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Professional Standards Regarding Benzodiazepines and Z-Drugs

Preamble

The standard establishes the professional, ethical and practice requirements for physicians in relation to prescribing benzodiazepines and Z-drugs in outpatient community settings. The standard does not address prescribing for palliative or end-of-life patients, acute seizure disorders, akathisia, and alcohol withdrawal.

Definitions

Benzodiazepines are gamma-aminobutyric acid (GABA) receptor agonists that have hypnotic, anxiolytic, muscle relaxant and anti-convulsant properties. Benzodiazepines are commonly divided into three groups depending on how quickly they are eliminated from the body:

- Short acting - half-life: less than 12 hours such as midazolam and triazolam.
- Intermediate acting - half-life: between 12-24 hours such as alprazolam, lorazepam and temazepam.
- Long acting - half-life: greater than 24 hours such as diazepam, clonazepam, clorazepate and flurazepam.

Benzodiazepines are monitored by the Nova Scotia Prescription Monitoring Program (NSPMP).

Z-Drugs are non-benzodiazepine and hypnotic drugs of the imidazopyridine class**.** They are GABA receptor agonists but because they have a different structure, they produce fewer anxiolytic and anticonvulsant effects than benzodiazepines. The Z-drugs are typically prescribed for insomnia and include zaleplon, zolpidem and zopiclone. The Z -drugs tend to be quicker acting and have shorter half-lives than the benzodiazepines. They are not "safer" than benzodiazepines as they carry the same risks of physiological dependence and protracted withdrawal as benzodiazepines. The only Z-drug currently monitored by the Nova Scotia Prescription Monitoring Program (NSPMP) is Zolpidem through the *Controlled Drugs and Substance Act, Schedule IV*.

Professional Standards

1. Before initiating treatment with benzodiazepine or Z-drugs, physicians must:

    a) Make reasonable efforts to first optimize non-pharmacological treatments including non-benzodiazepine or non-Z-drug treatment modalities;

b) Check either the Nova Scotia Prescription Monitoring Program (NSPMP) eAccess or the Nova Scotia Drug Information System (DIS) for the medication profile of patients seeking a prescription for opioids, controlled substances, benzodiazepines, tramadol and zolpidem;

c) Evaluate the patient's existing medication regime and medical conditions, while documenting an assessment of the patient's risk of addiction and diversion; and

d) Document the history, assessment, physical exam, diagnosis/differential diagnosis, consent, and treatment plan including follow-up care in the medical record. Document the explanation of the risks associated with treatment including physical dependence, withdrawal, and possible impairment, including dangers of driving or operating machinery. Confirm patients are not receiving duplicate prescriptions and advise patients of the consequences of this.

2. When initiating treatment of patients with benzodiazepine or Z-drugs, physicians must:

   a) Prescribe the lowest effective dose of benzodiazepines or Z-drugs for the shortest possible duration (2-4 weeks);

   b) Not exceed the maximum recommended dosage of benzodiazepines or Z-drugs except in exceptional circumstances with reasons documented;

   c) Specify the dispensing interval on each prescription, so that the pharmacist and patient are aware of the minimum duration of treatment (the number of days the prescription should last); and

   d) Not prescribe opioids concurrently with benzodiazepines and/or Z-drugs except in exceptional circumstances such as within the context of a taper.

3. When managing patients being treated with benzodiazepines and Z-drugs, including but not limited to those patients on long-term therapy, physicians must:

   a) Monitor patients for signs of physical dependence; and

   b) Document their reasoning as to why the patient requires on-going therapy of benzodiazepines and Z-drugs.

4. With respect to tapering patients on benzodiazepines and Z-drugs, physicians must:

   a) First consider switching patients to longer acting agents prior to tapering;

   b) Be available to monitor and support patients through the tapering process; and

   c) Reduce dosages gradually while regularly monitoring patients' response.

Additional Considerations for Older Patients

Senior patients have an increased sensitivity to benzodiazepines and decreased metabolism of long-acting medications. New starts of benzodiazepines and Z-drugs for patients over 65 must:

- be implemented with extreme caution and not used as first choice for insomnia, agitation, delirium or for managing behaviors arising from dementia;
- take into consideration declining renal, hepatic and cognitive function and polypharmacy in older patients;
- include discussion and documentation of additional risks more common in this age group including falls, impaired motor skills and coordination, postural instability, confusion, drowsiness and possible negative effects on cognition and memory; and
- monitor and reevaluate the use and effectiveness of the medications regularly.

Legacy Patients

It's not uncommon for primary care physicians to take over the care of patients maintained on unusual medication regimes, including benzodiazepines and Z-drugs. This standard should be read concurrently with the College's *Professional Standards and Guidelines Regarding Caring for Legacy Patients*.

Resources

College of Physicians and Surgeons of Nova Scotia

- Professional Standards and Guidelines Regarding Informed Patient Consent to Treatment
- Professional Standard Initiation of Opioid Therapy for Acute Pain
- Professional Standard and Guidelines Regarding Prescribing
- Professional Standards and Guidelines Regarding Caring for Legacy Patients

Canadian Medical Protective Association

- Good Practices Guide: Medications for the elderly

The 2017 Canadian Guideline for Opioids for Chronic Non- Cancer Pain

Choosing Wisely Canada

BZRA Deprescribing Algorithm 2019

Acknowledgements

The development of this College standard was informed by the College of Physicians and Surgeons of Manitoba's *Standard of Practice Prescribing Benzodiazepines & Z-Drugs*.

Document History

First Approved by the Council of the College of Physicians and Surgeons of Nova Scotia on: **March 25, 2022**

Date of next review: **2025**