# APPENDIX 5. HYPNOTIC AND ANXIOLYTIC REDUCTION/WITHDRAWAL RESOURCES

## 5a) Example of guidelines for reduction/withdrawal of hypnotics and anxiolytics

* Print out a computer list of patients on repeat prescriptions for anxiolytics and hypnotics.
  + **Hypnotics**
  + Temazepam
  + Nitrazepam
  + Zopiclone
  + Zolpidem
  + Loprazolam
  + Lormetazepam
  + **Anxiolytics**
  + Diazepam
  + Chlordiazepoxide
  + Lorazepam
  + Oxazepam
* Identify those patients who have repeat prescriptions (including repeat acute prescriptions) of hypnotics and anxiolytics. Patients who have not ordered a prescription within the last 6 months should have the drug removed from repeat (with GP agreement).
* 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
  + Where benzodiazepines are being prescribed for muscle spasm.
* The GP should agree the final list of patients to be included in the scheme.
* Invite the patient to discuss a supported withdrawal regimen. 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 the computer records and/or paper notes to gather the required information to complete the patient clinical summary. Send the patient self-help on sleep and relaxation.
* In the initial consultation with the patient reiterate the benefits of withdrawing from benzodiazepines and explain the possible treatment withdrawal regimens.
* 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. Urine testing for benzodiazepines will help confirm whether patients are taking the drugs on a regular basis.
* If the patient agrees to participate in the scheme, agree on a treatment regimen and arrange a follow-up appointment.
* Record the agreed plan in the patient held record sheet. Provide patient with information leaflets regarding non-drug alternatives to reduce anxiety and sleep problems.
* Following the consultation, document the outcome in the patient’s medical notes. Print out a prescription if one is required (leave prescription for GP to sign with clinical summary sheet).
* In the patient clinical summary sheet complete the outcome box and pass to the responsible GP. Once the GP has read it, they should initial it and record in the patient’s medical notes.
* With the patient’s consent, explain the intervention to local pharmacies and other relevant stakeholders (e.g. out of hours services) 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. WP10MDA prescriptions may be helpful for patients who have difficulty managing the dose reduction themselves.
* If the patient is suitable for a managed withdrawal regimen follow the flow chart in the guidelines and refer to Appendices 5k and 5l for examples of withdrawal schedules.
* Offer patients general support if they call the practice for advice. If patient wishes, arrange for an appointment to explain the programme.
* If the patient is not suitable for withdrawal consider whether not to take action or to refer to the substance misuse services or to psychiatric services.
* Classify your patient by Read code on your computer system in order to make identification easier. Everyone withdrawing from hypnotics/anxiolytics should have this added to their record.

## 5b) Example of an anxiolytic and hypnotic audit

|  |
| --- |
| **Practice Agreement Form** |

|  |
| --- |
| **Start date:** |

**Authorisation (all partners to sign)**

I agree to give permission to the prescribing support pharmacist/technician/lead nurse (delete as applicable) to view patients’ medical records and the data contained on the prescribing system.

I agree to allow my patients to participate in the ………………………………in accordance with the criteria specified in the audit document.

|  |
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| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_ |
| **Signature of prescribing support pharmacist/lead nurse**  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_  **Signature of head of pharmacy and medicines management**  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_ |

**Anxiolytic/hypnotic audit**

The audit will assess current practice and identify patients suitable for intervention. Selected patients will receive a letter explaining the side effects and advising the need for a drug dose reduction. Previous studies have shown that some patients will reduce the use of hypnotics and anxiolytics without further intervention, and others will see their GP to discuss the matter. A re-audit to assess the effect of the changes will be undertaken.

**Aims and objectives**

The aim of the audit is to ensure the practice has a policy in place to:

* review patients receiving long-term hypnotics or anxiolytics and identify those who are suitable for dose reduction.
* ensure that the prescribing of newly initiated anxiolytics and hypnotics is in line with the GP practice policy regarding the use of these drugs.

**Audit criteria**

* Patients have a documented indication for using a hypnotic or anxiolytic.
* Documentation (patient records) demonstrates that advice was provided on non-drug therapies for insomnia and anxiety.
* Patients not previously taking a regular anxiolytic/hypnotic shouldn’t be prescribed more than a short (e.g. 1–2 weeks) course of any benzodiazepine or z-drug.
* Patients are advised about the potential for dependence and this is documented in their records.
* Patients are seen by a GP before a second prescription is issued.
* Prescription of benzodiazepines or z-drugs should only be issued by a generalist GP for:
  + those patients on a short course that will be stopped;
  + those who are actively reducing with no problems;
  + those who have been referred to a specialist service because of problems and are now on a reducing course and are stable;
  + those who have been assessed as needing to stay on these drugs for medical/psychiatric reasons.

**Standards**

100% of patients should be identified for consideration

**Audit method**

* Identify all patients on prescriptions for hypnotics and anxiolytics (include repeats and repeat acutes).
* Hypnotics/anxiolytics include: nitrazepam, loprazolam, lormetazepam, temazepam, diazepam, chlordiazepoxide, lorazepam, oxazepam, zolpidem, zopiclone.
* Complete data collection form using patient computer records.
* Determine the duration that patients have been taking the drug.
* Examine records to see if patients have a contraindication to reduction.
* Re-audit in 6 months to look at progress (using the follow up data collection form). This will identify any patients who have changed back or new patients that have been prescribed the drugs since the first audit.

**Hypnotics and anxiolytics audit – Data collection form**

**Practice** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient ID** | **Drug/Dose** | **Length of treatment**  **(wks)** | **Documented indication**  **Y/N** | **Advised on non-drug treatment**  **Y/N** | **Advised on potential for dependence**  **Y/N** | **Initial Rx for less than 14 days**  **Y/N** | **Seen by GP before 2nd Rx**  **Y/N** | **Assessed for withdrawal in last 12 months**  **Y/N** | **C/I to reduction**  **Y/N**  **(reason)** | ***Action:***  **1 – Letter**  **2 – See GP**  **3 – Refer to SMS**  **4 – Refer to Psychiatric services**  **5 – No action** |
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**Review of original patients after 6 months**

**Practice** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient ID** | **Drug** | **Initial dosage**  **(mg diazepam equivalent/day)** | **Dosage after 6 months**  **(mg diazepam equivalents/day)** | **% Reduction** | **Seen by SMS**  **(if originally referred)**  **Y/N** | **Seen by psychiatric services (if originally referred)**  **Y/N** | **Outcome following referral to SMS or psychiatric services**  **1 – No action**  **2 – Withdrawal programme**  **3 – Specific recommendations** |
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**Audit results**

* Number of patients on repeat prescriptions for anxiolytics or hypnotics...............
* Number of patients with documented indication..................
* Number of patients advised on non-drug treatment................
* Number of patients advised on the potential for dependence..............
* Number of patients that had an initial prescription for 14 days or less...............
* Number of patients seen by GP before second prescription issued..............
* Number of patients assessed for withdrawal in the last 12 months...............
* Number of patients with more than 28 days drug supply on repeat prescription...............

**Action taken**

* Number of patients sent a letter.................
* Number of patients that have been asked to see GP.............
* Number of patients referred to substance misuse service or secondary care..............
* Number of patients to continue current treatment.................

**Action Plan/Points**

|  |  |
| --- | --- |
| **Action points** | **Date completed** |
| 1 All prescribers informed of results  [Please add your own planned actions here] |  |

**Re-audit date:**

## 5c) Example of a letter for community pharmacists

**Practice name and address**

Dear Colleague

We are working with patients to reduce their hypnotic and anxiolytic drug usage.

As you are aware, NICE guidelines do not advise long-term use of these drugs and recommend they should only be given for a maximum period of four weeks. We will be reducing prescriptions to two-week supplies and would be grateful if you could assist in helping any affected patients with any queries they may have.

If you would like to discuss this in further detail please do not hesitate to contact us.

We have enclosed a copy of the letter that will be sent to patients informing them of this policy along with copies of sleep and relaxation self-help information.

Yours sincerely

## 5d) Examples of patient letters to review hypnotic and/or anxiolytic treatment

### i) Removal of benzodiazepines/z-drugs from repeat prescriptions

**Practice name and address**

Dear ………………………………..

I note from our records that you have been taking ………….………………………… tablets, but have not requested a supply since …………………………

I will be removing these tablets from your repeat prescription list, but if you feel that you need to take them again please make an appointment to see me.

Yours sincerely

### ii) Patient-initiated withdrawal

**Practice name and address**

Dear ………………………

I note from our records that you have been taking ………………………………. tablets for some time now. There has been increasing concern about sleeping and anxiety drugs (such as ……………………………) when they are taken for long periods of time. National guidelines state they should not be used for more than four weeks, the Welsh Government and health board are advising that use of this medication should be reduced. This is because:

* with time your body adapts to these drugs and they become less effective (tolerance develops);
* taking them for long periods can worsen anxiety and sleeplessness;
* these drugs may cause drowsiness, clumsiness and confusion. You may not be safe to drive or to operate machinery. They may also lead to falls (and fractures), particularly in elderly people;
* these drugs are addictive.

Our aim is to help you become less reliant on the tablets and to reduce the amount you are taking, with the possibility of stopping them completely at a future date. However, stopping this treatment suddenly can lead to unpleasant withdrawal symptoms and therefore needs to be done in a very gradual and controlled way. We plan to reduce your prescription over the next few months and monitor your progress as part of the practice’s medication review process.

We would like you to consider only taking the tablets when absolutely necessary in order to reduce the number of tablets you currently use.

I have enclosed some leaflets to explain why we are doing this and to help you gradually cut down the number of tablets you take. If you would like further help or advice please feel free to contact me at the practice.

If you have any other queries or concerns please do not hesitate to contact the practice to discuss them.

Yours sincerely

### iii) Practice-initiated withdrawal

**Practice name and address**

Dear ………………………

I note from our records that you have been taking ………………………………. tablets for some time now. There has been increasing concern about sleeping and anxiety drugs (such as ……………………………) when they are taken for long periods of time. National guidelines state they should not be used for more than four weeks, and the Welsh Government and health board are advising that use of this medication should be reduced. This is because:

* with time your body adapts to these drugs and they become less effective (tolerance develops);
* taking them for long periods can worsen anxiety and sleeplessness;
* these drugs may cause drowsiness, clumsiness and confusion. You may not be safe to drive or to operate machinery. They may also lead to falls (and fractures), particularly in elderly people;
* these drugs are addictive.

Our aim is to help you become less reliant on the tablets and to reduce the amount you are taking, with the possibility of stopping them completely at a future date. However, stopping this treatment suddenly can lead to unpleasant withdrawal symptoms and therefore needs to be done in a very gradual and controlled way. We plan to reduce your prescription over the next few months and monitor your progress as part of the practice’s medication review process.

To encourage you to do this we have produced a withdrawal programme for you, which we would like you to follow. This will be attached to your next prescription, which will be for a 14-day supply of tablets.

If you have any queries or concerns please contact the practice to discuss them.

Yours sincerely

### iv) Clinic appointment

**Practice name and address**

Dear ………………………

I note from our records that you have been taking ………………………………. tablets for some time now. There has been increasing concern about sleeping and anxiety drugs (such as ……………………………) when they are taken for long periods of time. National guidelines state they should not be used for more than four weeks, the Welsh Assembly Government and health board are advising that use of this medication should be reduced. This is because:

* with time your body adapts to these drugs and they become less effective (tolerance develops);
* taking them for long periods can worsen anxiety and sleeplessness;
* these drugs may cause drowsiness, clumsiness and confusion. You may not be safe to drive or to operate machinery. They may also lead to falls (and fractures), particularly in elderly people;
* these drugs are addictive.

Our aim is to help you become less reliant on the tablets and to reduce the amount you are taking, with the possibility of stopping them completely at a future date. However, stopping this treatment suddenly can lead to unpleasant withdrawal symptoms and therefore needs to be done in a very gradual and controlled way. We plan to reduce your prescription over the next few months and monitor your progress as part of the practice’s medication review process.

To encourage you to do this the practice is setting up a clinic for patients to discuss the long-term use of sleeping and anxiety tablets. …………………………………………., will be running the clinic, and I have made an appointment for you to see them on the …………………………….… at………………….. If this is inconvenient please telephone the practice to re-arrange your appointment.

If you have any other queries or concerns please contact the practice to discuss them.

Yours sincerely

### v) Pharmacist-led clinic

**Practice name and address**

Dear ………………………

I note from our records that you have been taking ………………………………. tablets for some time now. There has been increasing concern about sleeping and anxiety drugs (such as ……………………………) when they are taken for long periods of time. This is because:

* with time your body adapts to these drugs and they become less effective (tolerance develops).
* taking them for long periods can worsen anxiety and sleeplessness.
* these drugs may cause drowsiness, clumsiness and confusion. You may not be safe to drive or to operate machinery. They may also lead to falls (and fractures), particularly in elderly people.
* these drugs are addictive.

Our aim is to help you become less reliant on the tablets and to reduce the amount you are taking, with the possibility of stopping them completely at a future date. However, stopping this treatment suddenly can lead to unpleasant side effects (withdrawal symptoms) and therefore needs to be done in a very gradual and controlled way.

We plan to change your prescription over the next few months to gradually withdraw you from them. This will reduce the risks associated with taking these tablets regularly. We will also monitor your progress as part of the practice’s medication review process.

To encourage you to do this a pharmacist (employed by the health board) will be working with the surgery to provide a support service for patients who are taking medication for anxiety or to help them sleep. A clinic will take place at the surgery each……….., and we would encourage you to make an appointment to discuss your progress and any concerns you may have.

If you have any other queries or concerns please contact the practice to discuss them.

Yours sincerely

### vi) Request to make a GP appointment

**Practice name and address**

Dear ………………………

I note from our records that you have been taking ………………………………. tablets for some time now. There has been increasing concern about sleeping and anxiety drugs (such as ……………………………) when they are taken for long periods of time. National guidelines state they should not be used for more than four weeks, and the Welsh Assembly Government and health board are advising that use of this medication should be reduced. This is because:

* with time your body adapts to these drugs and they become less effective (tolerance develops);
* taking them for long periods can worsen anxiety and sleeplessness;
* these drugs may cause drowsiness, clumsiness and confusion. You may not be safe to drive or to operate machinery. They may also lead to falls (and fractures), particularly in elderly people;
* these drugs are addictive.

Our aim is to help you become less reliant on the tablets and to reduce the amount you are taking, with the possibility of stopping them completely at a future date. However, stopping this treatment suddenly can lead to unpleasant withdrawal symptoms and therefore needs to be done in a very gradual and controlled way. We plan to reduce your prescription over the next few months and monitor your progress as part of the practice’s medication review process.

To encourage you to do this, the practice has removed sleeping and anxiety medicines from the repeat medication system. This means that patients like yourself, who currently order their prescriptions for these medicines without seeing the doctor, will now have to make an appointment to discuss a very gradual and supported withdrawal. If you do not make an appointment you will not receive a further prescription for your sleeping and/or anxiety medication. Medication for other conditions will not be affected.

We would be grateful if you could therefore make an appointment to discuss your……tablets/capsules with us. The receptionists are aware of this letter and will help you as much as possible in booking you an appointment.

If you have any other queries or concerns please contact the practice to discuss them.

Yours sincerely

## 5e) Stopping your medicine: benzodiazepines and z-drugs. A guide for patients

***What are benzodiazepines and z-drugs, and why are they used?***

Benzodiazepines are a group of medicines that can be prescribed for short periods to help with sleeping problems or to help with episodes of severe anxiety. Examples include temazepam and nitrazepam for sleeping problems, and diazepam and lorazepam for anxiety.

Z-drugs act in a similar way to benzodiazepines and are used to help with sleeping problems. Examples of z-drugs are zolpidem and zopiclone.

Benzodiazepines and z-drugs are only available on prescription and must only be taken by the person they were prescribed for.

Benzodiazepines and z-drugs often work well for a short period of two to four weeks, but if you use them for longer, the medicine may lose its effect and you may become dependent on it.

***What are the side effects of taking benzodiazepines and z-drugs?***

Benzodiazepines and z-drugs act on the brain and may therefore:

* affect your memory and concentration
* make you feel confused or irritable
* make you feel drowsy
* make you more likely to have a fall
* make you more likely to have an accident, either at home, work or in the car.

***Why should I stop taking a benzodiazepine or z-drug?***

There are many good reasons why you should stop taking your benzodiazepine or z-drug:

* If you have used it for a long time and the medicine has lost its effect, it will no longer help with the condition you are taking it for.
* You may become, or may have already become, dependent on it. If you stop, you will have fewer side effects, so you will be:
  + More alert and able to concentrate
  + Less drowsy
  + Less irritable and depressed
  + Less likely to have an accident when driving

***How should I stop taking my benzodiazepine or z-drug?***

1. **DO NOT stop taking your medicine suddenly**

You should discuss stopping your medicine with your doctor, pharmacist or practice nurse to make sure that you reduce your dose slowly. Different people will need to reduce their dose at different speeds. Once you have decided to stop, it is important that you make this a slow gradual process, as this will give you a better chance of long-term success. It is important that you take it at your own pace – one that feels right for you.

1. **Plan how you will reduce and stop**

Your doctor, pharmacist or practice nurse will give you advice on how you should reduce the dose of your medicine and help you think about other ways of dealing with your worries/sleep problems. Depending on which medicine you are taking, it may be easier to withdraw if you change to diazepam tablets. Diazepam tablets are available in a number of different strengths, which makes it easier to reduce your dose more slowly. Your doctor, pharmacist or practice nurse will let you know if you can change to diazepam and will tell you how you can reduce your dose. Most people find that about one to two weeks between each dose reduction works for them, but everyone should find their own level.

1. **Keep a diary**

Keeping a diary can help as it records your progress and achievements. This will give you more confidence and encouragement to carry on.

1. **Don’t go back!**

When people begin to reduce their dose, they often become more able to deal with normal day-to-day events and may feel much better. However, it is also common to have a bad patch at some time during the process. If you feel you are going through a bad patch, stick with the current dose until you feel ready to reduce again; this may take several weeks but it is important that you take it at your own pace. Any reduction in dose is a step in the right direction.

1. **Be aware of possible side effects**

If your medicine is reduced slowly it is unlikely that you will have any side effects, but it is a good idea to be aware of possible side effects as they will tell you that you may need to reduce more slowly:

* *Aches and pains* can be common when reducing the dose of benzodiazepines and z-drugs; taking painkillers can help you feel better.
* *Sleeping problems* may occur when reducing your dose, so it is important to get some exercise as this can help you sleep. Try not to worry about not sleeping; the more you worry about not getting sleep, the less sleep you are likely to get.
* *Stomach and bowel problems*, such as diarrhoea and irritable bowel syndrome may occur. These symptoms usually disappear after stopping the medicine completely, but you may wish to discuss them with your doctor or pharmacist.
* *Sinus problems* can cause sinus pain; taking painkillers can help.
* *Vivid dreams and nightmares* may occur. As you reduce your dose, your dreaming will return and although they may sometimes be disturbing, it is a sign that your sleep is returning to normal and that your body is re-adjusting successfully.
* *Hot flushes and shivering*. The feeling of burning and extreme heat and sweating is also common, while some people can suddenly feel cold.
* *Panic attacks* can be very distressing but they are never fatal and usually last no more than 30 minutes. Getting control of your breathing by taking slower and deeper breaths will help you feel less panic.
* *Anxiety may be* mistaken for the condition that your medicine was prescribed for in the first place.
* *Agoraphobia* can make you feel unable to go out on your own, or can simply mean not wanting to go out even though you are able to with effort. Usually, as you continue to reduce your dose, these feelings go away.

***With time these symptoms should pass – don’t give up. Good luck!***

## 5f) Rhoi’r gorau i’ch meddyginiaeth: bensodiasepinau a chyffuriau-z. Canllaw i gleifion

***Beth yw bensodiasepinau a chyffuriau-z a pham eu bod yn cael eu defnyddio?***

Grŵp o feddyginiaethau y gellir eu presgripsiynu am gyfnodau byr er mwyn helpu gyda phroblemau cysgu neu helpu gydag achosion o bryder difrifol yw bensodiasepinau. Mae enghreifftiau’n cynnwys temazepam a nitrazepam ar gyfer problemau cysgu, a diazepam a lorazepam ar gyfer pryder.

Mae cyffuriau-z yn gweithio mewn ffordd debyg i bensodiasepinau ac fe’u defnyddir i helpu gyda phroblemau cysgu. Enghreifftiau o gyffuriau-z yw zolpidem a zopiclone.

Dim ond ar bresgripsiwn y gellir cael bensodiasepinau a chyffuriau-z a dylid ond eu cymryd gan y person y maent wedi’u presgripsiynu ar ei gyfer.

Bydd bensodiasepinau a chyffuriau-z yn aml yn gweithio’n dda am gyfnod byr o rhwng dwy a phedair wythnos, ond os byddwch yn eu defnyddio am fwy o amser efallai y bydd y feddyginiaeth yn colli ei heffaith a gallech ddod yn ddibynnol arni.

***Beth yw sgileffeithiau cymryd bensodiasepinau a chyffuriau-z?***

Mae bensodiasepinau a chyffuriau-z yn gweithredu ar yr ymennydd a gallant felly:

* effeithio ar eich cof a’ch gallu i ganolbwyntio
* gwneud i chi deimlo’n ddryslyd neu’n bigog
* gwneud i chi deimlo’n gysglyd
* gwneud i chi fod yn fwy tebygol i gael codwm
* gwneud i chi fod yn fwy tebygol i gael damwain, naill ai yn eich cartref, yn y gwaith neu yn y car.

***Pam ddylwn i roi’r gorau i gymryd bensodiasepin neu gyffur-z?***

Mae nifer o resymau da pam y dylech roi’r gorau i gymryd eich bensodiasepin neu gyffur-z:

* Os ydych chi wedi bod yn defnyddio’r feddyginiaeth ers amser hir a’i bod wedi colli ei heffaith, ni fydd yn helpu mwyach gyda’r cyflwr rydych yn ei chymryd ar ei gyfer.
* Efallai y byddwch yn dod yn ddibynnol, neu wedi dod yn ddibynnol, ar y feddyginiaeth. Os byddwch yn rhoi’r gorau i’w chymryd fe gewch lai o sgileffeithiau, felly fe fyddwch yn:
  + fwy effro ac yn gallu canolbwyntio’n well
  + llai cysglyd
  + llai pigog ac isel eich ysbryd
  + llai tebygol o gael damwain wrth yrru

***Sut ddylwn i roi’r gorau i gymryd bensodiasepin neu gyffur-z?***

1. **PEIDIWCH â rhoi’r gorau i gymryd eich meddyginiaeth yn sydyn**

Dylech drafod roi’r gorau i gymryd eich meddyginiaeth gyda’ch meddyg, fferyllydd neu nyrs practis er mwyn gwneud yn siŵr eich bod yn lleihau eich dos yn araf. Bydd angen i wahanol bobl leihau eu dos ar gyflymder gwahanol. Unwaith eich bod wedi penderfynu rhoi’r gorau i’r feddyginiaeth, mae’n bwysig eich bod yn gwneud hon yn broses araf a graddol, gan y bydd hynny’n rhoi gwell siawns i chi gael llwyddiant yn yr hirdymor. Mae’n bwysig eich bod yn gwneud hyn wrth eich pwysau eich hun - neu’r hyn sy’n gyfforddus i chi.

1. **Cynlluniwch sut y byddwch yn lleihau ac yn rhoi’r gorau i’r feddyginiaeth**

Bydd eich meddyg, fferyllydd neu nyrs practis yn rhoi cyngor i chi ynglŷn â sut y dylech leihau dos eich meddyginiaeth ac yn eich helpu i feddwl am ffyrdd eraill o ddelio â’ch pryderon/problemau cysgu. Yn dibynnu ar pa feddyginiaeth yr ydych yn ei chymryd, gallai fod yn haws i ddiddyfnu os byddwch yn newid i dabledi diazepam. Gellir cael tabledi daiazepam mewn nifer o wahanol gryfderau, sy’n ei gwneud hi’n haws i leihau eich dos yn fwy araf. Bydd eich meddyg, fferyllydd neu nyrs practis yn rhoi gwybod i chi os gallwch newid i diazepam ac yn dweud wrthych sut i leihau eich dos. Mae’r rhan fwyaf o bobl yn teimlo bod tua wythnos neu ddwy rhwng pob lleihad mewn dos yn gweithio ar eu cyfer iddynt hwy, ond dylai pawb ddod o hyd i’w lefel ei hun.

1. **Cadw dyddiadur**

Gall cadw dyddiadur helpu gan ei fod yn cofnodi eich cynnydd a’ch cyflawniadau. Bydd hyn yn rhoi mwy o hyder ac anogaeth i chi ddal ati.

1. **Peidiwch â throi’n ôl!**

Pan fydd pobl yn dechrau lleihau eu dos, byddant yn aml yn gweld eu bod yn gallu delio’n well â digwyddiadau arferol pob dydd ac efallai y byddant yn teimlo’n llawer gwell. Fodd bynnag, mae hefyd yn gyffredin i gael cyfnod anodd ar ryw adeg yn ystod y broses. Os ydych chi’n teimlo eich bod yn mynd drwy gyfnod anodd, parhewch ar y ddos rydych arni nes eich bod yn teimlo’n barod i’w lleihau unwaith eto; gallai hyn gymryd nifer o wythnosau ond mae’n bwysig eich bod yn mynd ar eich cyflymder eich hun. Mae unrhyw leihad mewn dos yn gam yn y cyfeiriad cywir.

1. **Byddwch yn ymwybodol o sgileffeithiau posibl**

Os bydd eich meddyginiaeth yn cael ei lleihau’n raddol mae’n annhebygol y byddwch yn cael sgileffeithiau, ond mae’n syniad da bod yn ymwybodol o’r sgileffeithiau posibl gan y byddant yn dweud wrthych efallai bod angen i chi leihau’n arafach:

* Gall *dolur a phoen* fod yn gyffredin pan fyddwch yn lleihau’r dos o bensodiasepinau a chyffuriau-z; gall cymryd poenladdwyr eich helpu i deimlo’n well.
* Gall *problemau cysgu* ddigwydd wrth leihau eich dos, felly mae’n bwysig gwneud rhywfaint o ymarfer corff gan y gall hyn eich helpu i gysgu. Ceisiwch beidio â phoeni am fethu mynd i gysgu; po fwyaf y byddwch yn poeni am fethu cysgu y lleiaf o gwsg y byddwch yn debygol o’i gael.
* Gall *problemau stumog a’r coluddyn*, megis dolur rhydd a syndrom coluddyn llidus ddigwydd. Bydd y symptomau hyn fel arfer yn diflannu ar ôl rhoi’r gorau’n llwyr i’r feddyginiaeth, ond efallai y byddwch am drafod y rhain gyda’ch meddyg neu fferyllydd.
* Gall *problemau sinws* achosi poen yn y sinws; gall cymryd poenladdwyr helpu gyda hyn.
* Efallai y cewch *freuddwydion byw a hunllefau*. Wrth i chi leihau eich dos, bydd eich breuddwydio arferol yn dychwelyd ac er y gallant weithiau beri trallod, maent yn arwydd bod eich cwsg yn dychwelyd i normal a bod eich corff yn ail-addasu’n llwyddiannus.
* *Pyliau o wres a theimlo’n rhynllyd*. Mae’r teimlad o losgi a gwres eithafol a chwysu hefyd yn gyffredin, tra gall rhai pobl deimlo’n oer yn sydyn.
* Gall *cyfnodau o banig* beri trallod ond nid ydynt byth yn angheuol ac fel arfer ni fyddant yn para mwy na 30 munud. Bydd rheoli eich anadlu drwy gymryd anadliadau dyfnach yn eich helpu i deimlo llai o banig.
* Efallai y bydd *pryder* yn cael ei gamgymryd amy cyflwr y cafodd eich meddyginiaeth ei phresgripsiynu ar ei gyfer yn wreiddiol.
* Gall *agoraffobia* wneud i chi deimlo na allwch fynd allan ar eich pen eich hun, neu gall olygu nad ydych eisiau mynd allan er y gallwch wneud hynny gydag ymdrech. Fel arfer, wrth i chi barhau i leihau eich dos, bydd y teimladau hyn yn diflannu.

***Dros amser dylai’r symptomau hyn gilio – peidiwch â rhoi’r gorau iddi. Pob hwyl!***

## 5g) Patient clinical summary for hypnotic/anxiolytic withdrawal programme

|  |  |
| --- | --- |
| **Name of patient:** |  |
| **Date of birth:** |  |
| **Name of anxiolytic/hypnotic prescribed:** |  |
| **Date initiated:** |  |
| **Duration of anxiolytic/hypnotic treatment:** |  |
| **Frequency of ordering** |  |
| **Last ordered:** |  |
| **Indication:** |  |
| **Other relevant medication or medical history:** |  |
| **Allergies:** |  |
| **Previous withdrawal attempt:** |  |
| **Pharmacist recommendation:** |  |
| **Withdrawal option selected:** |  |
| **Equivalent dose of diazepam, if appropriate:** |  |

**Pharmacist signature** ………………………………….. **Date** ………………….

**GP signature** …………………………………. **Date** …………………

## 5h) Example of a patient hypnotic or anxiolytic reduction card

**This surgery has agreed with you the following reduction regimen of your medication:**

Name of patient……………………………………………………………………….

Name of usual doctor............................................................................................

Date of first appointment ......../………/………. (DD/MM/YYYY)

**Agreement to be kept by the patient (copy in the notes)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Drug name** | **Strength** | **No. of tablets/day** | **No. of weeks** | **Total number given** | **Reduction every fortnight** | **Date** |
|  |  |  |  |  |  |  |

## 5i) Example of a patient record sheet

Please bring this record sheet to each appointment.

**NAME**……………………………………………………………………………………………

**DOB**………………………………………………………………………………………………

**ADDRESS**………………………………………………………………………………………

……………………………………………………………………………………………………

**INITIAL DRUG AND DOSAGE**………………………………………………………………..

**CONVERTED DOSE OF DIAZEPAM (IF APPLICABLE)** …………………………………………………......................................................................

……………………………………………………………………………………………………

**WITHDRAWAL REGIMEN**

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | **DRUG AND DOSAGE** | **DATE FOR NEXT APPOINTMENT** | **COMMENTS** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## 5j) An example of a patient contract for hypnotic and anxiolytic withdrawal

I have discussed the gradual reduction of ……………………………and have agreed that the reduction will be carried out in the following way:

* The reduction agreed with my doctor/pharmacist will be written on the reduction card and will be kept by both of us as a record of the agreement.
* The next reduction will also be discussed and the agreement will be written on the reduction card.
* I will be able to get my prescription for this/these drugs by giving my reduction card to the receptionist with 48 hours notice.
* I will not be able to get my prescription earlier than planned without seeing my doctor to discuss why.
* If I feel that I am having problems and explain this to the receptionist, my doctor will try to see me as soon as is reasonable.
* If I am unable to resolve these problems with my doctor, I understand that I will be referred to either a voluntary agency for support or to a hospital specialist team and that my medication will not be reduced again until they have seen me.

**Patient’s signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor’s signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## 5k) 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 experience 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 programme.
* Reassure patients that if they are experiencing any difficulty with the withdrawal schedule, they can contact the surgery for advice.
* A copy of the protocol should be given to the patient and the patient’s pharmacy. A record should be kept in the patient’s medical notes, and where possible, information shared with out of hours services.

**Examples of hypnotic withdrawal schedules**

**Nitrazepam**

Start from the most relevant point of the schedule depending on the patient’s current dose.

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

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

**Temazepam**

Start from the most relevant point of the schedule depending on the patient’s current dose.

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

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

**Lormetazepam**

Start from the most relevant point of the schedule depending on the patient’s current dose.

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Dose** | **Number of 500 microgram tablets/day** | **Number of 500 microgram tablets/week** |
| **Starting dose** | Lormetazepam 1.5 mg | 3 | 21 |
| **Stage 1 (1–2 weeks)** | Lormetazepam 1 mg | 2 | 14 |
| **Stage 2 (1–2 weeks)** | Lormetazepam 500 micrograms | 1 | 7 |
| **Stage 3 (1–2 weeks)** | Lormetazepam 250 micrograms | ½ | 4 |
| **Stage 4 (1–2 weeks)** | Lormetazepam 250 micrograms *alternate nights* | ½ | 2 |
| **Stage 5** | Stop lormetazepam |  |  |

**Zopiclone**

Start from the most relevant point of the schedule depending on the patient’s current dose.

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Dose** | **Number of tablets/day** | **Number of tablets/week** |
| **Starting dose** | Zopiclone 15 mg | 2 x 7.5 mg | 14 x 7. 5 mg |
| **Stage 1 (1–2 weeks)** | Zopiclone 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)** | Zopiclone 7.5 mg | 1 x 7.5 mg | 7 x 7.5 mg |
| **Stage 3 (1–2 weeks)** | Zopiclone 3.75 mg | 1 x 3.75 mg | 7 x 3.75 mg |
| **Stage 4 (1–2 weeks)** | Zopiclone 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 depending on the patient’s current dose.

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

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

## 5l) Reduction protocols to support the withdrawal from 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 experience 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 programme.
* Reassure patients that if they are experiencing any difficulty with the withdrawal schedule, they can contact the surgery for advice.
* A copy of the protocol should be given to the patient and the patient’s pharmacy. A record should also be kept in the patient’s medical notes and where possible, information shared with out of hours services.
* 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.

|  |  |
| --- | --- |
| **Approximate equivalent doses to diazepam 5 mg** | |
| Chlordiazepoxide | 15 mg |
| Lorazepam | 500 micrograms |
| Oxazepam | 15 mg |

**Examples of anxiolytic withdrawal schedules:**

**Diazepam**

Start from the most relevant point of the schedule depending on the patient’s current dose.

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Daily dose** | **Number of tablets/day** | **Number of tablets/week** |
| **Starting dose** | Diazepam 70 mg | 7 x 10 mg | 49 x 10 mg |
| **Stage 1 (1–2 weeks)** | Diazepam 65 mg | 6 x 10 mg  1 x 5 mg | 42 x 10 mg  7 x 5 mg |
| **Stage 2 (1–2 weeks)** | Diazepam 60 mg | 6 X 10 mg | 42 x 10 mg |
| **Stage 3 (1–2 weeks)** | Diazepam 55 mg | 5 x 10 mg  1 x 5 mg | 35 x 10 mg  7 x 5 mg |
| **Stage 4 (1–2 weeks)** | Diazepam 50 mg | 5 x 10 mg | 35 x 10 mg |
| **Stage 5 (1–2 weeks)** | Diazepam 45 mg | 4 x 10 mg  1 x 5 mg | 28 x 10 mg  7 x 5 mg |
| **Stage 6 (1–2 weeks)** | Diazepam 40 mg | 4 x 10 mg | 28 x 10 mg |
| **Stage 7 (1–2 weeks)** | Diazepam 35 mg | 3 x 10 mg  1 x 5 mg | 21x 10 mg  7 x 5 mg |
| **Stage 8 (1–2 weeks)** | Diazepam 30 mg | 3 x 10 mg | 21x 10 mg |
| **Stage 9 (1–2 weeks)** | Diazepam 25 mg | 2 x 10 mg  1 x 5 mg | 14 x 10 mg  7 x 5 mg |
| **Stage 10 (1–2 weeks)** | Diazepam 20 mg | 2 x 10 mg | 14 x 10 mg |
| **Stage 11 (1–2 weeks)** | Diazepam 18 mg | 1 x 10 mg  4 x 2 mg | 7 x 10 mg  28 x 2 mg |
| **Stage 12 (1–2 weeks)** | Diazepam 16 mg | 1 x 10 mg  3 x 2 mg | 7 x 10 mg  21 x 2 mg |
| **Stage 13 (1–2 weeks)** | Diazepam 14 mg | 1 x 10 mg  2 x 2 mg | 7 x 10 mg  14 x 2 mg |
| **Stage 14 (1–2 weeks)** | Diazepam 12 mg | 1 x 10 mg  1 x 2 mg | 7 x 10 mg  7 x 2 mg |
| **Stage 15 (1–2 weeks)** | Diazepam 10 mg | 1 x 10 mg | 7 x 10 mg |
| **Stage 16 (1–2 weeks)** | Diazepam 8 mg | 4 x 2 mg | 28 x 2 mg |
| **Stage 17 (1–2 weeks)** | Diazepam 6 mg | 3 x 2 mg | 21 x 2 mg |
| **Stage 18 (1–2 weeks)** | Diazepam 4 mg | 2 x 2 mg | 14 x 2 mg |
| **Stage 19 (1–2 weeks)** | Diazepam 3 mg | 1½ x 2 mg | 11 x 2 mg |
| **Stage 20 (1–2 weeks)** | Diazepam 2 mg | 1 x 2 mg | 7 x 2 mg |
| **Stage 21 (1–2 weeks)** | Diazepam 1 mg | ½ x 2 mg | 4 x 2 mg |
| **Stage 22** | Stop |  |  |

**Lorazepam**

Start from the most relevant point of the schedule depending on the patient’s current dose.

Lorazepam has a short half-life, therefore conversion to diazepam during withdrawal may help to reduce withdrawal symptoms. Make initial dose reductions using the patient’s existing medication (see table below). Once the dose has been reduced to the equivalent of 20 mg diazepam per day, convert to diazepam and continue to reduce according to the schedule. Conversion from lorazepam to diazepam has been staggered to allow time for the patient to stabilise between dose changes.

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Daily dose** | **Number of tablets/day** | **Number of tablets/week** | **Daily diazepam equivalent** |
| **Starting dosage** | Lorazepam 6 mg | 6 × 1 mg | 42 × 1 mg | 60 mg |
| **Stage 1 (1–2 weeks)** | Lorazepam 5.5 mg | 5½ × 1 mg | 39 × 1 mg | 55 mg |
| **Stage 2 (1–2 weeks)** | Lorazepam 5 mg | 5 × 1 mg | 35 × 1 mg | 50 mg |
| **Stage 3 (1–2 weeks)** | Lorazepam 4.5 mg | 4½ × 1 mg | 32 × 1 mg | 45 mg |
| **Stage 4 (1–2 weeks)** | Lorazepam 4 mg | 4 × 1 mg | 28 × 1 mg | 40 mg |
| **Stage 5 (1–2 weeks)** | Lorazepam 3.5 mg | 3½ × 1 mg | 25 × 1 mg | 35 mg |
| **Stage 6 (1–2 weeks)** | Lorazepam 3 mg | 3 × 1 mg | 21 × 1 mg | 30 mg |
| **Stage 7 (1–2 weeks)** | Lorazepam 2.5 mg | 2½ × 1 mg | 18 × 1 mg | 25 mg |
| **Stage 8 (1–2 weeks)** | Lorazepam 2 mg | 2 × 1 mg | 14 × 1 mg | 20 mg |
| **Stages 9–12. Convert lorazepam to diazepam\*** | | | | |
| **Stage 9 (1 week)** | Lorazepam 1.5 mg + Diazepam 5 mg | 1.5 × 1 mg +  1 × 5 mg | 11 × 1 mg  + 7 × 5 mg | 20 mg |
| **Stage 10 (1 week)** | Lorazepam 1 mg  + Diazepam 10 mg | 1 × 1 mg +  1 × 10 mg | 7 × 1 mg  + 7 × 10 mg | 20 mg |
| **Stage 11 (1 week)** | Lorazepam 0.5 mg + Diazepam 15 mg | 0.5 × 1 mg +  3 × 5 mg | 4 × 1 mg  + 21 × 5 mg | 20 mg |
| **Stage 12 (1 week)** | Stop lorazepam Diazepam 20 mg | 2 × 10 mg | 14 × 10 mg | 20 mg |
| **Stage 13 (1–2 wks)** | Diazepam 18 mg | 1 x 10 mg  4 x 2 mg | 7 x 10 mg  28 x 2 mg | 18 mg |
| **Stage 14 (1–2 wks)** | Diazepam 16 mg | 1 x 10 mg  3 x 2 mg | 7 x 10 mg  21 x 2 mg | 16 mg |
| **Stage 15 (1–2 wks)** | Diazepam 14 mg | 1 x 10 mg  2 x 2 mg | 7 x 10 mg  14 x 2 mg | 14 mg |
| **Stage 16 (1–2 wks)** | Diazepam 12 mg | 1 x 10 mg  1 x 2 mg | 7 x 10 mg  7 x 2 mg | 12 mg |
| **Stage 17 (1–2 wks)** | Diazepam 10 mg | 1 x 10 mg | 7 x 10 mg | 10 mg |
| **Stage 18 (1–2 wks)** | Diazepam 8 mg | 4 x 2 mg | 28 x 2 mg | 8 mg |
| **Stage 19 (1–2 wks)** | Diazepam 6 mg | 3 x 2 mg | 21 x 2 mg | 6 mg |
| **Stage 20 (1–2 wks)** | Diazepam 4 mg | 2 x 2 mg | 14 x 2 mg | 4 mg |
| **Stage 21 (1–2 wks)** | Diazepam 3 mg | 1½ x 2 mg | 11 x 2 mg | 3 mg |
| **Stage 22 (1–2 wks)** | Diazepam 2 mg | 1 x 2 mg | 7 x 2 mg | 2 mg |
| **Stage 23 (1–2 wks)** | Diazepam 1 mg | ½ x 2 mg | 4 x 2 mg | 1 mg |
| **Stage 24** | Stop |  |  |  |

*\*for patients receiving < 20 mg diazepam daily equivalent, see separate schedule*

**Chlordiazepoxide**

Chlordiazepoxide is long-acting therefore conversion to diazepam is not required.

Start from the most relevant point of the schedule depending on the patient’s current dose.

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Daily dose** | **Number of tablets/day** | **Number of tablets/week** | **Daily diazepam equivalent** |
| **Starting dosage** | Chlordiazepoxide 90 mg | 9 × 10 mg | 63 × 10 mg | 30 mg |
| **Stage 1 (1–2 weeks)** | Chlordiazepoxide 75 mg | 7 × 10 mg  1 × 5 mg | 49 × 10 mg  7 × 5 mg | 25 mg |
| **Stage 2 (1–2 weeks)** | Chlordiazepoxide 60 mg | 6 × 10 mg | 42 × 10 mg | 20 mg |
| **Stage 3 (1–2 weeks)** | Chlordiazepoxide 50 mg | 5 × 10 mg | 35 × 10 mg | 16.6 mg |
| **Stage 4 (1–2 weeks)** | Chlordiazepoxide 45 mg | 4 × 10 mg  1 × 5 mg | 28 × 10 mg  7 × 5 mg | 15 mg |
| **Stage 5 (1–2 weeks)** | Chlordiazepoxide 40 mg | 4 × 10 mg | 28 × 10 mg | 13.3 mg |
| **Stage 6 (1–2 weeks)** | Chlordiazepoxide 35 mg | 3 × 10 mg  1 × 5 mg | 21 × 10 mg  7 × 5 mg | 11.6 mg |
| **Stage 7 (1–2 weeks)** | Chlordiazepoxide 30 mg | 3 × 10 mg | 21 × 10 mg | 10 mg |
| **Stage 8 (1–2 weeks)** | Chlordiazepoxide 25 mg | 2 × 10 mg  1 × 5 mg | 14 × 10 mg  7 × 5 mg | 8.3 mg |
| **Stage 9 (1–2 weeks)** | Chlordiazepoxide 20 mg | 2 × 10 mg | 14 × 10 mg | 6.6 mg |
| **Stage 10 (1–2 weeks)** | Chlordiazepoxide 15 mg | 1 × 10 mg  1 × 5 mg | 7 × 10 mg  7 × 5 mg | 5 mg |
| **Stage 11 (1–2 weeks)** | Chlordiazepoxide 10 mg | 1 × 10 mg | 7 × 10 mg | 3.3 mg |
| **Stage 12 (1–2 weeks)** | Chlordiazepoxide 5 mg | 1 × 5 mg | 7 × 5 mg | 1.6 mg |
| **Stage 13** | Stop |  |  |  |

**Oxazepam**

Oxazepam has a short half-life therefore conversion to diazepam is recommended. *Note:* some patients will prefer to remain on the original drug for the duration of the withdrawal.

Start from the most relevant point of the schedule depending on the patient’s current dose.

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Daily dose** | **Number of tablets/day** | **Number of tablets/week** | **Daily diazepam equivalent** |
| **Starting dosage** | Oxazepam 120 mg | 8 × 15 mg | 56 × 15 mg | 40 mg |
| **Stage 1 (1–2 weeks)** | Oxazepam 105 mg | 7 × 15 mg | 49 × 15 mg | 35 mg |
| **Stage 2 (1–2 weeks)** | Oxazepam 90 mg | 6 × 15 mg | 42 × 15 mg | 30 mg |
| **Stage 3 (1–2 weeks)** | Oxazepam 75 mg | 5 × 15 mg | 35 × 15 mg | 25 mg |
| **Stage 4 (1–2 weeks)** | Oxazepam 60 mg | 4 × 15 mg | 28 × 15 mg | 20 mg |
| **Stages 5–8. Convert oxazepam to diazepam\*** | | | | |
| **Stage 5 (1 week)** | Oxazepam 45 mg + Diazepam 5 mg | 3 × 15 mg  + 1 × 5 mg | 21 × 15 mg  + 7 × 5 mg | 20 mg |
| **Stage 6 (1 week)** | Oxazepam 30 mg  + Diazepam 10 mg | 2 × 15 mg  + 1 × 10 mg | 14 × 15 mg  + 7 × 10 mg | 20 mg |
| **Stage 7 (1 week)** | Oxazepam 15 mg  + Diazepam 15 mg | 1 × 15 mg  + 3 × 5 mg | 7 × 15 mg  + 21 × 5 mg | 20 mg |
| **Stage 8 (1 week)** | Stop Oxazepam + Diazepam 20 mg | 2 × 10 mg | 14 × 10 mg | 20 mg |
| **Stage 9 (1–2 weeks)** | Diazepam 18 mg | 1 x 10 mg  4 x 2 mg | 7 x 10 mg  28 x 2 mg | 18 mg |
| **Stage 10 (1–2 weeks)** | Diazepam 16 mg | 1 x 10 mg  3 x 2 mg | 7 x 10 mg  21 x 2 mg | 16 mg |
| **Stage 11 (1–2 weeks)** | Diazepam 14 mg | 1 x 10 mg  2 x 2 mg | 7 x 10 mg  14 x 2 mg | 14 mg |
| **Stage 12 (1–2 weeks)** | Diazepam 12 mg | 1 x 10 mg  1 x 2 mg | 7 x 10 mg  7 x 2 mg | 12 mg |
| **Stage 13 (1–2 weeks)** | Diazepam 10 mg | 1 x 10 mg | 7 x 10 mg | 10 mg |
| **Stage 14 (1–2 weeks)** | Diazepam 8 mg | 4 x 2 mg | 28 x 2 mg | 8 mg |
| **Stage 15 (1–2 weeks)** | Diazepam 6 mg | 3 x 2 mg | 21 x 2 mg | 6 mg |
| **Stage 16 (1–2 weeks)** | Diazepam 4 mg | 2 x 2 mg | 14 x 2 mg | 4 mg |
| **Stage 17 (1–2 weeks)** | Diazepam 3 mg | 1½ x 2 mg | 11 x 2 mg | 3 mg |
| **Stage 18 (1–2 weeks)** | Diazepam 2 mg | 1 x 2 mg | 7 x 2 mg | 2 mg |
| **Stage 19 (1–2 weeks)** | Diazepam 1 mg | ½ x 2 mg | 4 x 2 mg | 1 mg |
| **Stage 20** | Stop |  |  |  |

*\*for patients receiving < 20 mg diazepam daily equivalent, see separate schedule*

**Patients receiving < 20 mg equivalent diazepam daily dose of short-acting benzodiazepines (lorazepam and oxazepam)**

Where the dose of a short-acting benzodiazepine is equivalent to less than 20 mg diazepam, first convert to an equivalent dose of diazepam using a staggered cross-over:

e.g. lorazepam:

Lorazepam 1 mg

Lorazepam 0.5 mg + diazepam 5 mg for 1 week

Diazepam 10 mg for 1 week

e.g. oxazepam:

Oxazepam 45 mg

Oxazepam 30 mg + diazepam 5 mg for 1 week

Oxazepam 15 mg + diazepam 10 mg for 1 week

Diazepam 15 mg for 1 week

Subsequently, reduce from an appropriate point on the diazepam reduction schedule. Note: some patients will prefer to remain on the original drug for the duration of the withdrawal.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Daily dose** | **Number of tablets/day** | **Number of tablets/week** |
| **Stage 1 (1–2 weeks)** | Diazepam 20 mg | 2 x 10 mg | 14 x 10 mg |
| **Stage 2 (1–2 weeks)** | Diazepam 18 mg | 1 x 10 mg  4 x 2 mg | 7 x 10 mg  28 x 2 mg |
| **Stage 3 (1–2 weeks)** | Diazepam 16 mg | 1 x 10 mg  3 x 2 mg | 7 x 10 mg  21 x 2 mg |
| **Stage 4 (1–2 weeks)** | Diazepam 14 mg | 1 x 10 mg  2 x 2 mg | 7 x 10 mg  14 x 2 mg |
| **Stage 5 (1–2 weeks)** | Diazepam 12 mg | 1 x 10 mg  1 x 2 mg | 7 x 10 mg  7 x 2 mg |
| **Stage 6 (1–2 weeks)** | Diazepam 10 mg | 1 x 10 mg | 7 x 10 mg |
| **Stage 7 (1–2 weeks)** | Diazepam 8 mg | 4 x 2 mg | 28 x 2 mg |
| **Stage 8 (1–2 weeks)** | Diazepam 6 mg | 3 x 2 mg | 21 x 2 mg |
| **Stage 9 (1–2 weeks)** | Diazepam 4 mg | 2 x 2 mg | 14 x 2 mg |
| **Stage 10 (1–2 weeks)** | Diazepam 3 mg | 1½ x 2 mg | 11 x 2 mg |
| **Stage 11 (1–2 weeks)** | Diazepam 2 mg | 1 x 2 mg | 7 x 2 mg |
| **Stage 12 (1–2 weeks)** | Diazepam 1 mg | ½ x 2 mg | 4 x 2 mg |
| **Stage 13** | Stop |  |  |