Information and Materials to Support Benzodiazepine Withdrawal in General Practice

Medication Tapering Template:

Fact Sheets for Patients:

Information for General Practitioners:

Access the full RACGP Guideline Reccomendations:

Prescribing drugs of dependence in general practice, Part B; Benzodiazepines

https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Drugs%20of%20dependence/Prescribing-drugs-of-dependence-in-general-practice-Part-B-Benzodiazepines.pdf

2.2 Insomnia

✓ Key points

- Insomnia is a common problem seen in general practice. The understanding of chronic insomnia is still evolving.
- In acute insomnia, sleep often returns to normal once the precipitating factor has resolved.
- In chronic insomnia, treatment is focused on addressing underlying comorbid precipitants (where present), and psychological and behavioural management.
- Pharmacotherapy for acute and chronic insomnia may be necessary for severe or resistant cases of insomnia. The decision to prescribe should be on an individual basis and involve serious consideration of all risks and possible benefits.
- Benzodiazepines and Z drugs have been shown to be effective treatments and may be prescribed for short-term or intermittent use. Harm, such as dependence and adverse events, may occur with both drug groups.
- Dose reduction and cessation should be discussed with the patient on first prescription and commenced once sleep patterns return to normal.
- Pharmacological treatment should be accompanied by specific patient education and regular review.

	Evidence statements	Grade
Rec 1	Cognitive behavioural therapy (CBT) based treatment packages for chronic insomnia, including sleep restriction and stimulus control, are effective and therefore should be offered to patients as first-line treatment.	A
Rec 2	Z drugs and short-acting benzodiazepines are efficacious for insomnia.	A
Rec 3	Prescription of zolpidem and zopiclone should be treated with the same caution as benzodiazepines.	A
Rec 4	Intermittent dosing may reduce the risk of tolerance and dependence.	B
Rec 5	If hypnotics are to be used for treating insomnia, it is recommended that treatment is short term (not more than 4 weeks) and at the lowest possible dose.	B

Fact Sheet

A reduction plan for your sleeping tablets

NPS MEDICINEWISE

From your health professional

Patient education material

For: _____ (patient name)

Your doctor will plan with you how to stop your sleeping tablets. You may need to stop gradually so it is easier to get used to being without the medicine.

Sleeping tablets

Sleeping tablets may be helpful in the short term in some situations. However, they can disturb the normal rhythm of your sleep, so it won't be as deep or restful. Ideally, they should be used for 2 weeks or less and only when required.

They can cause unwanted effects like daytime drowsiness, dizziness, problems with balance (this can increase your risk of falls), memory loss, poor concentration and weak bladder (incontinence).

Sleeping tablets can be addictive and stopping them becomes more difficult the longer you use them.

Stopping your sleeping tablets can improve your memory, daytime alertness and quality of sleep, and can reduce your risk of falls.

Not everyone stops taking their sleeping tablets the first time they try. If this happens, it's worthwhile trying again when you're ready.

Alternatives to medicines

Learn and practise techniques to help you relax and sleep. Your doctor can help you learn, or suggest courses.

Withdrawal symptoms

You may experience withdrawal symptoms. Not everyone has the same symptoms and the amount of discomfort caused by these varies.

Symptoms may include poor concentration, dizziness, muscle pains, tremors ('the shakes'), and feeling irritable, restless, anxious or depressed. You may also notice that your difficulty sleeping returns when you start reducing your tablets. This generally lasts for 1 – 3 days and does not mean that you still need your sleeping tablets.

Your doctor will help you manage withdrawal symptoms or sleeping difficulties if these occur.

Helpful hints when reducing your sleeping tablets

- Start your reduction plan when you are not feeling stressed.
- Keep in regular contactwith your doctor to discuss how you are dealing with reducing your sleeping tablets.
- Find a supporter (e.g. a friend or relative who is a good listener).
- Try not to drink alcohol, or keep the amount you drink to a minimum. Drinking alcohol during this time may make your withdrawal symptoms worse (see over).

At the start, have a review with your doctor once weekly

- A successful reduction plan can take several weeks to months.
- Discuss with your doctor how you can manage any changes in your mood, sleep, alcohol use, or amount you smoke, which may occur when reducing your sleeping tablets.
- Record which tablets you have taken and when (see over).
- Record any symptoms you may have and discuss these with your doctor.
- Keep a diary of the times you sleep, and for how long (you can download a sleep diary from www.nps.org.au/sleep).

Your reduction plan

(Your doctor may change this depending on your symptoms)

Medicine name and strength: _____

To be completed by the doctor: Indicate the number of tablets/capsules to be taken							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Week 1 beginning / /							
Week 2 beginning / /							
Week 3 beginning / /							
Week 4 beginning / /							
Week 5 beginning / /							
Week 6 beginning / /							
Week 7 beginning / /							
Week 8 beginning / /							

Date of follow-up appointments: _____

To be completed by the patient: Record the number of tablets/capsules taken							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Week 1 beginning / /							
Week 2 beginning / /							
Week 3 beginning / /							
Week 4 beginning / /							
Week 5 beginning / /							
Week 6 beginning / /							
Week 7 beginning / /							
Week 8 beginning / /							

Name of your support person: _____

Record any withdrawal symptoms you experience (see over)

Sleep right Sleep tight
For more information go to: **www.nps.org.au/topics/sleep_campaign** or scan the **QR Code**

Published March 2010. Updated October 2012.

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Resource D. Communication with patients

D.1 Benzodiazepine fact sheet for patients*

What are benzodiazepines?

Benzodiazepines are a group of prescription-only medicines that have a sedating and calming effect on the brain and nervous system. They are also known as sedatives or tranquillisers. Examples of benzodiazepines include medicines containing one of the following active ingredients: diazepam, lorazepam, oxazepam, temazepam and alprazolam.

They come in tablet and capsule form, and some are available for intravenous use in hospital settings.

How do benzodiazepines work?

Benzodiazepines differ in how quickly the active ingredient starts to work and how long the effect lasts. The effect of the medicine also depends on the prescribed dose, and on the individual (eg height, weight, health status and previous experience with benzodiazepines), which can impact on how the medication will work.

Benzodiazepines can help treat symptoms of anxiety and sleeping problems (eg insomnia). As non-medicine therapies have proven benefit in these conditions, benzodiazepines are generally considered only if these options are inappropriate or have failed.

If you have been diagnosed with an anxiety disorder, benzodiazepines can make you feel calmer. If you have insomnia, benzodiazepines may help you fall asleep. They are sometimes used for other reasons, such as a medication before an operation to alleviate nervousness.

After taking benzodiazepines, people can describe feeling drowsy, relaxed, confused/fuzzy and having a heavy sensation in their arms and legs. Coordination and reflexes can be effected too, which means you should not take benzodiazepines if you need to be focused and coordinated (eg drive a car or operate heavy machinery).

Benzodiazepines are usually taken for a set period until the intended therapeutic effect is achieved. Then, the dose is reduced and plans to stop it are made.

If you take benzodiazepines for a prolonged time, the body may adapt and get used to the effects of the medication. Stopping the medication can lead to withdrawal symptoms that includes anxiety and restlessness. Withdrawal symptoms are often mild, but can be severe if you are on high doses of a benzodiazepine. Serious side effects, including seizures, can occur if you stop taking high doses suddenly.

Can benzodiazepines be addictive?

Although addiction (cravings, abuse, misuse, compulsive or uncontrollable benzodiazepine-seeking behaviour) is possible with benzodiazepines, it is rare in people who are taking therapeutic doses for a specific reason over a short period as prescribed by their doctor.

You may be at a greater risk of developing an addiction to benzodiazepines if you have a history of drug dependence, or if you are currently misusing any substance including alcohol or strong pain killers (opioid drugs).

Before prescribing a benzodiazepine, your doctor will ask you questions about these sorts of things to help prevent addiction.

What are the possible side effects of benzodiazepines?

Benzodiazepines are associated with a number of side effects including:

- drowsiness and unsteadiness, potentially increasing the risk of a fall
- impairment in judgement and dexterity, making tasks such as driving or using heavy machinery more difficult
- forgetfulness, confusion, irritability
- paradoxical aggression and excitability (although this is rare, it is the opposite effect to what is expected with these medicines).

Taking benzodiazepines in combination with other drugs or alcohol can be very dangerous, and in some cases fatal.

Can I take benzodiazepines for a long time?

Benzodiazepines are usually taken for a short length of time. In rare instances, some patients will require long-term therapy with benzodiazepines. This is after a serious consideration of risks and benefits of long-term therapy between you and your doctor. If you and your doctor have decided that benzodiazepines are an important part of your long-term treatment, then you should continue to take them as prescribed and keep checking in with your doctor for review.

If you have been taking benzodiazepines regularly for longer than 4 weeks and wish to stop them, your doctor would be happy to advise you on how to do this. Do not stop or significantly alter the dose abruptly. Many people can stop taking benzodiazepines without difficulty. For others, gradual reduction helps prevent or reduce any withdrawal symptoms.

Where can I get more information?

- The Victorian Government's Better Health Channel website, www.betterhealth.vic.gov.au
- The Australian Drug Foundation's help and support page, www.druginfo.adf.org.au/contact-numbers/help-and-support, lists sources of information and advice.

* Kenny T, Harding M. Benzodiazepines and Z Drugs [Internet]. London: patient.co.uk; 2014 [updated October 2014]. Available at http://patient.info/health/benzodiazepines-and-z-drugs [Accessed 11 June 2015].

D.3 Stopping benzodiazepines (benzodiazepine withdrawal) fact sheet for patients

How would I benefit by stopping benzodiazepines?

People who have been on long-term benzodiazepines often feel like they need to stay on them. This may be because of fears about returning symptoms of anxiety or sleeplessness, or due to withdrawal symptoms or needing the medication to feel normal.

While you might feel 'normal' when you take benzodiazepines, studies have found people who stopped taking them have:

- improved memory and reaction times
- increased levels of alertness
- improved quality of life (more vitality, better ability to function).

Stopping benzodiazepines also reduces your risk of falls, accidents, fractures and other injuries.

How should I stop taking benzodiazepines?

The best place to start is by talking to your general practitioner (GP). Some people can stop quickly and easily; others need a more gradual approach with additional support. Your GP can advise you on the rate at which you should reduce the dose and help you to consider other ways of dealing with your worries or sleeping problems. Sometimes your GP will change your prescription to a different benzodiazepine before withdrawing.

If you are taking other addictive medicines, in addition to benzodiazepines, you may need specialist help to come off the various medicines. Your GP will be able to advise you or refer you to local services that can help.

Some tips for withdrawing from benzodiazepines:

- **Choose when to start reducing** – If you have been taking benzodiazepines to help you cope with a personal crisis, it may be advisable to wait until things settle down before starting to reduce the dose. Consider starting while on holiday, when you have less pressure from work, fewer family commitments or less stress.
- **Do not try to stop suddenly** – Unless your GP has advised you to do so. You should reduce your medication in a slow, gradual process, as this often gives a better chance of long-term success. You can go as slowly as you need to.
- **Do not increase the dose** – It is common to have a bad patch at some time during the withdrawal. You might be tempted to go back to the higher dose, but it is best to stick with the current dose. Don't consider a further reduction until you feel ready; this may take several weeks.
- **Get help and support** – Consider asking family or friends for encouragement and support, or consider joining a self-help group. Advice and support from other people in similar circumstances, or those who have come off a benzodiazepine, can be very encouraging.
- **Keep a record** – Keeping a diary can help as it records your progress and achievements. This in itself will give you more confidence and encouragement to carry on.

How do I cope with withdrawal symptoms?

Not everyone experiences the same degree or type of symptoms when withdrawing from benzodiazepines. The best way to cope is to go slowly to minimise the withdrawal symptoms. It can also help to know what to expect and know that these will pass.

- Panic attacks commonly occur due to the effects of adrenaline and rapid, shallow breathing (hyperventilation). When this happens, you may experience palpitations, sweating, unsteady legs and trembling. Regaining control of your breathing can help to alleviate the symptoms.
- Anxiety is also common upon withdrawal, especially if dose reduction is not gradual enough.
- Agoraphobia can present in a range of forms from a reluctance to go out in public to feeling completely unable to do so. However agoraphobic feelings usually lessen as withdrawal continues.
- Aches and pains are very common during withdrawal.
- Problems with sleeping can occur during withdrawal. Strategies such as ensuring enough exercise during the day, resolving concerns before bedtime and not trying to force sleep can help.
- Stomach and bowel problems such as diarrhoea and irritable bowel syndrome are very common during withdrawal and can be very distressing. Your GP may be able to recommend a diet and indigestion remedies that can improve these symptoms, which usually disappear after withdrawal is complete.
- Hot flushes and shivering are also common.
- Sinus problems are experienced by many people as they withdraw.
- Vivid dreams and nightmares are another common occurrence during withdrawal. However this may in fact be a good sign, as it can indicate your sleep and your body are re-adjusting to normal.

* Kenny T, Harding M. Stopping Benzodiazepines and Z Drugs [Internet]. London: patient.co.uk; 2014 [updated October 2014]. Available at www.patient.co.uk/health/stopping-benzodiazepines-and-z-drugs [Accessed 11 June 2015].
Welsh Medicines Partnership. Educational pack – Material to support appropriate prescribing of hypnotics and anxiolytics across Wales. Wales: Welsh Medicines Partnership; 2011. Available at www.awmsg.org/docs/awmsg/medman/Educational%20Resource%20Pack%20-%20Material%20to%20support%20appropriate%20prescribing%20of%20hypnotics%20and%20anxiolytics%20across%20Wales.pdf [Accessed 12 June 2015].

5. Discontinuing benzodiazepines

5.1 Discontinuing after short-term use

For patients on less than 4 weeks of benzodiazepine therapy, it should be possible to stop medication without tapering. Caution should be exercised with patients who are at risk of seizures.

5.2 Discontinuing after longer term use – Withdrawal

Withdrawal is possible for most patients on longer term benzodiazepines, although the process of reduction may be difficult and lengthy. The withdrawal process is aided by a good therapeutic alliance between the GP and patient, with specialist support where needed. Discontinuation is usually beneficial as it is followed by improved psychomotor and cognitive functioning, particularly in the elderly.[189] Up to 15% of patients who experience withdrawal will go on to have protracted symptoms lasting months to years.[2]

Withdrawal strategies will vary with the type of dependence (therapeutic dose, prescribed high dose, recreational high dose or polydrug). Withdrawal symptoms are highly variable and each patient will need tailored withdrawal management that will also address any underlying problems. Withdrawal symptoms may appear in 1–2 days for agents with shorter half-lives, but may not appear until 3–7 days for agents with longer half-lives.

Table 4. Acute withdrawal symptoms

Anxiety symptoms		**Distorted perceptions**	**Major incidents** Mainly when high doses are stopped abruptly
Psychological	Physical		
• Anxiety • Panic attacks • Insomnia • Poor memory • Depression • Paranoia • Intrusive memories • Cravings • Nightmares • Excitability • Agoraphobia • Social phobia • Obsessions • Rage, aggression • Irritability	• Agitation • Tremor • Headache • Weakness • Dizziness • Nausea • Vomiting • Diarrhoea • Constipation • Palpitations • Rashes • Tingling, numbness, altered sensation • Fatigue • Flu-like symptoms	• Hypersensitivity to sound, light, touch, taste • Abnormal body sensation eg itching, pain, stiffness, blurred vision, paraesthesia, muscle twitching, tinnitus, burning sensations • Feeling self or world to be abnormal (depersonalisation or derealisation)	• Fits (1–2% of patients) • Delirium (rare) • Transient hallucinations (visual, tactile, auditory) or illusions (rare) • Psychosis (very rare)

Reproduced with permission from Ford C, Law F. Guidance for the use and reduction of misuse of benzodiazepine prescribing and other hypnotics and anxiolytics in general practice. 2014.[38]

Protracted benzodiazepine withdrawal symptoms include:[30]

- anxiety
- depression
- diarrhoea, constipation, bloating
- insomnia
- irritability
- muscle aches
- poor concentration and memory
- restlessness
- less commonly, perceptual disturbances and panic attacks
- occasionally, seizures and symptoms of psychosis.

The symptoms and duration of benzodiazepine withdrawal can vary, mostly impacted by the level of dose reduction. Although, other contributing factors can include a history of polydrug dependence, seizures, anxiety, depression or trauma, or when the total daily dose is not clear (due to doctor shopping or illegal purchase).

5.2.1 Patients taking 'therapeutic doses'

For patients who have early/mild dependence, minimal interventions such as advisory letters, other information provision or GP advice should be offered. Where dependence is established, gradual dose reduction of prescribed benzodiazepine is recommended (both grade A recommendations from the British Association for Psychopharmacology).[153]

Switching from a short half-life benzodiazepine to a long half-life benzodiazepine before gradual taper should be reserved for patients having problematic withdrawal symptoms on reduction (grade D recommendation from the British Association for Psychopharmacology).[153]

Additional psychological therapies increase the effectiveness of gradual dose reduction, particularly in patients with insomnia and panic disorder. Consideration should be given to targeted use of these interventions (grade B recommendation from the British Association for Psychopharmacology).[153]

5.2.2 Patient taking high doses of benzodiazepines or who are users of illicit drugs (polydrug users)

So called 'harm-reduction dosing' or maintenance prescribing of benzodiazepines for patients using polydrugs cannot be recommended on the basis of existing evidence, as prescribing benzodiazepines does not appear to prevent use of other drugs.[153] There are some evidence that maintenance dosing of benzodiazepines may reduce high-dose problematic benzodiazepine use in some patients (grade D recommendation from the British Association for Psychopharmacology).[153]

5.3 General principles for the management of withdrawal of benzodiazepines

If dependence on benzodiazepines has become established, it is often difficult to treat and can become a long-term, distressing problem.[25] All patients with dependence should be encouraged to discontinue the drug and offered a detoxification program at regular intervals. For some patients, discontinuation will be difficult, but the effort should be made. For other patients, a reduction in dose, rather than discontinuation, will be the first goal.

Evidence-based recommendations for general practice management of benzodiazepine withdrawal are difficult due to a lack of data. The following are general principles:

- Review the patients' prescription records and discuss the situation to those receiving long-term benzodiazepines.
- Send patients letters suggesting methods of tapering off benzodiazepines (this may be enough to motivate them to withdraw).
- Teach patients ways to deal with anxiety and insomnia (either as primary conditions or due to withdrawal).
- Acknowledge that withdrawing from benzodiazepines can be stressful.
- Encourage family and friends to provide encouragement and practical help during withdrawal.
- Refer patients to appropriate services (eg psychologist or support groups). Only refer to drug or alcohol dependence services if the service has shown specific interest in benzodiazepine dependence or the patient also has a drug or alcohol problem.
- Advise patients to make changes in lifestyle such as regular exercise.
- Advise patients to avoid alcohol.
- Advise patients to avoid mild stimulants (eg coffee and chocolate [theobromine]) as these can cause anxiety, panic and insomnia.
- Postpone advice on smoking cessation until after the benzodiazepine has been withdrawn.[189]

Benzodiazepine reduction requires a team approach with regular communication between the prescriber and other practitioners involved in the patient's care (eg pharmacist, counsellor, psychiatrist, addiction services).

5.4 Tapering dosing

The clearest strategy for withdrawing benzodiazepines in primary care is to taper the medication.[189]

Slow discontinuation of benzodiazepines is recommended to avoid withdrawal symptoms (eg rebound anxiety, agitation, insomnia or seizures) particularly when use exceeds 8 weeks. However, clear evidence for the optimal rate of tapering is lacking. The British National Formulary recommends a minimum of 6 weeks,[190] while Lader recommends a maximum of 6 months.[189] The exact rate of reduction should be individualised according to the drug, dose and duration of treatment (refer to *Table 5*).

Two-thirds of patients can achieve cessation with gradual reduction of dose alone. Others need additional psychological therapies and a limited number of patients benefit from additional pharmacotherapy.[191] CBT performed in a single, extended (20-minute) consultation with a GP, with a handout, has been shown to increase non-use at 1 year from 15% to 45%.[192] A systematic review comparing routine care to brief interventions, gradual dose reduction and psychological interventions found all interventions increased benzodiazepine discontinuation over routine care, with gradual dose reduction plus psychological interventions the most effective.[191]

All patients on a reduction regime must obtain prescriptions from one prescriber and through one pharmacy, where time-limited dispensing may be required (eg once or twice a week at a specified time). Plans should be in place to cover absences of the usual prescribing doctor from the practice. Consider working closely with the patient's pharmacist with staged supply or supervised dosing to assist the patient with dose reduction and cessation, if they are unable to manage this themselves.

Table 5. Recommendations for tapering benzodiazepines		
Duration of use	**Recommended taper length**	**Comments**
<6 to 8 weeks	Taper may not be required	Depending on clinical judgment and patient stability/preference, consider implementing a taper, particularly if using a high-dose benzodiazepine or an agent with a short or intermediate half-life, such as alprazolam or triazolam
8 weeks to 6 months	Slowly over 2–3 weeks	Go slower during latter half of taper. Tapering will reduce, not eliminate, withdrawal symptoms. Patients should avoid alcohol and stimulants during benzodiazepine withdrawal
6 months to 1 year	Slowly over 4–8 weeks	
>1 year	Slowly over 2–4 months	

A common first step in withdrawal is to substitute diazepam for the benzodiazepine being taken.[189] The slower elimination of diazepam creates a smoother taper in blood level.[102]

Refer to *Resource D.2B* for withdrawal protocols.

5.5 Additional pharmacotherapies

Pharmacotherapy interventions have limited use in benzodiazepine withdrawal. Generally, other drugs are used to address symptoms rather than substitute for benzodiazepines.

Carbamazepine – Carbamazepine has shown some usefulness, however, there is not enough evidence to recommend its use.[193]

Antidepressants – There is limited evidence that antidepressants help in benzodiazepine withdrawal, unless depression (or anxiety disorders/panic disorders) are present or emerge during withdrawal.[191,193]

Melatonin – Melatonin may help benzodiazepine reduction in older people with insomnia.[194]

5.6 Should every patient be withdrawn?

There may be a small number of patients whose quality of life improves with the stable use of benzodiazepines. This may justify long-term therapy. The decision to continue long-term benzodiazepine treatment needs to be clearly documented. The decision may also involve a second opinion by a specialist in an area relevant to the patient's needs. These patients still require regular, ongoing review and re-assessment of the risks and benefits of benzodiazepine use.

Attempts at withdrawal are more likely to succeed if the patient is able to contemplate the ultimate goal of cessation, and the doctor and patient are able to work together in a productive therapeutic relationship to achieve this.

Some patients struggle to reduce and cease benzodiazepine use. However, this group can often reduce their daily dose markedly and this is accompanied by a decrease in risk and side effects. They may continue on low-dose benzodiazepines (eg 2–5 mg diazepam daily) for an extended period. Continued regular review may assist in the majority who will successfully cease benzodiazepines in the longer term. This decision should be made on a case-by-case basis.

For patients who have complex, multiple morbidities, GPs should seek advice from mental health and addiction specialists, as well as other relevant specialists (eg neurologists) to assist with development of the best plan to assist the patient.

D.2 Benzodiazepine reduction in the practice population

D.2A Practice letter to patients about benzodiazepine reduction

[*Insert practice name*]

Address

Date

Dear [*Patient name*]

We are currently undertaking a review of prescriptions for medications collectively known as benzodiazepines and sleeping tablets. I am writing to you because our records show that you have received a number of prescriptions for one or more of these types of medications in the past 12 months.

A growing body of evidence suggests that if these medications are used for long periods, they can have harmful side effects, including anxiety symptoms, memory and sleep problems, and they can be addictive. We do not recommend long-term use.

We are writing to ask you to consider cutting down your dose of tablets and perhaps stopping them completely at some time in the future. As each person is different, we would like to discuss this with you in person within the next 3 months.

The best way to cut down your tablets is to take them only when you feel they are absolutely necessary. It is best to cut down gradually; otherwise you may have some withdrawal side effects. You should not stop your tablets suddenly. Once you start to reduce your dose you may start to notice that you feel a lot better and you may be able to think about stopping altogether.

Please make an appointment with your GP to discuss this further. If you have not attended to discuss this within the next 3 months, we may not be able to continue to prescribe this medicine for you. If you have already discussed this with your doctor, or have stopped your medications, this letter does not apply to you.

Yours sincerely,

[*Dr name*]

D.2B Practice guide to reduction and withdrawal of benzodiazepines (and Z drugs) in the practice population

- Print a list of patients on repeat prescriptions for benzodiazepines (and Z drugs).
- Identify patients who have repeat prescriptions (including repeat acute prescriptions) of hypnotics and anxiolytics. In agreement with the general practitioner (GP), remove drug repeats for patients who have not ordered a prescription within the last 6 months.
- Agree on exclusion criteria (with GP) to identify patients not suitable for withdrawal, for example:
  - drug or alcohol problems, unless GP advises otherwise
  - terminal illness
  - acute crisis
  - risk of suicide
  - severe mental illness (liaise with psychiatrist)
  - organic brain disease
  - epilepsy requiring benzodiazepines as part of anticonvulsant therapy
  - benzodiazepine prescriptions for muscle spasm.
- The GP(s) should agree on the final list of patients to be included in the scheme.

- Invite the patient to discuss a supported withdrawal regime. If the withdrawal is to be managed by a GP, then it would be beneficial for the patient to see the same doctor throughout the process.
- Prior to the consultation, use computer records and/or paper notes to gather the required information to complete the patient clinical summary. Send the patient self-help information on sleep and relaxation.
- In the initial consultation with the patient, reiterate the benefits of withdrawing from benzodiazepines and explain the possible treatment withdrawal regimes.
- Find out how often the patient takes the hypnotic/anxiolytic, as some patients stockpile these medicines and never take them, some only take them occasionally, whereas others may give them to someone else. The anxiolytic/hypnotic can be stopped in these patients.
- If the patient agrees to participate in the scheme, agree on a treatment regime and arrange a follow-up appointment.
- Record the agreed plan in the patient-held record sheet. Provide the patient with information leaflets regarding non-drug alternatives to reduce anxiety and sleep problems.
- Following the consultation, document the outcome on the patient's electronic record and in the paper notes. Print out a prescription if one is required (leave the prescription for the GP to sign with the clinical summary sheet).
- In the patient's clinical summary sheet, complete the outcome box and pass it to the responsible GP. Once the GP has read it, they should initial it and pass it to the receptionist for filing in the patient's notes.
- Explain the intervention to local pharmacies to ensure a consistent message is conveyed to patients.
- Ensure the patient fully understands how prescriptions will be issued and that all practice staff are briefed on this.
- Offer patients general support if they call the practice for advice. If the patient wishes, arrange for an appointment to explain the program.
- If the patient is not suitable for withdrawal, consider whether no action should be taken, or to refer to the substance misuse services or psychiatric services.
- Classify your patient on your computer system in order to make identification easier. Everyone withdrawing from hypnotics/anxiolytics should have this added to their record.

Reduction protocols to support the withdrawal from hypnotics

Different withdrawal plans are given for guidance only. The rate of withdrawal should be individualised according to the drug, dose and duration of treatment. Patient factors such as personality, lifestyle, previous experiences and specific vulnerabilities should also be taken into account.

- Throughout the process, it is important to provide advice on good sleep hygiene and basic measures to reduce anxiety.
- At each stage, enquire about general progress and withdrawal symptoms.
- If patients experience difficulties with a dose reduction, encourage them to persevere and suggest delaying the next step down. Do not revert to a higher dose.
- Offer information leaflets to help with the withdrawal program.
- Reassure patients that if they are experiencing any difficulties with the withdrawal schedule, they can contact the practice for advice.
- A copy of the protocol should be given to the patient and the patient's pharmacy. A copy should be also kept in the practice's records.

Examples of hypnotic withdrawal schedules

To be adapted and adjusted according to individual patient needs.

Nitrazepam

Start from the most relevant point of the schedule based on the patient's current dose.

Note that the dosage reduction withdrawal schedule is flexible and should be tailored to individual patients.

Table D.2.1. Sample nitrazepam withdrawal schedule

	Dose of nitrazepam	Number of 5 mg tablets/day	Number of 5 mg tablets/week
Starting dose	20 mg	4	28
Stage 1 (1–2 weeks)	15 mg	3	21
Stage 2 (1–2 weeks)	12.5 mg	2½	18
Stage 3 (1–2 weeks)	10 mg	2	14
Stage 4 (1–2 weeks)	7.5 mg	1½	11
Stage 5 (1–2 weeks)	5 mg	1	7
Stage 6 (1–2 weeks)	2.5 mg	½	4
Stage 7 (1–2 weeks)	2.5 mg *alternate nights*	½	2
Stage 8	Stop nitrazepam		

Temazepam

Start from the most relevant point of the schedule based on the patient's current dose.

Note that the dosage reduction withdrawal schedule is flexible and should be tailored to each individual patient.

Table D.2.2. Sample temazepam withdrawal schedule

	Dose of temazepam	Number of 10 mg tablets/day	Number of 10 mg tablets/week
Starting dose	30 mg	3	21
Stage 1 (1–2 weeks)	25 mg	2½	18
Stage 2 (1–2 weeks)	20 mg	2	14
Stage 3 (1–2 weeks)	15 mg	1½	11
Stage 4 (1–2 weeks)	10 mg	1	7
Stage 5 (1–2 weeks)	5 mg	½	4
Stage 6 (1–2 weeks)	5 mg *alternate nights*	½	2
Stage 7	Stop temazepam		

Zopiclone

Start from the most relevant point of the schedule based on the patient's current dose.

Note that the dosage reduction withdrawal schedule is flexible and should be tailored to each individual patient.

Table D.2.3. Sample zopiclone withdrawal schedule

	Dose of zopiclone	Number of tablets/ day	Number of tablets/ week
Starting dose	15 mg	2 x 7.5 mg	14 x 7.5 mg
Stage 1 (1–2 weeks)	11.25 mg	1 x 7.5 mg 1 x 3.75 mg	7 x 7.5 mg 7 x 3.75 mg
Stage 2 (1–2 weeks)	7.5 mg	1 x 7.5 mg	7 x 7.5 mg
Stage 3 (1–2 weeks)	3.75 mg	1 x 3.75 mg	7 x 3.75 mg
Stage 4 (1–2 weeks)	3.75 mg *alternate nights*	1 x 3.75 mg	4 x 3.75 mg
Stage 5	Stop zopiclone		

Zolpidem

Start from the most relevant point of the schedule based on the patient's current dose.

Note that the dosage reduction withdrawal schedule is flexible and should be tailored to each individual patient.

Table D.2.4. Sample zolpidem withdrawal schedule

	Dose of zolpidem	Number of 5 mg tablets/day	Number of 5 mg tablets/week
Starting dose	10 mg	2	14
Stage 1 (1–2 weeks)	7.5 mg	1½	11
Stage 2 (1–2 weeks)	5 mg	1	7
Stage 3 (1–2 weeks)	2.5 mg	½	4
Stage 4 (1–2 weeks)	2.5 mg *alternate nights*	½	2
Stage 5	Stop zolpidem		

Reduction protocols for anxiolytics

Different withdrawal plans are given for guidance only. The rate of withdrawal should be individualised according to the drug, dose and duration of treatment. Patient factors such as personality, lifestyle, previous experiences and specific vulnerabilities should also be taken into account.

- Throughout the process, it is important to provide advice on good sleep hygiene and basic measures to reduce anxiety.
- At each stage, enquire about general progress and withdrawal symptoms.
- If patients experience difficulties with a dose reduction, encourage them to persevere and suggest delaying the next step down. Do not revert to a higher dosage.
- Offer information leaflets to help with the withdrawal program.
- Reassure patients that if they are experiencing any difficulties with the withdrawal schedule, they can contact the practice for advice.
- Give the patient and the patient's pharmacy a copy of the protocol. Keep a copy in the practice's records.
- If a patient has complex needs, refer to appropriate specialist services for further advice.
- Lorazepam and oxazepam have short half-lives making withdrawal effects more pronounced. Patients treated with these drugs may need to be converted to diazepam during the withdrawal process. Initial dose reductions should be made using their current medication, followed by conversion to diazepam, and subsequent reduction of the diazepam dose according to the following schedules.

Note: Some patients will prefer to remain on the original drug for the duration of the withdrawal.

Table D.2.5. Diazepam equivalent doses

Approximate equivalent doses to diazepam 5 mg	
Lorazepam	0.5 mg
Oxazepam	15 mg
Clonazepam	0.25 mg

Resource D.2B is adapted with permission from Educational pack – Material to support appropriate prescribing of hypnotics and anxiolytics across Wales – Welsh Medicines Partnership, April 2011. For more information visit: http://awttc.org/about_wmp.html