Prescribing Benzodiazepines

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The good news is that benzodiazepine misuse and dependence have significantly declined in Australia over the past three decades mainly due to increasing awareness among GPs and psychiatrists about the very narrow indications for this group of drugs, as well as their dependency potential and the much better availability of alternative evidence based psychotropics for depression and anxiety. This trend has also been helped by the setting up of prescription shopper services (1800 631 181) which can be contacted at any time by any doctor if they are concerned their patient is receiving scripts from many doctors.

Furthermore, some of the more problematic substances such as Flunitrazepam and Alprazolam are now Schedule 8 drugs and are monitored by the state governments Medicines Regulation and Quality (MRQ; (07) 3328 9821).

Despite the noted reduction, problematic benzodiazepine continues to be an issue amongst poly-substance users and remains readily available for sale on the streets from diverted prescriptions, and increasingly from purchasers using international mailing services.

GP Approach

For the GP, the best approach remains to be cautious and seek out alternatives before prescribing benzodiazepines as there are no longer any real indications for long term use. If they are going to be prescribed for the short-term management of anxiety or insomnia, it's best to do so for no more than two weeks to prevent neuroadaptation and thus physiological dependence. If you have dependent patients or inherit them from interstate etc., confront the issue straight away and begin a reduction plan.

Evidence shows that doctors just mentioning it as a problem has a very beneficial effect. The evidence would now suggest that in most cases this is best undertaken gradually as an outpatient which places GP's in an ideal position to carry this out.

Addiction psychiatrists and addiction medicine physicians generally use a simple conversion table such as that in "Psychotropic Guidelines" and convert whichever benzodiazepine the patient is on, over to diazepam (a long acting benzodiazepine) equivalents. The patient can then be safely reduced using the handy heuristic of TTTT; i.e. reduce by Ten percent per week over a Ten week period with a Terminal Taper. The Terminal Taper means you may want to slow down the reduction for the last 10 per cent.

Inpatient detoxification may be required if this continues to fail, but usually inpatient benzodiazepine withdrawal has a high relapse rate, and can be very distressing for long term benzodiazepine users. In addition, there is a risk of withdrawal seizures in some cases due to the very powerful anticonvulsant properties of the benzodiazepines class of drugs.

Doctors at Gold Coast Alcohol and Other Drugs Service are available for phone support to any GP attempting such a withdrawal on (07) 5687 9119.

HALF-LIVES AND EQUIVALENT POTENCIES OF BENZODIAZEPINE ANXIOLYTICS

Benzodiazepine	Half-life (hrs) [active metabolite]	Approximate equivalent oral dosages (mg)
Alprazolam (Xanax)	6-12	0.5
Clonazepam (Klonepin)	18-50	0.5
Lorazepam (Ativan)	10-20	1
Diazepam (Valium)	20-100 [26-200]	10
Chlordiazepoxide (Librium)	5-30	25
Clorazepate (Tranxene)	[36-200]	15
Oxazepam (Serax)	4-15	20

Brett, J., and Murnion, B. (2015). Management of benzodiazepine misuse and dependence. Australian Prescriber, 38, 152-155

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