbamazepine 'reduces plasma concentration' (BNF).

Appendix iii

Suggested reduction programme from 30mg of Diazepam

The formula below follows the guidelines of NHS Clinical Knowledge Summary (CKS) which is now incorporated into National Institute for Clinical Excellence (NICE) guidelines. It is based on client experience and feedback during the withdrawal process. This ensures that the client has stabilised before making the next cut and means that there can be no set timetable. Each step is governed by the individual. Before starting the reduction the client should be stable on 30mgs, preferably taking 10mg 3 times a day.

Starting dosage $10 \times 10 \times 10 = 30\text{mgs}$

| CUT | AMOUNT (mgs) | CUT | AMOUNT (mgs) |
|-----|-------------------------------|-----|-------------------------------|
| 1. | $10 \times 10 \times 08 = 28$ | 10. | $05 \times 05 \times 04 = 14$ |
| 2. | $10 \times 08 \times 08 = 26$ | 11. | $05 \times 04 \times 04 = 13$ |
| 3. | $08 \times 08 \times 08 = 24$ | 12. | $04 \times 04 \times 04 = 12$ |
| 4. | $08 \times 08 \times 06 = 22$ | 13. | $04 \times 04 \times 03 = 11$ |
| 5. | $08 \times 06 \times 06 = 20$ | 14. | $04 \times 03 \times 03 = 10$ |
| 6. | $06 \times 06 \times 06 = 18$ | 15. | $03 \times 03 \times 03 = 09$ |
| 7. | $06 \times 06 \times 05 = 17$ | 16. | $03 \times 03 \times 02 = 08$ |
| 8. | $06 \times 05 \times 05 = 16$ | 17. | $03 \times 02 \times 02 = 07$ |
| 9. | $05 \times 05 \times 05 = 15$ | 18. | $02 \times 02 \times 02 = 06$ |

At this point there should be a pause in reduction, while the client transfers to liquid instead of tablets. When stabilisation is achieved, then the reduction programme can continue.

Understand that from now on everything is in **mls** not **mgs**.

2mgs = 5mls.

| CUT | AMOUNT (mls) | CUT | AMOUNT (mls) |
|-----|--------------------------------------|-----|---|
| 19. | $5.0 \times 5.0 \times 5.0 = 15$ mls | 32. | $2.0 \times 2.0 \times 1.5 = 5.5$ |
| 20. | $5.0 \times 5.0 \times 4.0 = 14$ | 33. | $2.0 \times 1.5 \times 1.5 = 5.0$ |
| 21. | $5.0 \times 4.0 \times 4.0 = 13$ | 34. | $1.5 \times 1.5 \times 1.5 = 4.5$ |
| 22. | $4.0 \times 4.0 \times 4.0 = 12$ | 35. | $1.5 \times 1.5 \times 1.0 = 4.0$ |
| 23. | $4.0 \times 4.0 \times 3.0 = 11$ | 36. | $1.5 \times 1.0 \times 1.0 = 3.5$ |
| 24. | $4.0 \times 3.0 \times 3.0 = 10$ | 37. | $1.0 \times 1.0 \times 1.0 = 3.0$ |
| 25. | $3.0 \times 3.0 \times 3.0 = 9.0$ | 38. | $1.0 \times 1.0 \times 0.5 = 2.5$ |
| 26. | $3.0 \times 3.0 \times 2.5 = 8.5$ | 39. | $1.0 \times 0.5 \times 0.5 = 2.0$ |
| 27. | $3.0 \times 2.5 \times 2.5 = 8.0$ | 40. | $0.5 \times 0.5 \times 0.5 = 1.5$ |
| 28. | $2.5 \times 2.5 \times 2.5 = 7.5$ | 41. | $0.5 \times 0.5 = 1.0$ |
| 29. | $2.5 \times 2.5 \times 2.0 = 7.0$ | 42. | $0.5 = 0.5$ |
| 30. | $2.5 \times 2.0 \times 2.0 = 6.5$ | 43. | The final cut (43) leaves the client Benzodiazepine-free. |
| 31. | $2.0 \times 2.0 \times 2.0 = 6.0$ | | |

Appendix iv

Sleep leaflet

In their 'sleeping well' leaflet, the Royal College of Psychiatrists provides the following information:-

What about medication?

People have used sleeping tablets for many years, but we now know that they:

- don't work for very long;
- make you tired and irritable the next day;
- lose their effect quite quickly, so you have to take more and more to get the same effect;
- are addictive. The longer you take sleeping tablets, the more likely you are to become dependent on them.

There are some newer sleeping tablets (Zolpidem, Zaleplon and Zopiclone), but these seem to have many of the same drawbacks as the older drugs, such as Nitrazepam, Temazepam and Diazepam.

Sleeping tablets should only be used for short periods (less than 2 weeks) - for instance, if you are so distressed that you cannot sleep at all.

If you have been on sleeping tablets for a long time, it is best to cut down the dose slowly after discussing it with your doctor.

Link to 'mind' webpages on sleep problems

http://www.mind.org.uk/help/diagnoses_and_conditions/sleep_problems/sleep_problems

Appendix v

“How do I know if I’m becoming dependant on tranquilisers?”

You should suspect you might be becoming dependant if:-

- You find the dose you are taking does not seem to work as well as when it was first prescribed.
- You may find that you seem to need more and more of the drug to get the same effect. This will be the same whether the drug was prescribed for anxiety or as a sleeping tablet.
- You may also notice that when you stop taking the drug for any reason you become more nervous and panicky, or get more unusual symptoms. These include intense itching, becoming very sensitive to light or noise or tingling in the hands and feet.”

Appendix vi

Extract from the APS Patient Information Leaflet

Do not stop taking your tablets suddenly. If you do, you may suffer from withdrawal symptoms. These may include headache, muscle pain, tension, severe anxiety, confusion, restlessness and irritability. In severe cases of withdrawal, you may experience a feeling of things being unreal, a feeling of detachment from your surroundings, numbness and tingling in the hands and feet, sounds seeming to be louder than usual and which can sometimes be painful if the sounds are loud, sensitivity to light or touch, hallucinations and fits. If your doctor decides to stop your tablets, he/she will reduce the dose gradually.

When you stop taking diazepam, you may feel anxious, depressed and restless and have difficulty sleeping. You may also experience sweating and diarrhoea. If this happens, go to your doctor for advice.

After taking diazepam

...other side effects are loss of memory, difficulty sleeping, anxiety, loss of co-ordination, confusion (particularly in the elderly), depression, dizziness, blurred or double vision, slurred speech, nausea, vomiting, abdominal pain, diarrhoea, constipation, headache, low blood pressure, changes in sexual desire, the production of too much or too little saliva, skin reactions, shaking, incontinence, or problems passing water.

Very rarely, jaundice, (characterised by the yellowing of the skin or the whites of the eyes) and increased levels of certain substances in the blood may occur.

Restlessness, agitation, irritability, aggressiveness, delusions, rages, nightmares, hallucinations, psychiatric disorders, and unsuitable behaviour or other changes in behaviour have also occurred.

If you have these or any other effects whilst taking diazepam, tell your doctor immediately.

Approved Prescription Services.
Revised November 2002

Appendix vii

Useful Contacts

Drug and Alcohol Agencies

.....

BAT (Battle Against Tranquilisers)

www.bataid.org

Office 0117 9690303
(for GP's / Practitioners)

Helpline 0844 8269317
(for clients)

SGDAS (South Gloucestershire Drug and Alcohol Services)

Tel: 01454 868750

Freephone: 0800 0733011

Other useful contacts and organisations

.....

North Bristol Advice Centre

<http://www.northbristoladvice.org.uk/>

North Bristol Advice Centre
2 Gainsborough Square
Lockleaze
Bristol BS7 9XA

Tel: 0117 951 5751

Fax: 0117 935 5975

Minicom: 0117 952 7681

Email: team@northbristoladvice.org.uk

Womankind

<http://www.womankindbristol.org.uk/>

Womankind
3rd Floor, Brunswick Court
Brunswick Square
Bristol BS2 8PE

helpline 0845 458 2914

or 0117 9166461

E-Mail info@womankindbristol.org.uk

Samaritans

<http://www.samaritans.org/>

Tel: 08457 909090

E-Mail: jo@samaritans.org

Cruse

<http://www.cruse.org.uk/Bristol/>

Telephone 0117 926 4045

E-mail bristol@cruse.org.uk

Bristol Mindline

Mind Line helpline 0808 808 0330

Relate

<http://www.relate-avon.org.uk/>

133 Cheltenham Road
Bristol BS6 5RR

Tel: 0117 942 8444

Email info@relate-avon.org.uk

Shelter

<http://www.shelter.org.uk/>

Bristol Office
34 Portland Square
Bristol BS2 8RG

Telephone: 0800 800 4444

Appendix viii

Helpful extract from The NHS Clinical Knowledge Summaries (CKS) for use by GP's

Current knowledge, information and guidance information

The NHS Clinical Knowledge Summaries (CKS) is a new resource procured for NHS England in 2006 that evolves and enhances the previous PRODIGY service. PRODIGY Knowledge forms a mandatory element of GP systems.

In 2006 PRODIGY updated its guidance on Benzodiazepines and Z drugs. Some questions are put and answered; these include:

- **Are they motivated to stop the drug?** If a person is not motivated to stop taking their Benzodiazepines or z drug, do not pressurise them to stop as this is likely to be counter-productive, increasing their anxieties about withdrawing.
- **Is this a suitable time to withdraw the drug?** The chances of successfully withdrawing the Benzodiazepine or z drug are improved when a person's physical health, psychological health and personal circumstances are stable. In some circumstances it may be more appropriate to wait until other problems are sorted out or improved before starting withdrawal of the drug.
- **Listen and understand** why they do not want to stop the drug.
- **Address any concerns they have about stopping.** Reassure them that they will be in control of their withdrawal and that they can proceed at a rate that suits them.
- **Discuss the benefits of stopping the drug.** This discussion should include an explanation of tolerance, adverse effects and the risks of continuing the drug.
- **Provide written material about the benefits of stopping the drug** and give them time to consider these issues.
- **Review at a later date** if necessary and reassess their motivation to stop.
- **Withdrawal schedules need to be flexible and tailored to the individual** because there are marked variations between people and how they cope with withdrawal.
- **Whenever possible give the person control over their own withdrawal schedule** because they are in the best position to judge how well they are coping with withdrawal. The size of the dose reduction and the interval between dose reductions can both be varied to suit the individual. At times they may need to be maintained for a longer period of time on a fixed dose, rather than continuing to taper their dose.
- **Avoid increasing the dose.** In general, increasing the dose undermines the progress a person has made.

- **The suggested rate of withdrawal** is in steps of between 5% and 10% of their current daily dose. The decrease in dosage therefore becomes smaller as the overall dose decreases.
- **Withdrawal is most easily managed from diazepam because** it has longer half-life and it is available in 10mg, 5mg and 2mg tablets as well as in liquid formulation which allows for small dosage reduction during withdrawal.
- **It is recommended that a person should be switched to diazepam from short-acting Benzodiazepines before withdrawing** when they are using short-acting potent Benzodiazepines, lorazepam or alprazolam or are using preparations which do not allow for small reductions in dose, including flurazepam, loprazolam, lormetazepam, oxazepam. The decision about switching to diazepam should be made with the person after a discussion.
- **Conversion to diazepam** is best carried out in stages, one dose at a time.
- **Be flexible** in following the schedule and be guided by the patient.

The Mental Health Act of 2007: Changes to exclusions from operation of 1983 Act.

Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of subsection 2.

The Chief Medical Officer Update 37.

In 2007 a reminder update was sent to all doctors by the Chief Medical Officer addressing prescribing habits.

Drug Safety Update MHRA and CHM, October 3rd 2007. Lorazepam: reduction of recommended maximum dose.

Maximum dose of lorazepam for short-term symptomatic treatment is 4mg per day for severe, disabling anxiety, and 2mg for severe disabling insomnia. Prescribers are reminded of previous advice. Doses of lorazepam above 4mg per day are not considered appropriate in view of the recommended maximum treatment duration of 4 weeks, which includes a dose-reduction period.

Appendix ix

British National Formulary 61 March 2011

Notification of drug misusers

Doctors should report cases of drug misuse to their regional or national drug misuse database or centre—see below for contact telephone numbers. The National Drug Treatment Monitoring System (NDTMS) was introduced in England in April 2001; regional (NDTMS) centres replace the Regional Drug Misuse Databases. A similar system has been introduced in Wales.

Notification to regional (NDTMS) or national centre should be made when a patient starts treatment for drug misuse. All types of problem drug misuse should be reported including opioid, **Benzodiazepine**, and CNS stimulant.

The regional (NDTMS) or national centres are now the only national and local source of epidemiological data on people presenting with problem drug misuse; they provide valuable information to those working with drug misusers and those planning services for them. The databases cannot, however be used as a check on multiple prescribing for drug addicts because the data is anonymised.

Enquiries about the regional (NDTMS) or national centres (including information on how to submit data) can be made to one of the centres listed below:

ENGLAND

- **Eastern**
Tel: (01223) 767904
Fax: (01223) 330 345
- **South East**
Tel: (01865) 334734
Fax: (01865) 334 964
- **London**
Tel: (020) 7972 1986
Fax: (020) 7972 1998
- **North West**
Tel: (0151) 231 4533
Fax: (0151) 231 4515
- **North East**
Tel: (0191) 334 0372
Fax: (0191) 334 0391
- **Yorkshire and the Humber**
Tel: (0113) 341 2923
Fax: (0113) 341 3082
- **South West**
Tel: (0117) 970 6474 ext 311
Fax: (0117) 970 7021
- **East Midlands**
Tel: (0115) 971 2745
Fax: (0115) 971 2404
- **West Midlands**
Tel: (0121) 415 8556
Fax: (0121) 414 8197

SCOTLAND

- Tel: (0131) 551 8715
Fax: (0131) 551 1392

WALES

- Tel: (029) 2050 3343
Fax: (029) 2050 2330

In **Northern Ireland**, the Misuse of Drugs (Notification of and Supply to Addicts) (Northern Ireland) Regulations 1973 require doctors to send particulars of persons whom they consider to be addicted to certain controlled drugs to the Chief Medical Officer of the Department of Health and Social Services. The Northern Ireland contacts are:

Medical contact:

Dr Ian McMaster
C3 Castle Buildings
Belfast
BT4 3FQ

Tel: (028) 9052 2421

Fax: (028) 9052 0718

Email: ian.mcmaster@dhsspsni.gov.uk

Administrative contact:

Public Health Information & Research
Branch
Annex 2
Castle Building
Belfast
BT4 3SQ

Tel: (028) 9052 2520

Public Health Information & Research Branch also maintains the Northern Ireland Drug Misuse Database (NIDMD) which collects detailed information on those presenting for treatment, on drugs misused and injecting behaviour; participation is not a statutory requirement.

Appendix X General Information Leaflet

Patron: The Right Hon. Baroness Corston



Founded 1984

Recommended by Substance Misuse Management in General Practice (SMMGP)

Lessening the harm caused by benzodiazepine tranquilisers and sleeping pills and drugs with similar effects

Ring 0117 9663629

or visit the website at www.bataid.org

helpline: 08448269317

Chair: Dr Richard Lawson, MB, MRCPsych

UK Registered Charity No: 1056508

BAT's aims are:

- To help those who are addicted to benzodiazepines etc, and who wish to withdraw from them, to do so as comfortably as possible, and to help them make the necessary changes in life after withdrawal.
- To educate and inform all those who may come across the problem of benzodiazepine addiction, either personally or professionally, towards an understanding of the difficulties caused by this drug's actions and the compounding of these difficulties in withdrawal.
- To influence services in their prescribing, managing and supporting of clients who take/want to withdraw from, these drugs

Support Groups

Groups meet informally. *It is not necessary to be referred by a doctor.*

Groups meet in a spirit of mutual support to help anyone who wishes to consider the level of benzodiazepines etc they take or to come off these tranquilisers.

Anyone looking for help is very welcome to come along. Complete confidentiality is assured.

Telephone Help Line

Ring 08448269317 in complete confidentiality

Home Visits

We can offer home visits, either one-to-one or with you, your family and/or friends.

For further information:

Battle Against Tranquillisers

PO Box 658
BRISTOL BS99 1XP
(0117) 966 3629

Tranquillisers and Sleeping Pills

- Drugs prescribed on the NHS (which your GP can give you on an NHS prescription):**

Chemical/Generic Name Brand Name

| | |
|------------------|-----------------|
| Chlordiazepoxide | Librium |
| Clonazepam | Rivotril |
| Diazepam | Valium |
| Loprazolam | Dormonoc |
| Lorazepam | Ativan |
| Lormetazepam | |
| Nitrazepam | Mogadon |
| Oxazepam | Serenid-d/forte |
| Temazepam | |
| Zolpidem | Stilnoct |
| Zopiclone | Zimovane |
| Zaleplon | Sonata |

- Drugs now only available on a private prescription:**

Chemical/Generic Name Brand Name

| | |
|---------------|----------|
| Alprazolam | Xanax |
| Bromazepam | Lexotan |
| Clobazam | Frisium |
| Clorazepate | Tranxene |
| Flunitrazepam | Rohypnol |
| Flurazepam | Dalmane |

What is the latest advice?

Since 1988, the Committee on Safety of Medicines has recommended that benzodiazepines are only prescribed for anxiety that is severe and disabling. It recognises that benzodiazepines* are physically addictive and that long-term use may cause many problems.

(* The British National Formulary recommends that Zolpidem, Zopiclone and Zaleplon be treated like benzodiazepines due to their similarity).

What are these problems?

Many people believe themselves to be ill when, in fact, they are suffering from withdrawal symptoms.

How can I be having withdrawal symptoms when I am on a steady dose?

Your body gets used to the effects of the pills so quickly that, unless you keep increasing the dose, you start suffering withdrawal effects.

What can I do about the effects?

It is important, if you decide to cut down, or even come off, your pills, that you do so very slowly. This is not easy, which is why we are offering support groups and telephone help for you.

What is a support group like?

Our groups are friendly and welcoming. If you think you would like to come along, you can phone us and ask all the

questions you want to. A lot of people are nervous at first, and feel frightened that they will be pressured into reducing the amount they take before they are ready. We believe everyone has to decide for themselves - we'll help you whatever you decide. Most groups are run by people who have come off pills themselves, and understand how frightening this can be.

How can my doctor help?
Because benzodiazepines have so many physical effects, you may need to ask your doctor to check any symptoms which worry you. Doctors are increasingly aware of the problems caused by benzodiazepines, and will be happy to help you.

Where can I find the BAT Support Groups?

There is a support group on Wednesday evenings at 6.00-7.30pm at:

Bristol Mind
35, Old Market Street
Bristol

(5 minutes walk from Broadmead and buses)
For information about this and other groups, contact:

Battle Against Tranquillisers
PO Box 658
BRISTOL BS99 1XP
0117 9663629

Some of the most common effects that can be produced by benzodiazepine tranquilisers and sleeping pills.

- feeling afraid
- panic attacks
- agoraphobia and claustrophobia
- depression
- sleeplessness
- feelings of anger and anxiety
- lack of concentration
- feelings of unreality/depersonalisation
- lack of confidence
- aches and pains (muscle tension)
- stomach and bowel problems - diarrhoea and constipation
- rashes
- giddiness
- jaw pains
- blurred vision
- flu-like symptoms
- exhaustion
- Self-harm and suicidal feelings and actions.
- many people wonder why they have changed from being happy and outgoing, to being over-anxious and unconfident.

Appendix XI

Harm reduction leaflet



HOW MUCH DO YOU KNOW ABOUT BENZODIAZEPINES (BENZOS) AND THE 'Z' DRUGS?
Also known as:

Benzos
Diazines
Vallies
Temazzies
Blues
Zops
Moggies etc:

**WANT TO KNOW MORE?
CONTACT BATTLE AGAINST
TRANQUILLISERS!**

BAT: 0117 9663629.
www.bataid.org

DO YOU KNOW ABOUT THE LINK BETWEEN BENZOS AND RISKY BEHAVIOUR?

Using benzos clouds your thinking and affects your behaviour and decision-making skills. This makes it much more difficult to tell the difference between sensible and risky choices and can result in:

Shoplifting (*I felt I was invisible*)
Aggressive behaviour
Unstable behaviour (frequently misdiagnosed as Borderline Personality Disorder)
Memory loss (*people were telling me about things I had done, but I couldn't remember doing any of it*)
Risk-taking behaviour (sharing needles, unsafe sex, unwise relationships)

Sometimes people who use benzos, particularly binge-taking, take risks for the thrill. (*I wanted to see what would happen if I walked out into the road without looking. I used to get onto trains without a ticket, just to see if I could get away without paying.*)

IS THERE A BIGGER OVERDOSE RISK WITH BENZOS?

Most fatal overdoses happen as a result of taking a mixture of heroin, alcohol and benzos. This is because all three suppress your breathing. Taking a mixture of three substances which make breathing difficult, increases your chance of fatal overdose considerably.
Did you know that

'With recent benzo use the risk of fatal heroin overdose is 2.4 times greater than those with no evidence of use'

'If methadone is also being used, the risk is 10 times bigger'

(Benzodiazepines and Cocaine as Risk Factors in Fatal Opioid overdose: National Treatment Agency April 2007)

BUT

Don't stop using benzos suddenly! This is dangerous and could result in seizures and suicidal feelings, as well as lots of other unpleasant symptoms. If you want to cut down **or stop using benzos, you'll need lots of information and support, so contact BAT on 0117 9663629.**

IF YOU WANT MORE INFORMATION, OR YOU'D LIKE AN APPOINTMENT CONTACT:

BATTLE AGAINST TRANQUILLISERS (BAT)

PO BOX 658

BRISTOL

BS99 1XP

TEL: 0117 9663629

WEBSITE WITH EMAIL:
www.bataid.org

DO YOU KNOW ABOUT THE DANGERS OF INJECTING BENZOS?

Temazepam, when injected, can cause severe problems. It is highly irritant to the veins and people become very reckless in their behaviour. (The Safer Injecting Briefing)

Injecting benzos which are intended to be swallowed in tablet/capsule form, can cause severe vein and tissue damage, leading to ulcers.

Organ damage or stroke

Gangrene, leading to possible limb loss, is particularly linked to benzo injecting.

The injecting of benzodiazepines is associated with more HIV risk-taking. (Darke, Hall et al 1992)

Needle sharing leads to increased risk of HIV and Hep. C & B, blood poisoning (septicaemia) and skin abscesses.

DID YOU KNOW THAT

Withdrawals from Benzos last longer than with any other drug?

Withdrawal symptoms are sometimes mistaken for a mental health disorder?

If different amounts of benzos are used each day, you will be in withdrawal, even though you haven't made a reduction?

WHAT ARE THE WITHDRAWALS FROM BENZOS?

Feeling afraid, anxious and panicky

Agoraphobia (not wanting to go out) and claustrophobia (not wanting to stay in)

Depression

Not sleeping

Anger

Difficulty in concentrating

Feeling unreal

No confidence

Muscle pain

Rashes

Giddiness

Jaw pain

Blurred vision

Flu-like symptoms

Exhaustion

Over sensitivity to sound, light, touch and taste etc:

It is dangerous to stop using benzos suddenly. This can cause seizures and suicidal feelings.

Appendix xii

BNF No. 62 (September 2011) Guidance on prescribing

Emergency supply of medicines

Emergency supply requested by member of the public

Pharmacists are sometimes called upon by members of the public to make an emergency supply of medicines. The Prescription Only Medicines (Human Use) Order 1997 allows exemptions from the Prescription Only requirements for emergency supply to be made by a person lawfully conducting a retail pharmacy business provided:

- a. that the pharmacist has interviewed the person requesting the prescription-only medicine and is satisfied:
 - i. that there is immediate need for the prescription-only medicine and that it is impracticable in the circumstances to obtain a prescription without undue delay;
 - ii. that treatment with the prescription-only medicine has on a previous occasion been prescribed for the person requesting it;
 - iii. as to the dose that it would be appropriate for the person to take.
- b. that no greater quantity shall be supplied than will provide 5 days' treatment of phenobarbital, phenobarbital sodium, or Controlled Drugs in Schedules 4 or 5,(1) or 30 days' treatment for other prescription-only medicines, except when the prescription-only medicine is:
 - i. insulin, an ointment or cream, or a preparation for the relief of asthma in an aerosol dispenser when the smallest pack can be supplied;
 - ii. an oral contraceptive when a full cycle may be supplied;
 - iii. an antibiotic in liquid form for oral administration when the smallest quantity that will provide a full course of treatment can be supplied.
- c. that an entry shall be made by the pharmacist in the prescription book stating:
 - i. the date of supply;
 - ii. the name, quantity and, where appropriate, the pharmaceutical form and strength;
 - iii. the name and address of the patient;
 - iv. the nature of the emergency.
- d. that the container or package must be labelled to show:
 - i. the date of supply;
 - ii. the name, quantity and, where appropriate, the pharmaceutical form and strength;
 - iii. the name of the patient;
 - iv. the name and address of the pharmacy;
 - v. the words 'Emergency supply';
 - vi. the words 'Keep out of the reach of children' (or similar warning).

- e. that the prescription-only medicine is not a substance specifically excluded from the emergency supply provision, and does not contain a Controlled Drug specified in Schedules 1, 2, or 3 to the Misuse of Drugs Regulations 2001 except for phenobarbital or phenobarbital sodium for the treatment of epilepsy: for details see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition).(1)

Emergency supply requested by prescriber

Emergency supply of a prescription-only medicine may also be made at the request of a doctor, a dentist, a supplementary prescriber, a community practitioner nurse prescriber, a nurse, pharmacist, or optometrist independent prescriber, or a doctor or dentist from the European Economic Area or Switzerland, provided:

- a. that the pharmacist is satisfied that the prescriber by reason of some emergency is unable to furnish a prescription immediately;
- b. that the prescriber has undertaken to furnish a prescription within 72 hours;
- c. that the medicine is supplied in accordance with the directions of the prescriber requesting it;
- d. that the medicine is not a Controlled Drug specified in Schedules 1, 2, or 3 to the Misuse of Drugs Regulations 2001 except for phenobarbital or phenobarbital sodium for the treatment of epilepsy: for details see Medicines, Ethics and Practice,

London, Pharmaceutical Press (always consult latest edition);(1)

- e. that an entry shall be made in the prescription book stating:
- i. the date of supply;
 - ii. the name, quantity and, where appropriate, the pharmaceutical form and strength;
 - iii. the name and address of the practitioner requesting the emergency supply;
 - iv. the name and address of the patient;
 - v. the date on the prescription;
 - vi. when the prescription is received the entry should be amended to include the date on which it is received.

(1)Doctors or dentists from the European Economic Area and Switzerland, or their patients, cannot request an emergency supply of Controlled Drugs in Schedules 1, 2, or 3, or drugs that do not have a UK marketing authorisation.

Royal Pharmaceutical Society's guidelines

1. The pharmacist should consider the medical consequences of not supplying a medicine in an emergency.
2. If the pharmacist is unable to make an emergency supply of a medicine the pharmacist should advise the patient how to obtain essential medical care.

For conditions that apply to supplies made at the request of a patient see Medicines, Ethics and Practice, London Pharmaceutical Press, (always consult latest edition).

If you need this information in another format or language please contact 01454 868004

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