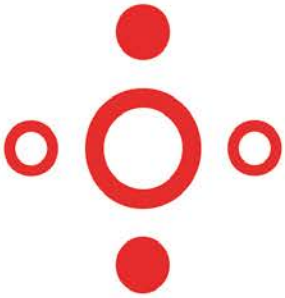
Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group



Educational Pack:

Material to Support Appropriate Prescribing of Hypnotics and Anxiolytics across Wales

July 2021

This document has been prepared by a multiprofessional collaborative group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

Please direct any queries to AWTTC:

All Wales Therapeutics and Toxicology Centre
The Routledge Academic Centre
University Hospital Llandough
Penlan Road
Llandough
Vale of Glamorgan
CF64 2XX

awttc@wales.nhs.uk
029 218 26900

The information in this document is intended to help healthcare providers make an informed decision. This document should not be used as a substitute for professional medical advice and although care has been taken to ensure the information is accurate and complete at the time of publication, the All Wales Therapeutics and Toxicology Centre (AWTTC) and All Wales Medicines Strategy Group (AWMSG) do not make any guarantees to that effect. The information in this document is subject to review and may be updated or withdrawn at any time. AWTTC and AWMSG accept no liability in association with the use of its content. Information presented in this document can be reproduced using the following citation:
All Wales Medicines Strategy Group. Educational Pack: Material to Support Appropriate Prescribing of Hypnotics and Anxiolytics across Wales. July 2021.

CONTENTS

BENZODIAZEPINES AND Z-DRUGS – SUMMARY FOR PRESCRIBERS 4
1.0 INTRODUCTION 6
1.1 Aim 6
2.0 HYPNOTICS AND ANXIOLYTICS 6
2.1 Benzodiazepines 7
2.1.1 Differences between benzodiazepines 7
2.1.2 Problems associated with the long-term use of benzodiazepines 8
2.1.3 Use of benzodiazepines in pregnancy 9
2.2 Z-drugs 9
2.2.1 Differences between z-drugs 9
2.2.2 Problems associated with long-term use of z-drugs 9
2.2.3 Use of z-drugs in pregnancy 10
3.0 INSOMNIA 10
3.1 Assessment of insomnia 10
3.2 Treatment of insomnia (Figure 1) 14
3.2.1 For all patients with insomnia: 14
3.2.2 For patients with short-term (<3 months duration) insomnia: 14
3.2.3 For patients with long-term (>3 months duration) insomnia: 15
3.2.4 Behavioural treatment for insomnia 17
3.3.5 Drug treatment for insomnia 18
4.0 GENERALISED ANXIETY DISORDER 19
4.1 Treatment of anxiety 19
4.1.1 Drug treatments for anxiety 20
5.0 SECONDARY CARE PRESCRIBING OF ANXIOLYTICS AND HYPNOTICS 22
6.0 REDUCING THE PRESCRIBING OF HYPNOTICS AND ANXIOLYTICS 22
6.1 Management of patients on long-term anxiolytics and/or hypnotics 22
6.2 Managed withdrawal of hypnotics and/or anxiolytics in primary care 23
6.2.1 Identifying patients 24
6.2.2 Agreeing the details of the withdrawal process 24
6.2.3 Initiating the withdrawal process 24
6.2.4 Initial consultation 25
6.2.5 Dose reduction for managed withdrawal programmes 26
6.2.6 Withdrawal symptoms 27
6.2.7 Managing someone who does not want to stop 27
REFERENCES 29
APPENDIX 1. MEDICINES FOR ANXIETY AND INSOMNIA: PATIENT INFORMATION LEAFLETS 33

1a) English – Medicines for anxiety and insomnia....33
1b) Welsh – Meddyginiaethau ar gyfer pryder ac insomnia....35
APPENDIX 2. ASSESSMENT TOOLS....37
2a) Sleep assessment tool....37
2b) Sleep condition indicator (SCI)....39
2c) Generalised anxiety disorder assessment (GAD 7)....40
2d) Sleep diary....41
2e) Anxiety diary....42
APPENDIX 3. INFORMATION FOR PATIENTS....43
3a) English - The good sleep guide....43
3b) Welsh - Y canllaw cysgu'n dda....44
3c) English - The good relaxation guide....45
3d) Welsh - Y canllaw ymlacio da....46
3e) English - Example of a letter to be given to patients newly prescribed a hypnotic or anxiolytic....47
3f) Welsh - Enghraifft o lythyr i'w roi i gleifion sydd newydd gael presgripsiwn ar gyfer cyffur hypnotig neu gyffur lleihau gorbryder....48
APPENDIX 4. GUIDES FOR HEALTHCARE PROFESSIONALS....49
4a) Example of secondary care guidelines on the prescribing of anxiolytics and hypnotics....49
4b) Example of a GP practice prescribing policy for benzodiazepines and z-drugs....51
4c) Example of GP practice guidelines for initiating hypnotics and anxiolytics....52
APPENDIX 5. HYPNOTIC AND ANXIOLYTIC REDUCTION/WITHDRAWAL RESOURCES....53
5a) Example of guidelines for reduction/withdrawal of hypnotics and anxiolytics....53
5b) Example of an anxiolytic and hypnotic audit....55
5c) Example of a letter for community pharmacists....60
5d) Examples of patient letters to review hypnotic and/or anxiolytic treatment....61
i) Removal of benzodiazepines/z-drugs from repeat prescriptions....61
ii) Patient-initiated withdrawal....62
iii) Practice-initiated withdrawal....63
iv) Clinic appointment....64
v) Pharmacist-led clinic....65
vi) Request to make a GP appointment....66
5e) Stopping your medicine: benzodiazepines and z-drugs. A guide for patients....67
5f) Rhoi'r gorau i'ch meddyginiaeth: bensodiasepinau a chyffuriau-z. Canllaw i gleifion....69
5g) Patient clinical summary for hypnotic/anxiolytic withdrawal programme....71

5h) Example of a patient hypnotic or anxiolytic reduction card.....72
5i) Example of a patient record sheet.....73
5j) An example of a patient contract for hypnotic and anxiolytic withdrawal.....74
5k) Reduction protocols to support the withdrawal from hypnotics.....75
5l) Reduction protocols to support the withdrawal from anxiolytics.....78

BENZODIAZEPINES AND Z-DRUGS – SUMMARY FOR PRESCRIBERS

Benzodiazepines and the "z-drugs" (zopiclone and zolpidem) enhance the action of the inhibitory neurotransmitter GABA. This results in hypnotic, anxiolytic, anticonvulsant, and muscle relaxant properties.

- The "z-drugs" zolpidem and zopiclone are preferred when pharmacological intervention is indicated for insomnia[1]. Benzodiazepines used for the treatment of insomnia include loprazolam, lormetazepam, nitrazepam and temazepam.
- Benzodiazepines used for the treatment of anxiety states include chlordiazepoxide, diazepam, lorazepam and oxazepam.

In general practice, it is well recognised that the long-term use of these medicines is not appropriate, as they are associated with a range of adverse effects.

The information below provides a summary of the key issues, and suggestions for supporting the management of these medicines.

Indications
Benzodiazepines are only indicated in specific circumstances, for the short term (no more than two weeks, but preferably shorter) management of insomnia and generalised anxiety disorder. Appropriate initiation as part of a wider management plan, for clearly established and documented diagnoses, can help to achieve a reduction in overall usage.

Insomnia[1]
Pharmacological intervention for short term insomnia (<3 months duration) is only indicated if sleep hygiene measures fail, daytime impairment is severe causing significant distress, and insomnia is likely to resolve soon (for example due to a short term stressor). Consider a short course (3-7 days) of a non-benzodiazepine hypnotic medication (z-drug).

Pharmacological therapy should be avoided in the management of long-term (>3 month duration) insomnia. However, for some people with severe symptoms or an acute exacerbation, a short course of a hypnotic drug (preferably less than 1 week) may be considered as a temporary adjunct to behavioural and cognitive treatment.

Generalised Anxiety Disorder[2]
Benzodiazepines should not be offered for the treatment of generalised anxiety disorder (GAD) in primary care, except as a short-term measure during crises.

Adverse effects
Benzodiazepines are associated with a number of adverse effects. Prescribing decisions should be made following a careful consideration of the risks and benefits of treatment for the individual patient. Benzodiazepines and z-drugs should generally be avoided in elderly patients due to an increased risk of adverse effects.

Adverse effects include drowsiness, forgetfulness and confusion, and falls (particularly in elderly patients). It should be noted that all benzodiazepines can impair driving ability and the risk of driving impairment is increased if the medicine is taken with alcohol. It is illegal to drive with legal drugs in the body if it impairs driving.

Longer term (> 1 month) use of benzodiazepines and z-drugs is associated with an increased risk of tolerance and dependence. Dependence is characterised by withdrawal effects (e.g. flu like symptoms, irritability, insomnia) on treatment discontinuation.

Differences between medicines
The pharmacokinetic properties (in particular the half-lives) of the benzodiazepines and z-drugs vary. This difference may have clinical significance.

The half-lives of zolpidem and zopiclone are approximately 2.5 hours and 5 hours respectively. Due to its shorter half-life, zolpidem may be less effective in maintaining sleep than zopiclone, but may also be associated with fewer residual effects the following day.

Benzodiazepines with shorter half-lives include lorazepam (approximately 12 hours); those with longer half-lives (24–48 hours) include diazepam and nitrazepam. Drugs with longer half-lives may be associated with residual effects the following day[3]. Benzodiazepines with shorter half-lives are likely to be associated with more problematic withdrawal.

Discontinuing benzodiazepines and z-drugs
Managed withdrawal is possible for many patients once problems related to prolonged drug use are explained and discussed, and some patients will voluntarily reduce their usage.

Benzodiazepines and z-drugs should not be withdrawn abruptly. A gradual dose tapering over several weeks or months (or sometimes longer), is recommended in most cases where withdrawal is indicated.

Prescribing – key points

- Before prescribing, consider and where possible, address any underlying factors or conditions that may contribute to or worsen insomnia or GAD.
- Offer non-drug interventions where appropriate.
- For insomnia offer advice on sleep hygiene (including sleep environment, sleep schedule, relaxation and exercise).
- Only prescribe benzodiazepines or z-drugs where clearly indicated (typically only for patients experiencing significant distress or during crises).
- Benzodiazepines should not be offered for the treatment of generalised anxiety disorder (GAD) in primary care, except as a short-term measure during crises. Where pharmacological intervention for GAD is indicated, a selective serotonin reuptake inhibitor is typically first line treatment.
- Where indicated, prescribe the lowest effective dose of a z-drug or benzodiazepine for the shortest possible duration (no longer than two weeks).
- Before prescribing discuss the risk of dependence and potential for withdrawal symptoms associated with longer term use.
- For patients appropriate for managed withdrawal discuss the risks of long term usage and encourage a voluntary reduction in usage.
- Do not withdraw benzodiazepines abruptly. A gradual withdrawal over several months and with additional support where necessary is usually indicated.

References

1. NICE Clinical Knowledge Summaries: Insomnia, available at: https://cks.nice.org.uk/topics/insomnia/
2. NICE Clinical Knowledge Summaries: Generalized anxiety disorder, available at: https://cks.nice.org.uk/topics/generalized-anxiety-disorder/management/management/
3. Wilson S, Anderson K, Baldwin D et al. British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadian rhythm disorders: An update. Journal of Psychopharmacology. 2019;33(8):923-947. Available at: https://pubmed.ncbi.nlm.nih.gov/31271339

1.0 INTRODUCTION

1.1 Aim

This educational pack aims to support the appropriate prescribing of hypnotics and anxiolytics across Wales by providing key health professionals with a practical approach for the initiation and review of hypnotic and anxiolytic prescribing. It includes examples of support material which can be used or adapted for this purpose.

It is anticipated that adoption of the 'best practice' examples presented within this pack will help to reduce the long-term prescribing of these drugs.

The pack may also facilitate reflective practice and the development of quality improvement projects.

The pack was originally developed in 2011 by the Welsh Medicines Partnership (WMP), was updated in 2016 to reflect changes in NICE guidance, the Misuse of Drugs Act and the Road Traffic Act, and has been updated in 2021 to reflect NICE guidance on the classification and management of insomnia.

2.0 HYPNOTICS AND ANXIOLYTICS

Hypnotic and anxiolytic medicines are used to help restore normal sleep behaviour and to reduce anxiety-linked symptoms. However, in general practice, it is well recognised that the long-term use of hypnotics and anxiolytics is not appropriate, as they are associated with a range of adverse effects such as drowsiness, falls, forgetfulness and confusion, in addition to problems of tolerance and dependence[4]. In England and Wales during 2018, there were 420 deaths involving benzodiazepines[5]. Furthermore, the number of deaths involving zopiclone or zolpidem has been steadily increasing since 2010, peaking at 1143 deaths in 2018. Across Wales alone, 15% of drug poisonings involved a benzodiazepine, with 50 deaths recorded in 2018[5].

A National Prescribing Indicator for hypnotics and anxiolytics was introduced in 2004–2005 with the aim of encouraging a reduction in inappropriate prescribing. Although the prescribing volume of hypnotics and anxiolytics in Wales has declined over recent years, there is considerable variation in prescribing rates of these medicines across health boards and between GP practices. In addition, use is still high in comparison to England[6]. Hypnotics and anxiolytics continue to be monitored as a National Prescribing Indicator.

Misuse of Drugs Act

Since publication of the original WMP document in 2011, the Advisory Council on the Misuse of Drugs recommended that zopiclone and zaleplon be controlled in the same manner as zolpidem, as it considered the risk of diversion and misuse, and the consequent harms, to be similar for all three z-drugs[7,8]. As a result of this recommendation, zopiclone and zaleplon became controlled under the Misuse of Drugs Act as Class C, Schedule IV substances in June 2014[9]. The marketing authorisation for Sonata® (zaleplon) in the European Union was subsequently withdrawn at the request of the marketing authorisation holder in 2015[10].

Road Traffic Act
In March 2015, a new offence came into force making it illegal to drive if you have over the specified limits of certain drugs in your blood, and you have not been prescribed them[11].

Benzodiazepines included in the drugs and driving offence[11,12]:

- Diazepam
- Flunitrazepam
- Lorazepam
- Oxazepam
- Temazepam
- Clonazepam

It should be noted that all benzodiazepines can impair driving ability and the risk of driving impairment is increased if the medicine is taken with alcohol. It is illegal to drive with legal drugs in your body if it impairs your driving. Further information is available at www.gov.uk/government/collections/drug-driving.

2.1 Benzodiazepines

Benzodiazepines are positive allosteric modulators of the gamma-aminobutyric acid type A ($GABA_A$) receptor which have hypnotic, anxiolytic, anticonvulsant, and muscle relaxant properties. The British National Formulary groups benzodiazepines into hypnotics and anxiolytics[13].

- Hypnotics are used for short-term treatment of insomnia and include nitrazepam, loprazolam, lormetazepam and temazepam.
- Anxiolytics are effective in alleviating anxiety states and include chlordiazepoxide, diazepam, lorazepam and oxazepam.

Benzodiazepines can cause physical dependence when used for more than 2–4 weeks, resulting in withdrawal symptoms such as sweating, insomnia, headache, tremor, nausea, palpitations, anxiety, depression, panic attacks or rarely psychosis or seizures. These symptoms may mimic the original anxiety disorder.

A basic knowledge of the mechanism of action of benzodiazepines and their neurobehavioral effects may help patients understand the complications associated with long-term use.

Sleep-wake function is regulated by arousing (noradrenaline, serotonin, acetylcholine, dopamine and histamine) and sleep-inducing (GABA and adenosine) neurotransmitters; enhancement of the latter is an effective hypnotic treatment for sleep-related disorders. Benzodiazepines act by enhancing the effects of GABA at $GABA_A$ receptors[14] (ubiquitously distributed in the brain), which increases GABA activity and reduces neuron firing, resulting in a sedating and sleep-inducing effect. However, following longer-term use, it is believed that neuroadaptive mechanisms result in benzodiazepines losing their effect, resulting in the need to take larger doses to achieve a similar effect. This phenomenon is known as tolerance, and is one of the signs of drug dependence or addiction.

2.1.1 Differences between benzodiazepines

All of the benzodiazepines have similar pharmacodynamic properties. However, their pharmacokinetic properties (i.e. how rapidly a drug enters the brain and how long its effects last) vary and these differences may be important and relevant to clinical practice (see Table 1):

- Benzodiazepines with high potency and short elimination half-lives (e.g. lorazepam and loprazolam) are more likely to lead to problematic withdrawal effects when being discontinued[15].

- Those with an intermediate half-life (e.g. temazepam) cause fewer problems when used for a short period.
- Those with long half-lives (e.g. nitrazepam, diazepam) can have residual effects the following day (e.g. daytime sedation and falls); however, some people are more susceptible to these effects than others[3].

Table 1. Differences between benzodiazepines

Drug	Indication	Dose (Generally use half an adult dose in elderly patients)	Half-life[a] (Varies between individuals e.g. prolonged in the elderly)	Dose equivalent to diazepam 5 mg[16]
Diazepam	Anxiety	2 mg tds max 30 mg in divided doses	24–48 hours	-
Chlordiazepoxide	Anxiety	10 mg tds max 100 mg in divided doses	6–30 hours	15 mg
Lorazepam	Anxiety	1–4 mg daily in divided doses	12 hours	0.5 mg
Oxazepam	Anxiety	15–30 mg 3–4 times a day	6–20 hours	15 mg
Diazepam	Insomnia associated with anxiety	5–15 mg at night	24–48 hours	-
Nitrazepam	Insomnia	5–10 mg at night	24–40 hours	5 mg
Temazepam	Insomnia	10–20 mg at night	8–15 hours	10 mg
Loprazolam	Insomnia	1–2 mg at night	8 hours	0.5–1 mg
Lormetazepam	Insomnia	0.5–1.5 mg at night	About 11 hours	0.5–1 mg
a. Half-life data from individual Summaries of Product Characteristics (SPCs) **tds: three times daily**				

2.1.2 Problems associated with the long-term use of benzodiazepines

The long-term use of benzodiazepines is associated with a number of adverse effects and other complications. Older people are more vulnerable to the adverse effects of benzodiazepines, such as impaired cognitive function and memory, which may be wrongly diagnosed as dementia[16].

Adverse effects (which may also occur with short-term use) include:

- drowsiness and falls
- impairment in judgement and dexterity
- increased risk of experiencing a road traffic accident
- forgetfulness, confusion, irritability, aggression, and paradoxical disinhibition

Complications related to long-term use include:

- depressive symptoms
- reduction in coping skills
- tolerance and dependence

Dependence often presents in one or more of the following ways:

- Patients gradually ‘need’ benzodiazepines to carry out normal day-to-day activities.
- Patients continue to take benzodiazepines although the original indication for the prescription is no longer relevant.
- Patients have difficulty in stopping treatment or reducing the dosage due to withdrawal symptoms.
- Patients contact their doctor regularly to obtain repeat prescriptions.
- Patients become anxious if the next prescription is not readily available.
- Patients may increase the dosage stated in the original prescription.

- Despite benzodiazepine therapy, patients may present with recurring anxiety symptoms, panic, agoraphobia, insomnia, depression and an increase in physical symptoms of anxiety.

2.1.3 Use of benzodiazepines in pregnancy

Use of benzodiazepines during pregnancy is not recommended. Prolonged use is associated with low birth weight, pre-term delivery and small for gestational age babies. Use in the third trimester may result in floppy baby syndrome. There is some evidence to suggest a link with congenital abnormalities including oral clefts, pylorostenosis and alimentary tract atresia, although data are somewhat conflicting[17,18]. Other approaches for the treatment of anxiety and insomnia are preferred[17]. There may be circumstances where the perceived benefit of benzodiazepine treatment during pregnancy outweighs the risk. Similarly, for patients already receiving a benzodiazepine, it may not be appropriate to discontinue treatment. In these instances, it may be advisable to seek specialist advice to guide management.

2.2 Z-drugs

Z-drugs are non-benzodiazepine hypnotics, developed with the intention of overcoming some of the adverse effects of benzodiazepines (such as next day sedation, dependence and withdrawal), but there is no firm evidence of differences in the effect of z-drugs and shorter-acting benzodiazepines[16]. Like benzodiazepines, they are also positive allosteric modulators of the $GABA_A$ receptor.

The two z-drugs currently available in the UK are zolpidem and zopiclone (as of May 2015, zaleplon is no longer available[10]). The SPCs for zolpidem and zopiclone warn about the possibility of the development of dependence and advise against prescribing quantities other than for short-term use[19,20]. In common with the benzodiazepines, the sedative effects of the z-drugs may persist into the next day[21].

2.2.1 Differences between z-drugs

The currently available z-drugs (zopiclone and zolpidem) have similar properties, but differ in their elimination half-lives (see table 2). Zopiclone has a longer half-life, and may be associated with an increased risk of next day hangover effects. Zolpidem has a shorter half-life, and is therefore less effective at maintaining sleep. It may be associated with a lower risk of next day effects, although susceptibility varies from person to person, and cannot be ruled out. Patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others[21]. Case reports have indicated that patients treated with Z-drugs (and benzodiazepines) may rarely experience hallucinations and unpredictable, unusual behaviour, which may occur more frequently with zolpidem.

Table 2. Differences between z-drugs

Drug	Indication	Dose (Generally use half an adult dose in elderly patients)	Half-life[a] (Varies between individuals e.g. prolonged in the elderly)	Dose equivalent to diazepam 5 mg[16]
Zopiclone	Insomnia	7.5 mg at night	5 hours	7.5 mg
Zolpidem	Insomnia	10 mg at night	Mean of 2.4 hours	10 mg
a. Half-life data from individual SPCs				

2.2.2 Problems associated with long-term use of z-drugs

Use of z-drugs for prolonged periods can result in tolerance, dependence and withdrawal syndrome[19,20]. Dependence may develop, and continuing treatment may serve only to prevent withdrawal symptoms[1], for example, anxiety, depression, impaired concentration, insomnia, abdominal cramps, palpitations and perceptual disturbances (such as hypersensitivity to physical, visual and auditory stimuli).

2.2.3 Use of z-drugs in pregnancy

Use of z-drugs in pregnancy is not recommended. If z-drugs are used during the last three months of pregnancy or during labour, due to their pharmacological action, effects on the neonate, such as hypothermia, floppy baby syndrome and respiratory depression, can be expected[19,20]. Cases of severe neonatal respiratory depression have been reported when zolpidem was used with other central nervous system (CNS) depressants at the end of pregnancy[20]. If a z-drug is prescribed to a woman of child-bearing potential, she should be advised to contact her doctor to discuss her treatment if she intends to become pregnant, or suspects that she is pregnant[19,20].

3.0 INSOMNIA

Insomnia is a common disorder, thought to affect about one third of the general population[22]. It is characterised by dissatisfaction with sleep quality, (such as difficulty in getting to sleep, difficulty staying asleep, early wakening or non-restorative sleep despite adequate time and opportunity to sleep[1]), which results in a reduction in daytime functioning or wellbeing. Insomnia is associated with reduced quality of life, and an increase in healthcare costs[23,24]. In addition, insomnia is associated with activation of the hypothalamic-pituitary-adrenal axis and the release of stress hormones, and may increase the risk of hypertension, depression and anxiety disorders[25,26]. Insomnia can be classified as short-term (with symptoms present for fewer than 3 months), or long-term, (with symptoms present for more than three months), with management based upon illness duration[1,3].However, studies demonstrate that insomnia is predominantly a long-term disorder. A population-based 3-year longitudinal study showed that 74% of patients with insomnia at baseline reported insomnia for at least one year, and 46% reported insomnia persisting over the entire 3-year study[27].

3.1 Assessment of insomnia

Before treatment initiation:

- Investigate the nature, duration and frequency of symptoms:
  - Assess the person's beliefs: What do they regard as normal sleep and what is the impact of insomnia on the person's quality of life, ability to drive, employment, relationships and mood. A person who does not experience any impairment of daytime functioning may simply have a reduced need for sleep or an unrealistic expectation of sleep, or incorrect perception of how long they are sleeping for.
  - Short-term insomnia is diagnosed if insomnia resulting in functional impairment has been present for less than 3 months[1].
  - Long-term insomnia is diagnosed if insomnia resulting in functional impairment has been present for longer than 3 months[1].
- Identify and rule out any potential causes of insomnia (see Table 3 for examples of possible causes of insomnia). Perform a general medical history; include information regarding caffeine and alcohol consumption, medication use (including 'over the counter' [OTC] agents), and symptoms of depression, anxiety and pain.
- Take a thorough sleep history: See Appendix 2a (sleep assessment tool), Appendix 2b (Sleep Condition Indicator) and Appendix 2c (GAD 7 – anxiety rating tool).
- Identify precipitator(s) of sleep disturbance and, if applicable, any remedies that were previously successful. In addition, note any history of insomnia that was previously resolved. Other questions may relate to sleep schedule and environment and include:
  - What time do you normally go to bed at night? What time do you wake up in the morning?

  - Do you often have trouble falling asleep at night?
  - About how many times do you wake up at night?
  - If you do wake up during the night, do you usually have trouble falling back asleep?
  - Does your bed partner say (or are you aware) that you kick or move about while asleep?
  - Does your bed partner say (or are you aware) that you frequently snore, gasp for air, or have difficulties breathing?
  - Are you sleepy or tired during the day?
  - Do you usually take one or more naps during the day?
  - How much sleep do you need to feel alert and function well?
  - Are you currently taking any type of medication or other preparation to help you sleep?

- If symptoms of sleep disturbance are evident, initial screening may require further questions:
  - Do you have the urge to move your legs, or do you experience uncomfortable sensations in your legs during rest or at night?
  - Do you have to get up often to urinate during the night?
  - How much physical activity or exercise do you get daily?
  - Are you exposed to natural outdoor light most days?
  - What medications do you take and at what time of day and night?
  - Do you suffer any uncomfortable side effects from your medications?
  - How much caffeine (e.g. coffee, tea, cola) and alcohol do you consume each day and night?
  - Do you often feel sad or anxious?
  - Have you suffered any personal losses recently?

- Look for possible causes of sleep disturbance (listed below) and where possible address appropriately:
  - External factors (e.g. light, noise, room temperature).
  - Change in sleep environment (e.g. hotel).
  - Physiological disturbance (e.g. shift work, daytime napping).
  - Jet lag.
  - Acute illness.
  - Psychological factors (e.g. anxiety, depression, stressful life events).
  - Substance misuse and drug withdrawal.
  - Stimulant use (e.g. caffeine, nicotine, over-the-counter or prescribed medicines).

If the underlying cause is not clear consider asking the person to keep a sleep diary for at least 2 weeks

Sleep diaries (see Appendix 2d) can provide patients with an insight into their actual sleep habits. They often reflect sleep trends, such as erratic schedules, or identify predominant sleep patterns, such as taking a long time to fall asleep, frequent awakenings, early morning awakenings, or a mixture. They can provide a starting point for the management of sleep problems in a personalised manner and can be used to monitor progress of certain treatments[28]. Use of an anxiety diary (see Appendix 2e) may also be of benefit where the patient reports feeling anxious.

Table 3. Drugs and medical co-morbidities underlying insomnia and treatment options

Therapeutic area	Drugs associated with insomnia	Medical co-morbidities associated with insomnia	Treatment options
Psychological (e.g. depression, anxiety)	Anti-depressants (*e.g. SSRIs, SNRIs*) Anticholinergics (*e.g. procyclidine*) Psycho-stimulants (*e.g. cocaine, nicotine, caffeine*) Alcohol	Depression Anxiety Schizophrenia Mania	Treat underlying condition (e.g. drug therapy, cognitive behavioural therapy [CBT]). Interventions to reduce alcohol intake or promote abstinence. Interventions to reduce substance use
Musculoskeletal	NSAIDs (*e.g. diclofenac, naproxen*) Indomethacin	Pain Rheumatic disorders Leg cramps Periodic limb movement disorder	Treat pain and other symptoms
Neurological	Selegiline	Dementia Stroke Neurodegenerative disorders (*e.g. Parkinson's disease*) Brain tumours Neuromuscular disorders Traumatic brain injury Fatal familial insomnia Pain Restless legs syndrome	For restless legs check ferritin, consider non-drug based measures (such as massage, exercise, stretching and warm baths before bed) or non-ergot dopamine antagonist drugs for severe cases
Respiratory	Methylxanthines (*e.g. aminophylline, theophylline*) Sympathomimetics (*e.g. salbutamol, pseudoephedrine*) Ipratropium	Chronic obstructive pulmonary disease Asthma Cough Obstructive sleep apnoea syndrome	Obstructive sleep apnoea syndrome: Continuous positive airways pressure or devices to improve airway; consider referral to a respiratory doctor or sleep physician.
Gastrointestinal	Ranitidine	Gastro-oesophageal reflux disease Peptic ulcer disease Constipation	
Endocrine	Corticosteroids	Hyperthyroidism	
Cardiovascular	ACE inhibitors Amiodarone Beta-blockers Digoxin Diuretics Statins Calcium channel blockers (*e.g. nifedipine, diltiazem*)	Nocturnal angina Ischaemic heart disease Congestive heart failure	

Infections		Lyme disease AIDS Pruritus	
Gynaecological/ urinary		Nocturia Menopausal symptoms	
Delayed sleep phase disorder (a circadian rhythm disorder)			Change work hours, melatonin in the evening and light exposure (via sunlight or artificial light box) in the morning.
Other parasomnias (sleep talking, sleep walking, sleep terrors, periodic limb movements, bruxism [teeth grinding], nightmare disorder, sleep-related eating disorder, sleep sex)			Consider referral.

3.2 Treatment of insomnia (Figure 1)

3.2.1 For all patients with insomnia:

- Consider referral if symptoms of other sleep disorders are present. For example, the Aneurin Bevan Sleep Centre. This service accepts referrals from GPs, including those in other health boards.
- Address any underlying causes of insomnia.
- Advise patients that they should not drive if they feel sleepy.
- Offer advice on sleep hygiene:
  - Normal sleep patterns change with age.
  - Maintain a comfortable sleep environment – a dark and quiet bedroom which isn't too hot or cold.
  - Keep to a regular sleep and waking schedule 7 days a week
    - Don't go to bed too early and try to sleep
    - Avoid naps.
  - Try some relaxation before going to bed.
  - Limit/avoid stimulants (caffeine, nicotine and alcohol).
  - Get regular exercise, but avoid within 4 hours of bedtime.
- Provide patient information on insomnia such as:
  - Mental Health Foundation How to sleep better.
  - NHS Insomnia.
  - Royal College of General Practitioners Top tips: insomnia in adults.
- Arrange follow up for review (2–4 weeks, dependant on the clinical situation).
- If symptoms have not improved, reassess the person — consider alternative diagnoses and the need for referral.
- Do not recommend over-the-counter treatments for insomnia.

In addition, information leaflets on sleep hygiene and/or relaxation should be recommended (Appendices 3a, 3b, 3c and 3d).

3.2.2 For patients with short-term (<3 months duration) insomnia:

If sleep hygiene measures fail, daytime impairment is severe causing significant distress, and insomnia is likely to resolve soon (for example due to a short term stressor), consider a short course (3-7 days) of a non-benzodiazepine hypnotic medication (z-drug).

- Do *not* prescribe hypnotics routinely – use only for short courses if acutely distressed.
- Do *not* prescribe hypnotics to older people or women who are pregnant or breastfeeding.

If sleep hygiene measures fail, daytime impairment is severe causing significant distress, and insomnia is not likely to resolve soon:

- Offer cognitive behavioural therapy for insomnia (CBT-I).
- CBT-I typically includes behavioural interventions (such as stimulus control and sleep restriction), cognitive therapy and relaxation training and can be provided face-to-face or digitally.
- Consider the need for adjunctive treatment with a short-term hypnotic medication (a z-drug or prolonged released melatonin if over 55 years of age).
- Do *not* prescribe hypnotics routinely — use only for short courses if acutely distressed.
- Do *not* prescribe hypnotics to older people or women who are pregnant or breastfeeding.

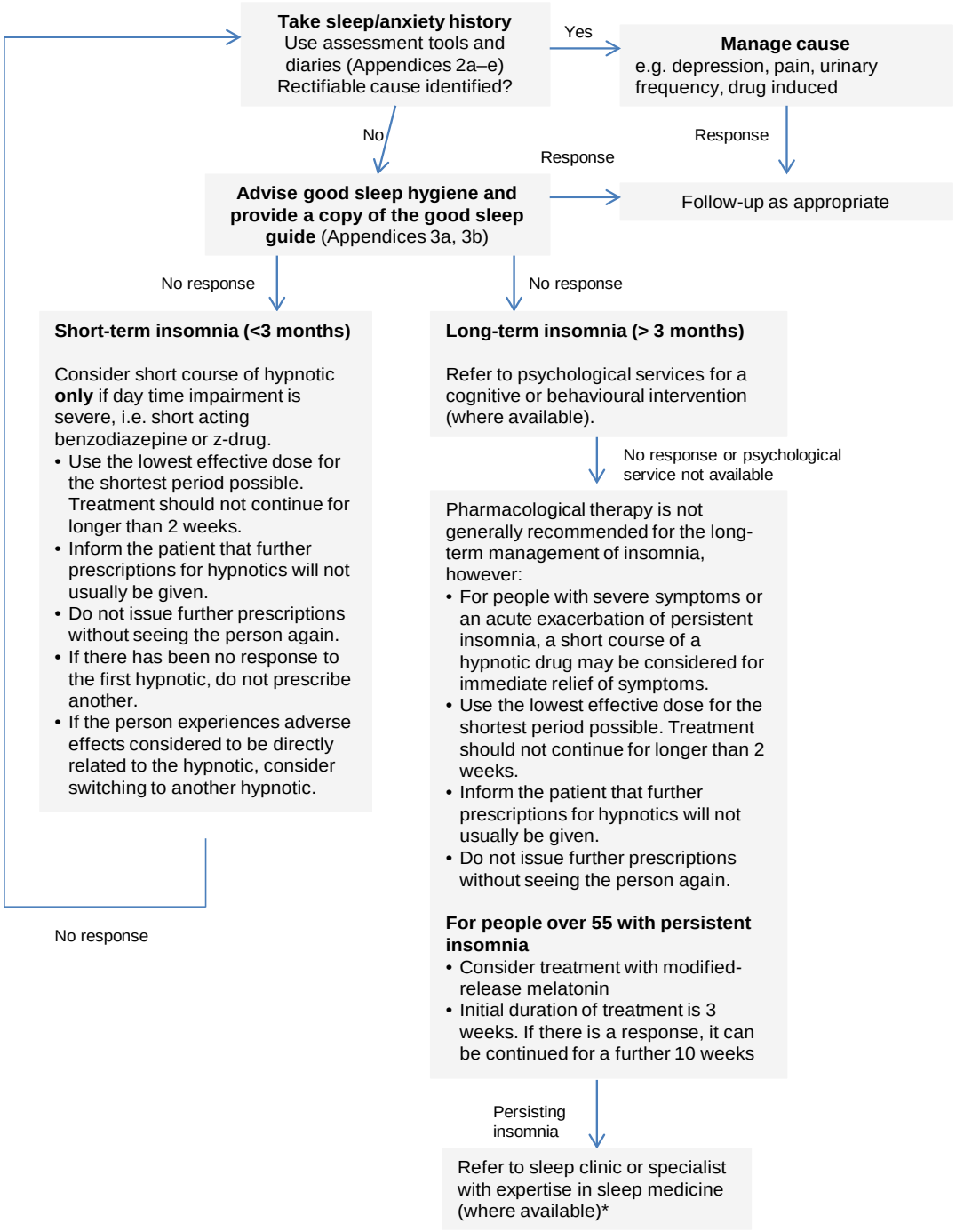
3.2.3 For patients with long-term (>3 months duration) insomnia:

First line treatment for chronic insomnia is cognitive behavioural therapy for insomnia (CBT-I). This can involve behavioural interventions (e.g. stimulus control, sleep restriction), cognitive therapy and relaxation training. It can be provided face to face or digitally.

Pharmacological therapy should be avoided in the long-term management of insomnia, however:

- For some people with severe symptoms or an acute exacerbation a short course of a hypnotic drug (preferably less than 1 week) may be considered as a temporary adjunct to behavioural and cognitive treatment.
- Do not prescribe long-term hypnotic treatment — for information on withdrawal of hypnotic medication, see the CKS topic on Benzodiazepine and z-drug withdrawal.
- For people over 55 years of age with persistent insomnia, treatment with a modified-release melatonin may be considered.
  - The recommended initial duration of treatment is 3 weeks. If there is a response to treatment, continue for a further 10 weeks only.
  - Discuss the risks (similar to those of other hypnotics including falls, and fractures) associated with melatonin treatment in the elderly.

Figure 1. Management of insomnia



*For example, The Aneurin Bevan Sleep Centre: https://abuhb.nhs.wales/hospitals/a-z-hospital-services/sleep-laboratory/ accepts referrals from GPs, including those in other health boards.

3.2.4 Behavioural treatment for insomnia

CBT is an effective treatment for insomnia performed either individually or in small groups, and has been found in some cases to be as effective as short-term prescription medication[29]. Furthermore, the beneficial effects of CBT may endure beyond the withdrawal from active treatment. CBT aims to address the various cognitive and behavioural aspects of insomnia using a combination of interventions such as behavioural strategies (such a bedtime/sleep restriction, stimulus control therapy, and relaxation), education (for example, about sleep hygiene), and cognitive strategies (cognitive therapy). Availability of CBT may vary; therefore a simple starting point for treatment of primary insomnia is to address sleep hygiene and to try a behavioural intervention such as sleep restriction or stimulus control.

Sleep restriction and sleep compression

- *Sleep restriction* counsels patients to reduce the amount of time spent in bed to correlate closely with actual time sleeping. Recommended sleep times are based on sleep diaries that are kept for two weeks before commencing sleep restriction therapy. For example, an individual who reports spending 8.5 hours in bed, but sleeping only 5.5 of these hours, would be counselled to limit his or her time spent in bed to 5.5 to 6 hours. Time allowed in bed is gradually increased in 15 to 20-minute increments (approximately once every five days if improvement is sustained) as sleep-efficiency increases, until the individual's optimal sleep time is obtained.
- *Sleep compression* counsels patients to decrease the time spent in bed gradually to match total sleep time rather than making an immediate substantial change, as is the case in sleep restriction therapy.

Stimulus control – advice for the patient

- Develop a sleep routine, such as maintaining a 30-minute relaxation period before bedtime or taking a hot bath 90 minutes before bedtime.
- Make sure the bedroom is restful and comfortable.
- Go to bed only if you are tired.
- Avoid heavy exercise within four hours of bedtime.
- Avoid caffeine, nicotine and alcohol.
- Avoid activities in the bedroom that keep you awake. Do not watch television, use electronic devices or work in bed.
- Sleep only in your bedroom.
- If you cannot fall asleep, leave the bedroom and return only when tired.
- Avoid daytime napping. If you do nap during the day, limit it to 30 minutes and do not nap, if possible, after 2 pm.

Cognitive control

- This technique aims to assist the management of persistent thoughts regarding incomplete tasks and 'unfinished business' in advance of bedtime, and therefore reduce intrusive bedtime thinking. It may be most effective for rehearsal, planning and self-evaluative thoughts which are important to the individual and which, if not dealt with, may intrude during the sleep-onset period.
- Ask the patient to set aside 15 to 20 minutes in the early evening to reflect on the day and to plan ahead for tomorrow, thus 'putting the day to rest'.

3.3.5 Drug treatment for insomnia

Hypnotic drugs help by improving aspects of sleep behaviour and daytime well-being; however, specific effects are determined by the pharmacokinetic properties of the drug (e.g. drug half-life). Hypnotics should only be prescribed for short periods of time, and in strict accordance with their licensed indications (see Appendices 1a, 1b, 3e and 3f). Drugs with longer half-lives (zopiclone) may be prescribed for patients with continuous sleep disturbances during the night; however, they may cause next-day carry-over effects.

If a hypnotic is prescribed:

- Consider the duration of action (short-acting is usually most appropriate), adverse effects, interactions and potential for dependency and abuse.
- Use the lowest effective dose for the shortest period possible — do not continue treatment for longer than 2 weeks (preferably less than one week).
- Inform the person that further prescriptions for hypnotics will not usually be given, ensure that the reasons for this are understood, and document this in the person's notes.
- Do not issue further prescriptions without seeing the person again.
- If there has been no response to the first hypnotic, do not prescribe another.

Benzodiazepines: given the risks associated with the use of benzodiazepines, their use should generally be avoided, and z-drugs preferred when a GABA modulating medicine is indicated. If benzodiazepines are used, patients should be prescribed the lowest effective dose for the shortest time possible. Maximum duration of treatment should be four weeks, including the dose tapering phase[30].

Zolpidem: has a short half-life, but despite this a Drug Safety Update was issued in May 2014 highlighting the risk of impaired driving ability the next day[31]. Due to its short half-life, zolpidem is less effective at maintaining sleep; therefore it may be prescribed for patients with sleep onset insomnia. The SPC states that treatment duration varies from a few days to two weeks with a maximum of four weeks, including tapering off where appropriate[20].

Zopiclone: has a longer half-life than zolpidem therefore may be prescribed for patients with continuous sleep disturbances during the night; however, it may cause next-day carry-over effects. The SPC for zopiclone states that long-term use is not recommended, that a course of treatment should employ the lowest effective dose, and that a single period of treatment should not exceed four weeks including any tapering off. It also states that the duration of treatment should be two to five days for transient insomnia and two to three weeks for short-term insomnia[19].

In order to prevent regular, long-term drug use, an approach consisting of intermittent, non-nightly dosing may be appropriate[32,33]. Patients on this regimen should only take medication on nights when needed to help reduce dependence problems and drug costs. In many instances this may depend on whether the patient can predict whether they will have sleeping difficulties on a particular night.

Melatonin is an endogenous hormone that helps regulate circadian rhythms, but levels are reduced in middle-aged and older people with insomnia[34,35]. Due to the role of melatonin in sleep and circadian rhythm regulation, and the age-related decrease in endogenous melatonin production, there is some evidence to suggest that melatonin may improve sleep quality particularly in people who are over 55 with primary insomnia.

A modified-release melatonin product (Circadin®) is licensed as monotherapy for the short-term treatment of primary insomnia characterised by poor quality of sleep in people aged 55 years or over[36].

In contrast to benzodiazepines, melatonin does not appear to cause motor or memory problems; however, long-term adverse effects have not been thoroughly studied.

Antihistamines such as promethazine and diphenhydramine are on sale to the public for occasional insomnia. However, use of over-the-counter treatments should not be recommended. Evidence of effectiveness is limited, and prolonged duration of action can often cause drowsiness the following day. The sedative effect of antihistamines may diminish after a few days of continued treatment[13]. Antihistamines are also associated with headache, psychomotor impairment and antimuscarinic effects, contributing to anticholinergic burden and related adverse effects. There have also been reports of diphenhydramine dependence requiring inpatient admission and management[37].

Herbal remedies, often containing valerian root, are available to purchase; however there is insufficient good quality evidence regarding the efficacy of valerian, or any other herbal remedies, in the management of insomnia[1].

4.0 GENERALISED ANXIETY DISORDER

Generalised anxiety disorder (GAD) is one of a range of anxiety disorders that includes panic disorder (with and without agoraphobia), post-traumatic stress disorder, obsessive-compulsive disorder, social phobia, specific phobias (for example spiders) and acute stress disorder[38]. The disorders are characterised by disproportionate, pervasive, uncontrollable, and widespread worry and a range of somatic, cognitive, and behavioural symptoms that occur on a continuum of severity[38]. Anxiety symptoms may range from mild and transient without daytime function impairment, to severe and persistent causing significant distress and a general reduction in quality of life[39]. Anxiety questionnaires can be helpful in detecting and assessing the severity and progress of GAD. NICE recommends the use of the Generalised Anxiety Disorder scale – 7 items (GAD-7) as part of the assessment for GAD (Appendix 2c)[2].

4.1 Treatment of anxiety

NICE guidelines regarding the management of GAD in adults are summarised below[38]:

- If GAD is comorbid with other psychological disorders, decide which disorder is most significant, in terms of severity and likelihood of response to treatment, and treat that first.
- If GAD is comorbid with harmful or dependent alcohol or substance abuse, this should be dealt with first as it may be contributing to the symptoms of GAD.
- For the management of GAD in the absence of comorbid psychological disorders, a stepped care approach should be used which draws attention to the different needs of people at different stages of their anxiety, and the interventions that are required. The interventions include: active monitoring, low- and high-intensity psychological interventions and drug treatment (see Figure 2: Management of GAD).

For further information on psychological interventions for anxiety, see NICE Clinical Knowledge Summaries on Generalised anxiety disorder[2] and NICE Guideline on Generalised anxiety disorder and panic disorder in adults: management[38].

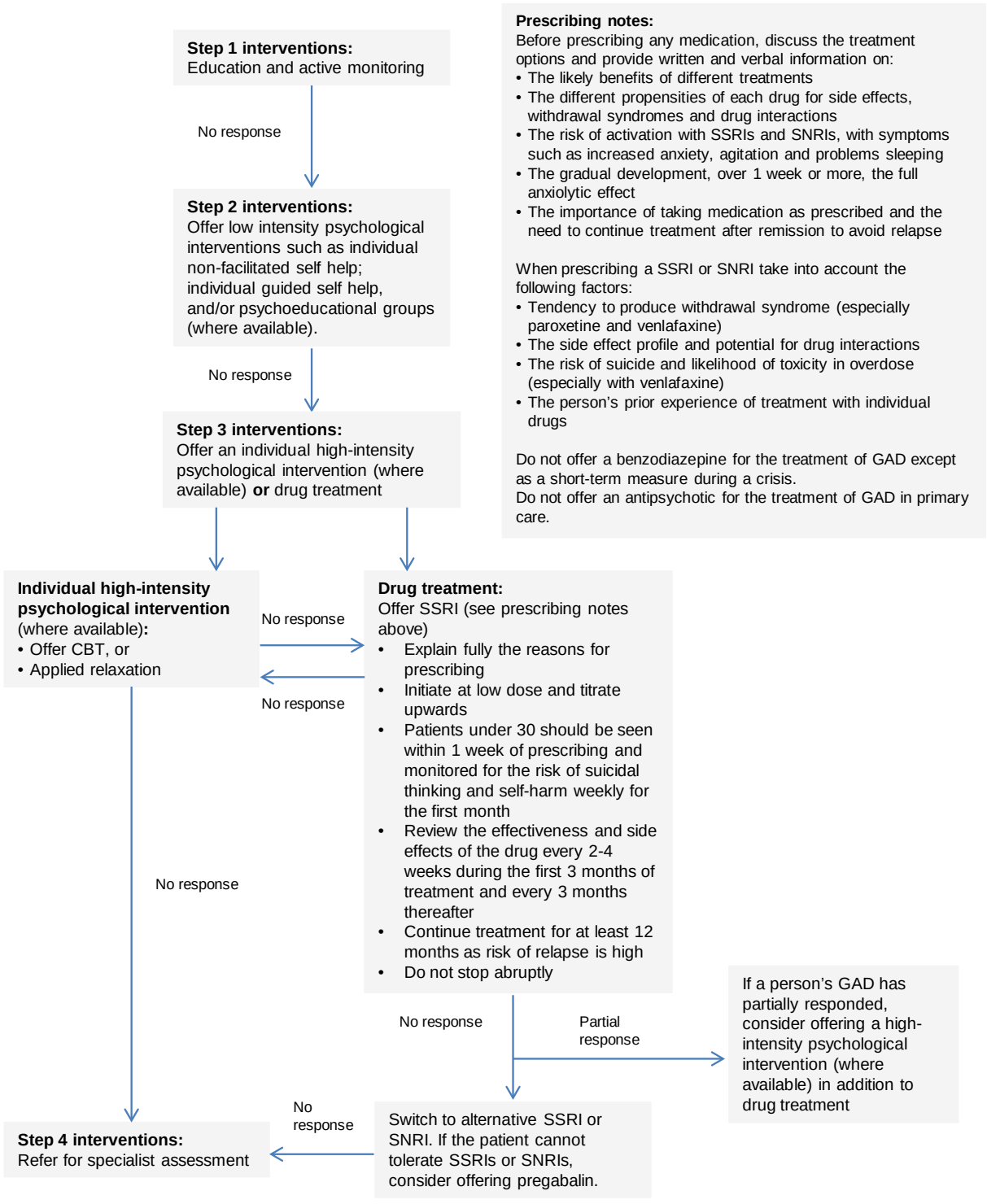
4.1.1 Drug treatments for anxiety

NICE guidance on GAD and panic disorder in adults identified four randomised control trials (RCTs) which compared benzodiazepines with placebo[38]. The results demonstrated inconsistent effects for most outcomes in GAD; therefore, benzodiazepines are not recommended as first-line treatment due to their well-documented potential for tolerance and dependence with long-term use.

- Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises[38] i.e. anxiety that is disabling and is causing the patient significant distress[2] (see Appendices 1a, 1b, 3e and 3f).
- Benzodiazepines are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with panic disorder[38].
- SSRIs should be offered as first-line drug treatment for patients with GAD. SNRIs may be used if there is no response to SSRIs[38]. Only where SSRIs and SNRIs are not tolerated should consideration be given to pregabalin[38], taking into account the small increased risk of suicidal thoughts and behaviour[40], and any patient history of substance abuse[41].
- Antidepressants should be the only pharmacological intervention used in the longer term management of panic disorder[38].

Where benzodiazepines are required, i.e. for use during crises, NICE recommends diazepam as the medicine of choice as there is extensive experience of its use for anxiety, and it has a longer half-life than other benzodiazepines[2]. The patient should be monitored closely in the early stages of treatment to assess response, adverse effects, compliance and suicide risk. Diazepam carries a significant risk of dependence if taken for longer than 2–4 weeks[2].

Figure 2. Management of GAD



5.0 SECONDARY CARE PRESCRIBING OF ANXIOLYTICS AND HYPNOTICS

Concerns surround the inadvertent continued use of hypnotics and benzodiazepine anxiolytics after hospital discharge. In contrast, hospital-initiated hypnotics may be stopped suddenly on discharge, sometimes after the patient has become dependent on them and rebound insomnia may be experienced. Consequently, the patient requests treatment to be restarted.

See Appendix 4a for an example of secondary care prescribing guidelines for anxiolytics and hypnotics.

When initiating hypnotics and anxiolytics, prescribers are reminded of GMC Good Practice Guidance relating to prescribing and managing medicines and devices. This includes the need to ensure that suitable arrangements are in place for monitoring, follow-up and review, taking account of the patients' needs and any risks arising from the medicines. It also includes the need to contribute to the safe transfer of patients between healthcare providers including the sharing of relevant information with colleagues involved in the patient's care within and outside the team.

6.0 REDUCING THE PRESCRIBING OF HYPNOTICS AND ANXIOLYTICS

A reduction in benzodiazepine and z-drug prescribing can be achieved through:

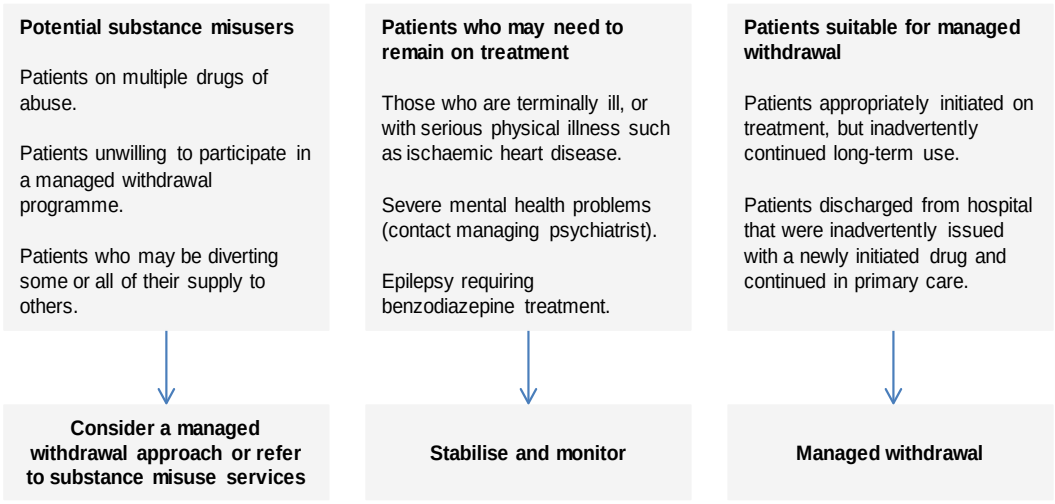
- Appropriate initiation: The Royal College of General Practitioners (RCGP) strongly advocates care in the initiation of any medicines that can lead to dependence[42], such as hypnotics and anxiolytics, by:
  - Establishing and documenting a clear diagnosis.
  - Only prescribing as part of a management plan.
  - Only initiating therapy according to treatment guidelines and ideally issue no more than two to four weeks supply.
  - Providing verbal and written information to patients upon initiation (Appendices 1a, 1b, 3e and 3f) regarding the complications of long-term use and associated side effects such as tolerance, dependence and withdrawal[43].
- Reviewing existing patients with the aim to withdraw treatment or reduce dosage where appropriate.

In 2010, the WMP report 'The nature and scope of benzodiazepine and z-drug prescribing in Wales' found that only 15% of LHBs had initiation policies for hypnotics and anxiolytics. In addition, only 45% of LHBs had withdrawal policies for hypnotics and 40% for anxiolytics[44]. Such policies may be a useful way of ensuring appropriate use of these medicines and therefore should be available and adhered to by all health boards. See Appendices 4b and 4c for examples of GP practice policy and guidelines for the prescribing of hypnotics and anxiolytics.

6.1 Management of patients on long-term anxiolytics and/or hypnotics

Patients currently taking hypnotics or anxiolytics will fall into several different categories and will therefore require different management strategies. Consider the management options outlined in Figure 3: Management of patients on long-term hypnotic and/or anxiolytic treatment.

Figure 3. Management of patients on long-term hypnotic and/or anxiolytic treatment



Withdrawal is possible in many patients once problems related to prolonged drug use are explained and discussed. Reports demonstrate that patients provided with information (e.g. a letter from their GP) explaining the disadvantages of regular use of the medicines will voluntarily reduce their usage[45].

A shared-care approach with substance misuse services may be required with more complex scenarios. In Betsi Cadwaladr University Health Board, the Prescribed Medication Support Service aims to reduce the number of patients dependent upon prescribed medication such as anxiolytics and hypnotics. It takes referrals from a number of healthcare professionals including GPs, pharmacists and secondary care clinicians. Further information is available here.

6.2 Managed withdrawal of hypnotics and/or anxiolytics in primary care

The withdrawal process in each practice is likely to involve a number of stages, starting with the identification of suitable patients, and ending with the successful discontinuation of benzodiazepine or z-drug treatment. See Appendix 5 for a variety of resources to help you undertake the withdrawal process.

The following summary highlights the process of a managed withdrawal based on a successful scheme (see Appendix 5a for further information):

- Step 1: Identify patients suitable for withdrawal; this may be done by undertaking an audit (see Appendix 5b) or running a search for all patients on benzodiazepines and z-drugs.
- Step 2: Discuss and agree within the practice the details of the withdrawal process.
- Step 3: Ensure all staff within the GP practice and local community pharmacists (Appendix 5c) are aware of the plans for withdrawal.
- Step 4: Initiate the withdrawal process:
  - Write to inform patients of the intention to withdraw treatment (see Appendix 5d for sample patient letters).
- Step 5: Invite patients to make an appointment to discuss drug withdrawal. Flexibility regarding appointments may be required for the first consultation. Provide patient with a copy of 'Coming off benzodiazepines and z-drugs – a guide for patients' (Appendix 5e and 5f)
- Step 6: Remove benzodiazepines or z-drugs from repeat prescriptions.
- Step 7: Initiate the dose reduction process using either the patients' current medication, or convert to diazepam equivalent. Issue short-term prescriptions to cover each individual dose reduction.

- Step 8: Continue the dose reduction schedule while monitoring for withdrawal effects.
- Step 9: During discontinuation, CBT therapy may provide further help.
- Step 10: Discontinue treatment.

6.2.1 Identifying patients

An audit may help to identify patients who are suitable for withdrawal (Appendix 5b). Alternatively a search may be run to identify all patients taking a hypnotic and/or anxiolytic.

6.2.2 Agreeing the details of the withdrawal process

To establish the practice's withdrawal process and policy, organise a staff meeting to discuss the initial review of hypnotic and anxiolytic prescribing. Invite local community pharmacists to the meeting, as their support will help the practice provide a consistent message to patients. Alternatively a letter may be sent to local community pharmacists informing them of the intention to undertake hypnotic and anxiolytic withdrawals (see Appendix 5c).

The meeting should be used to:

- Inform staff about the issues related to hypnotics and anxiolytics.
- Inform staff about the approach the practice will be employing.
- Agree on the management of long-term patients.
- Identify the practice lead to discuss any issues that may arise.
- Confirm the patients that have been identified by the audit for the reduction program.
- Agree how to manage the workload, for example:
- Clinical prioritisation: those on more than one benzodiazepine, those who are on the equivalent of 30 mg diazepam per day or more, those who have recently been issued a repeat prescription.
- Work logically through the identified groups (e.g. alphabetically).

6.2.3 Initiating the withdrawal process

Removal of benzodiazepines from repeat prescription

The search and/or audit may help identify patients who have a hypnotic or anxiolytic on repeat prescription, but who are no longer ordering them. A letter should be sent informing the patient that the medication will be removed from their repeat prescription (Appendix 5di – Removal of benzodiazepines/z-drugs from repeat prescriptions).

Patient initiated withdrawal programme

Attaching a letter or information leaflet to every hypnotic or anxiolytic prescription within the target group may encourage patients to initiate a dose reduction themselves (see Appendix 5dii – Patient-initiated withdrawal).

Leaflets describing self-help techniques may also be provided (e.g. 'Good sleep guide', [Appendix 3a and 3b] and 'Good relaxation guide' [Appendix 3c and 3d]). A copy of this information should also be given to each local community pharmacy to raise awareness of the information patients may want to discuss.

Following the leaflet approach, it is recommended to review patient's hypnotic/anxiolytic prescriptions to determine whether requests for further supplies have been reduced. Subsequently, a follow-up letter may be sent to individual patients with a withdrawal programme attached (see Appendix 5diii – Practice-initiated withdrawal) inviting them for an appointment to discuss their hypnotic or anxiolytic medication (see Appendix 5div – Clinic appointment and 5dv – Pharmacist-led clinic)

GP practice withdrawal programme

Before initiating the withdrawal programme, information leaflets or letters may be sent to patients to inform them of the practice's intention to invite them to discuss a withdrawal programme from their medication (see Appendix 5dvi – Request to make a GP appointment). This will alert them to the issues and enable them to start preparing for the proposed appointment.

A number of approaches may be taken to review patients:

- It may be appropriate to organise a specific clinic to simultaneously review a large number of patients.
- Add one patient to be reviewed (15-minute appointment) at the end of each doctor's normal session. This approach may be useful in practices with a larger number of GPs to involve everyone and divide the workload.
- The number of GP repeat prescription authorisations for hypnotics and anxiolytics could be reduced, and the patient asked to make an appointment for review of the hypnotic or anxiolytic.
- A routine medication review may be an opportunity to provide written information to the patient and to organise a further appointment to discuss a reduction program.

In order to manage workload it may be advisable to agree a specific number of patients who are invited to discuss managed hypnotic and/or anxiolytic reduction/withdrawal each week.

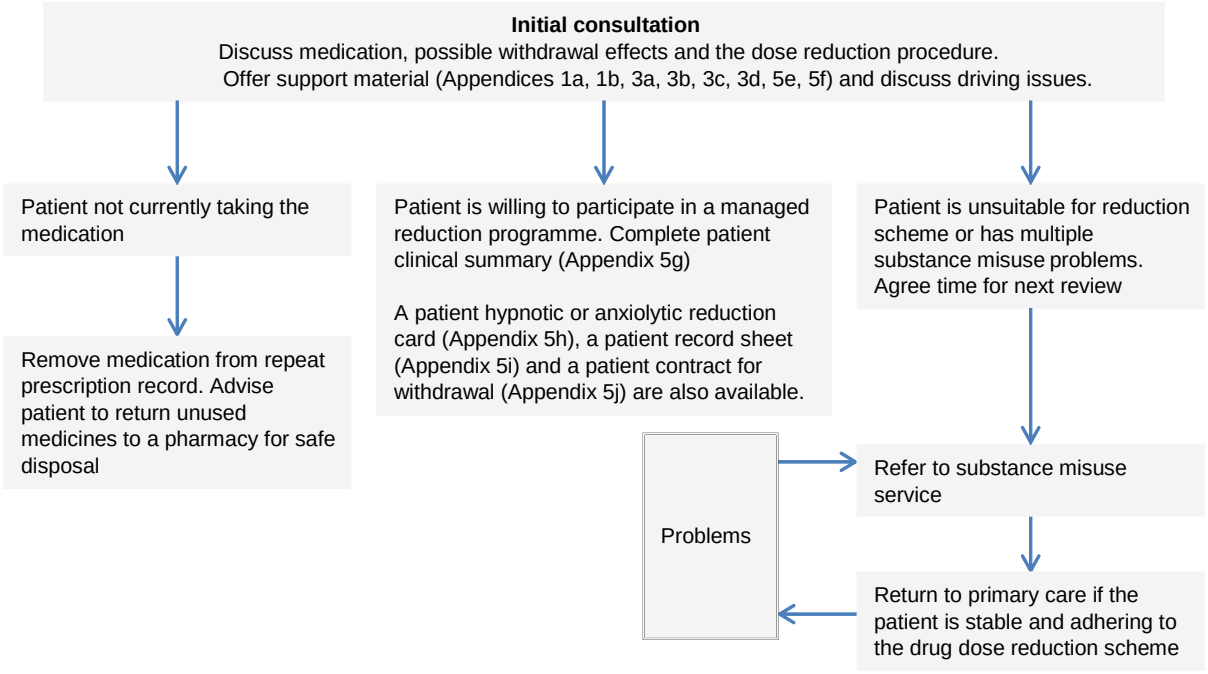
6.2.4 Initial consultation

The first appointment with the patient should cover the following points:

- The long-term use of benzodiazepines is not recommended.
- Tolerance can develop after short-term use; hence the medication may no longer be having the desired effect.
- The influence of these medicines on the ability to drive (note new driving laws) and carry out simple tasks.
- The risk of daytime drowsiness, memory loss and confusion/falls (fractures). Many patients do not realise how much they have been affected until they attempt to withdraw. Inform patients they will feel more alert in the morning once medicine use has stopped.
- Sleep is more natural and refreshing without a hypnotic. Recommend sleep hygiene and patient information leaflets (Appendices 3a, 3b, 3c and 3d), and suggest keeping a sleep diary (Appendix 2d).
- Address the cause of the sleep disturbance/anxiety (e.g. poor sleep hygiene, pain control, depression, medication).
- Alcohol intake.
- Withdrawal plan.
- When terminating treatment, withdrawal symptoms may occur; therefore the dosage should be reduced slowly. CBT therapy may be initiated during discontinuation to help withdrawal.
- Withdrawal symptoms may be similar to the original symptoms prior to treatment initiation and may persist for several weeks. Symptoms may begin within 24 hours and last for up to six weeks with maximum intensity between three days and two weeks.
- Lost prescriptions should not be replaced, and extra prescriptions should not be issued.

See Figure 4: Options following initial consultation, for next steps after consultation has taken place.

Figure 4. Options following initial consultation



6.2.5 Dose reduction for managed withdrawal programmes

There are two approaches to facilitate dose reduction:

- Patients may be slowly withdrawn from their current benzodiazepine or z-drug.
- Patients may be switched from their current anxiolytic or hypnotic to an equivalent dose of diazepam which is subsequently tapered down.

Conversion to an equivalent dose of diazepam is recommended when patients experience severe withdrawal symptoms. Lorazepam and oxazepam have short half-lives which may exacerbate withdrawal effects and make them difficult to manage. However, some patients prefer a reduction scheme with their current treatment, and successfully withdraw in this way. See Figure 5: Managed withdrawal of hypnotics and anxiolytics in primary care, for a withdrawal flow chart.

Examples of dose reduction schedules are included in Appendices 5k and 5l. These are intended to be used as a guide and should be tailored to the requirements of individual patients. Some general principles for dose reduction are listed as follows:

- Negotiate a gradual drug withdrawal schedule that is flexible. Be guided by the person in making adjustments so that they remain comfortable with the withdrawal[16].
- If patients struggle to manage their withdrawal, consider issuing WP10MDA prescriptions e.g. daily or weekly collections, where appropriate. In Wales, Schedule 2, 3, 4 and 5 Controlled Drugs can be supplied in instalments on a WP10MDA form[13]. More information can be found on the NICE Clinical Knowledge Summaries website.
- Monitor regularly to assess patient progress and to provide advice and encouragement.
- If withdrawal symptoms occur, maintain the current dose until symptoms improve. Do not revert to a higher dose.
- Make dose reductions in smaller steps if necessary; it is better to reduce slowly rather than too quickly.
- Incorporate CBT techniques during discontinuation to ameliorate withdrawal symptoms.

- Be aware that withdrawal may take three months to a year or longer. Some people may be able to withdraw in less time[16].
- If the patient did not succeed on their first attempt, encourage the person to try again. Remind them that reducing the dose, even if this falls short of complete withdrawal, can still be beneficial[16].

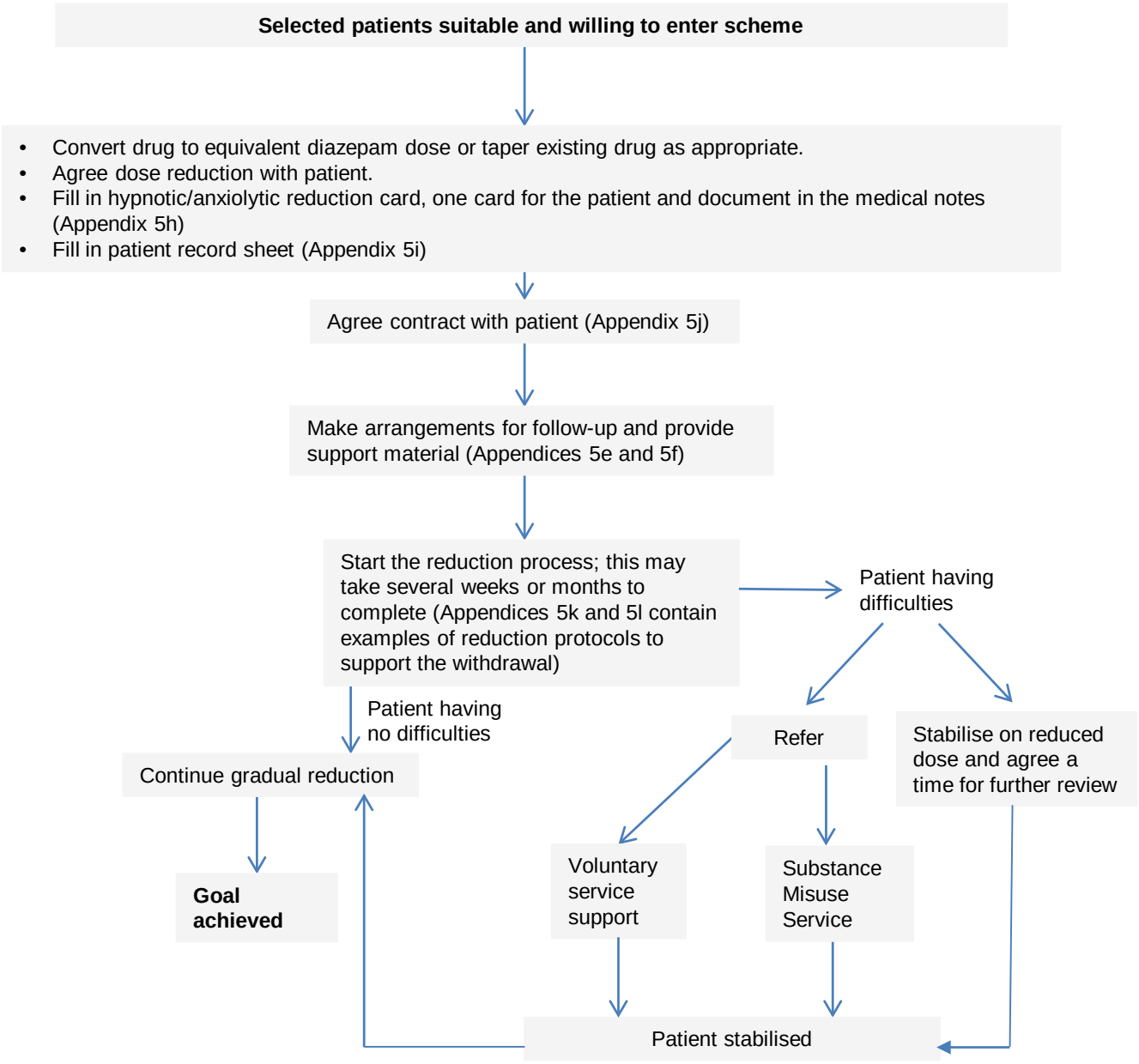
6.2.6 Withdrawal symptoms

- It is important to monitor patients regularly for withdrawal symptoms during the dose reduction process.
- Withdrawal symptoms occur in approximately 40% of patients who take benzodiazepines continuously for more than six weeks.
- Abrupt withdrawal can produce confusion, toxic psychosis, convulsions, or a condition resembling *delirium tremens*.
- Other withdrawal symptoms include flu-like symptoms, insomnia, anxiety, loss of appetite and body weight, tremor, perspiration, tinnitus and perceptual disturbances. These may be similar to the original complaint prior to treatment initiation and may encourage further prescribing; however, this should be avoided.
- The severity of withdrawal symptoms depends on several factors including treatment duration, drug dose, drug half-life, and baseline levels of anxiety and depression.
- Symptoms may begin within 24 hours for short-acting benzodiazepines, but may develop over several days with longer-acting drugs. Maximum intensity usually occurs between three and fourteen days but may continue for up to six weeks.

6.2.7 Managing someone who does not want to stop

- Do not pressurise the person to stop if they are not motivated to do so.
- Listen to the person, and address any concerns they have about stopping.
  - Explain that for most people who withdraw from treatment slowly, symptoms are mild and can usually be effectively managed by other means.
  - Reassure the person that they will be in control of the drug withdrawal and that they can proceed at a rate that suits them.
- Discuss the benefits of stopping the drug, including an explanation of tolerance, adverse effects, and the risks of continuing the drug.
- Review at a later date if appropriate and reassess the person's motivation to stop.
- In people who remain concerned about stopping treatment despite explanation and reassurance, persuading them to try a small reduction in dose may help them realise that their concerns are unfounded[16].

Figure 5. Managed withdrawal of hypnotics and anxiolytics in primary care



REFERENCES

1. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Insomnia. 2020. Available at: http://cks.nice.org.uk/insomnia. Accessed November 2020.
2. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Generalized anxiety disorder. 2015. Available at: http://cks.nice.org.uk/generalized-anxiety-disorder. Accessed November 2020.
3. Wilson S, Anderson K, Baldwin D et al. British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadian rhythm disorders: An update. *Journal of Psychopharmacology.* 2019;33(8):923-947. Available at: https://pubmed.ncbi.nlm.nih.gov/31271339. Accessed November 2020.
4. Baldwin D, Aitchison K, Bateson A et al. Benzodiazepines: Risks and benefits. A reconsideration. *Journal of Psychopharmacology.* 2013;27(11):967-971. Available at: https://pubmed.ncbi.nlm.nih.gov/24067791. Accessed November 2020.
5. Office for National Statistics. Deaths related to drug poisoning in England and Wales: 2018 registrations. 15/08/19. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsrelatedtodrugpoisoningbyselectedsubstances. Accessed September 2020.
6. All Wales Medicines Strategy Group. National Prescribing Indicators 2019-2020. 2020. Available at: https://awmsg.nhs.wales/files/national-prescribing-indicators/national-prescribing-indicators-2019-2020. Accessed September 2020.
7. Advisory Council on the Misuse of Drugs. ACMD advice on the control of Z-drugs (zaleplon, zolpidem and zopiclone). 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/237037/ACMD_advice_Z_drugs.pdf. Accessed November 2020.
8. Royal Pharmaceutical Society. Changes to legislation: tramadol, lisdexamfetamine, zopiclone and zaleplon. 10/06/2014.
9. Home Office. Circular 008/2014: changes to the Misuse of Drugs Act 1971. 2014. Available at: https://www.gov.uk/government/publications/circular-0082014-changes-to-the-misuse-of-drugs-act-1971. Accessed November 2020.
10. European Medicines Agency. Sonata. Withdrawal of the marketing authorisation in the European Union. 2015. Available at: https://www.ema.europa.eu/en/documents/public-statement/public-statement-sonata-withdrawal-marketing-authorisation-european-union_en.pdf. Accessed September 2020.
11. UK Government. Drugs and driving: the law. 2016. Available at: https://www.gov.uk/drug-driving-law. Accessed November 2020.
12. Medicines and Healthcare Products Regulatory Agency. Drug Safety Update: Drugs and driving: blood concentration limits to be set for certain controlled drugs in a new legal offence. Vol 7. 2014. Medicines and Healthcare Products Regulatory Agency. Available at: https://www.gov.uk/drug-safety-update/drugs-and-driving-blood-concentration-limits-to-be-set-for-certain-controlled-drugs-in-a-new-legal-offence. Accessed November 2020
13. National Institute for Health and Care Excellence. British National Formulary. Available at: https://bnf.nice.org.uk. Accessed September 2020.
14. Atack J. The benzodiazepine binding site of $GABA_A$ receptors as a target for the development of novel anxiolytics. *Expert Opinion on Investigational Drugs.* 2005;14(5):601-618. Available at: https://www.ncbi.nlm.nih.gov/pubmed/15926867. Accessed November 2020.
15. Hallfors D, and Saxe L. The Dependence Potential of Short Half-Life Benzodiazepines: A Meta-Analysis. *American Journal of Public Health.*

1993;83(9):5. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1694983/pdf/amjph00533-0110.pdf. Accessed November 2020.
16. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Benzodiazepine and z-drug withdrawal. 2015. Available at: https://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal. Accessed November 2020.
17. Taylor D, Barnes T, and Young A. *The Maudsley prescribing guidelines 13th edition.* 2018.
18. McAllister-Williams R, Baldwin D, Cantwell R et al. British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum. *Journal of Psychopharmacology.* 2017;31(5):519-552. Available at: https://pubmed.ncbi.nlm.nih.gov/28440103. Accessed November 2020.
19. electronic Medicines Compendium. Summary of Product Characteristics: Zimovane 7.5mg film-coated tablets. 2019. Available at: https://www.medicines.org.uk/emc/medicine/27165. Accessed November 2020.
20. electronic Medicines Compendium. Summary of Product Characteristics: Stilnoct 10mg Film-Coated Tablets. 2019. Available at: https://www.medicines.org.uk/emc/medicine/25411. Accessed November 2020.
21. National Institute for Health and Care Excellence. Technology Appraisal 77. Guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia (TA77). 2004. Available at: https://www.nice.org.uk/guidance/ta77. Accessed November 2020.
22. Morphy H, Dunn K, Lewis M et al. Epidemiology of insomnia: a longitudinal study in a UK population. *Sleep.* 2007;30(3):274-280. Available at: http://www.ncbi.nlm.nih.gov/pubmed/17425223. Accessed November 2020.
23. Léger D, Scheuermaier K, Philip P et al. SF-36: evaluation of quality of life in severe and mild insomniacs compared with good sleepers. *Psychosomatic medicine.* 2001;63(1):49-55. Available at: https://www.researchgate.net/publication/12120410_SF-36_Evaluation_of_Quality_of_Life_in_Severe_and_Mild_Insomniacs_Compared_With_Good_Sleepers. Accessed November 2020.
24. Chevalier H, Los F, Boichut D et al. Evaluation of severe insomnia in the general population: results of a European multinational survey. *Journal of Psychopharmacology.* 1999;13:S21-S24. Available at: https://www.ncbi.nlm.nih.gov/pubmed/10667452. Accessed November 2020.
25. Vgontzas A, Liao D, Bixler E et al. Insomnia with objective short sleep duration is associated with a high risk for hypertension. *Sleep.* 2009;32(4):491-497. Available at: https://www.ncbi.nlm.nih.gov/pubmed/19413143. Accessed November 2020.
26. Vgontzas A, Tsigos C, Bixler E et al. Chronic insomnia and activity of the stress system: a preliminary study. *Journal of Psychosomatic Research.* 1998;45:21-31. Available at: https://pubmed.ncbi.nlm.nih.gov/9720852/. Accessed November 2020.
27. Morin C, Belanger L, LeBlanc M et al. The natural history of insomnia: a population-based 3-year longitudinal study. *Archives of Internal Medicine.* 2009;169(5):447-453. Available at: http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/773500. Accessed November 2020.
28. Falloon K, Arroll B, Elley C et al. The assessment and management of insomnia in primary care. *BMJ.* 2011;342(d2899). Available at: http://www.bmj.com/content/342/bmj.d2899.long. Accessed November 2020.
29. Riemann D, and Perlis M. The treatments of chronic insomnia: a review of benzodiazepine receptor agonists and psychological and behavioural therapies.

Sleep Medicine Reviews. 2009;13(3):205-214. Available at: http://www.sciencedirect.com/science/article/pii/S1087079208000567. Accessed November 2020.

30. Medicines and Healthcare Products Regulatory Agency. Addiction to benzodiazepines and codeine. 2011. Available at: https://www.gov.uk/drug-safety-update/addiction-to-benzodiazepines-and-codeine. Accessed November 2020.
31. Medicines and Healthcare Products Regulatory Agency. Drug Safety Update: Zolpidem: risk of drowsiness and reduced driving ability. Vol 7. 2014. Available at: https://www.gov.uk/drug-safety-update/zolpidem-risk-of-drowsiness-and-reduced-driving-ability. Accessed November 2020
32. Krystal A, Erman M, Zammit G et al. Long-term efficacy and safety of zolpidem extended-release 12.5 mg, administered 3 to 7 nights per week for 24 weeks, in patients with chronic primary insomnia: a 6-month, randomized, double-blind, placebo-controlled, parallel-group, multicenter study. *Sleep.* 2008;31(1):79-90. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2225552/. Accessed November 2020.
33. Perlis ML, McCall WV, Krystal AD et al. Long-term, non-nightly administration of zolpidem in the treatment of patients with primary insomnia. *J Clin Psychiatry.* 2004;65(8):1128-1137. Available at: https://pubmed.ncbi.nlm.nih.gov/15323600/. Accessed November 2020.
34. Cajochen C, Krauchi K, and Wirz-Justice A. Role of melatonin in the regulation of human circadian rhythms and sleep. *Journal of Neuroendocrinology.* 2003;15(4):432-437. Available at: https://www.ncbi.nlm.nih.gov/pubmed/12622846. Accessed November 2020.
35. Haimov I. Melatonin rhythm abnormalities and sleep disorders in the elderly. *CNS Spectrums.* 2001;6(6):502-506. Available at: https://www.cambridge.org/core/journals/cns-spectrums/article/melatonin-rhythm-abnormalities-and-sleep-disorders-in-the-elderly/52D80D7A5ECDD29172380E4DD24F6D6C#. Accessed November 2020.
36. electronic Medicines Compendium. Summary of Product Characteristics: Circadin®. 2019. Available at: https://www.medicines.org.uk/emc/medicine/25643. Accessed November 2020.
37. Thomas A, Nallur D, Jones N et al. Diphenhydramine abuse and detoxification: a brief review and case report. *Journal of Psychopharmacology.* 2009;23(1):101-105. Available at: https://pubmed.ncbi.nlm.nih.gov/18308811/. Accessed November 2020.
38. National Institute for Health and Care Excellence. Clinical Guideline 113. Generalised anxiety disorder and panic disorder in adults: management (CG113). 2019. Available at: https://www.nice.org.uk/guidance/cg113. Accessed November 2020.
39. Baldwin D, Anderson I, Nutt D et al. Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: a revision of the 2005 guidelines from the British Association for Psychopharmacology. *Journal of Psychopharmacology.* 2014;28(5):403-439. Available at: https://pubmed.ncbi.nlm.nih.gov/24713617. Accessed November 2020.
40. Medicines and Healthcare Products Regulatory Agency. Drug Safety Update: Antiepileptics: risk of suicidal thoughts and behaviour. Vol 2. 10. 2008. MHRA. Available at: https://www.gov.uk/drug-safety-update/antiepileptics-risk-of-suicidal-thoughts-and-behaviour. Accessed November 2020
41. electronic Medicines Compendium. Summary of Product Characteristics: Lyrica Capsules. Available at: https://www.medicines.org.uk/emc/medicine/14651. Accessed November 2020.

42. Royal College of General Practitioners. Addiction to Medicines Consensus Statement. Available at: https://www.rcgp.org.uk/news/2013/january/~/media/Files/News/RCGP-Addiction-to-Medicine-consensus-statement.ashx. Accessed November 2020.
43. Royal College of General Practitioners. RCGP Substance Misuse and Associated Health Prescription and over-the-counter medicines misuse and dependence. Available at: http://www.rcgp.org.uk/learning/~/media/Files/SMAH/RCGP%20Factsheet%202_artwork_v3_28Apr.ashx Accessed November 2020.
44. Welsh Medicines Partnership. Nature and scope of benzodiazepine and "z" drug prescribing in Wales. 9/1/2010. Available at: https://gov.wales/nature-and-scope-benzodiazepine-and-z-drug-prescribing-wales-0. Accessed November 2020.
45. Ashton H. The diagnosis and management of benzodiazepine dependence. *Curr Opin Psychiatry.* 2005;18:249-255. Available at: https://www.ncbi.nlm.nih.gov/pubmed/16639148. Accessed November 2020.

APPENDIX 1. MEDICINES FOR ANXIETY AND INSOMNIA: PATIENT INFORMATION LEAFLETS

1a) English – Medicines for anxiety and insomnia

This summary is for people who are prescribed benzodiazepines (diazepam, chlordiazepoxide, loprazolam, lorazepam, lormetazepam, nitrazepam, temazepam) or people who are prescribed zolpidem or zopiclone, sometimes referred to as “z- drugs”.

What are benzodiazepines and z-drugs used for?
Benzodiazepines and z-drugs have a calming effect on your brain. They can help you to manage a short period of severe stress (anxiety) or sleeplessness (insomnia), which is affecting your well-being (quality of life). Benzodiazepines may be prescribed for anxiety or insomnia; z-drugs are prescribed for insomnia.

What are the side effects of benzodiazepines and z-drugs?
Like all medicines, benzodiazepines and z-drugs can have some unpleasant or unwanted effects (side effects).

They may cause problems such as:

- sleepiness and dizziness
- confusion and memory problems
- falling over, particularly in older patients

Because of these types of unwanted effects, benzodiazepines and z-drugs are associated with an increased risk of accidents on the road, or with work machinery. It is illegal to drive if you are taking one of these medicines and it affects your driving. **Do not drive, or operate machinery, if you are under the effects of these medicines.**

Taking benzodiazepines and z-drugs for long periods can cause some additional problems. These include:

- the effects starting to wear off (sometimes known as ‘tolerance’);
- symptoms coming back when you stop treatment; and
- withdrawal effects when you stop treatment, particularly if you suddenly stop taking them.

For these reasons, benzodiazepines and z-drugs should usually only be used for a short period of time (up to 2 weeks).

How long are benzodiazepines and z-drugs usually taken for?
These medicines are usually prescribed for the short-term treatment of severe anxiety or insomnia. Usually your doctor will prescribe these medicines for no more than two weeks of treatment.

You may be offered a follow-up appointment in case you need further support, alternative treatment, or referral (for example, to a team who can arrange relaxation treatments).

Sometimes people may have been treated with these medicines for longer than two weeks. If so, you should talk to your doctor about whether the medicine is still helping you, or whether you should try to gradually stop taking the medicine that you were prescribed.

If you have been taking a benzodiazepine or z-drug for a long period of time, you should **not** stop taking it without first talking with your doctor about stopping.

Stopping benzodiazepines and z-drugs
Stopping treatment too quickly can cause withdrawal symptoms, particularly if you have been taking these medicines for a long time. Withdrawal symptoms may include flu-like symptoms, anxiety, insomnia, nightmares and feeling irritable. If you are thinking about stopping your benzodiazepine or z-drug, talk to your doctor before you stop.

If you and your doctor decide that stopping treatment is right for you, this will usually happen in stages, by gradually reducing the amount you are taking. The dose will be reduced usually every one to two weeks, based upon how you are feeling. Depending on the dose you are taking, stopping treatment could happen over several weeks, several months, or even a year or longer.

What else can I do to help my insomnia?
Try to establish a regular sleep pattern. Try to go to bed and wake up at the same time each day, and avoid sleeping during the day.

Make sure that your bedroom is dark, quiet and calm, with a comfortable bed, and try to remove electronic devices such as televisions. Try not to use your bedroom for work.

Changes to your lifestyle can help to improve your sleep. Try to relax before going to bed, and avoid vigorous exercise and mental stimulation late at night. Listening to relaxing music, reading a book or taking a warm bath may help to relax you before bed. Avoid nicotine and caffeinated drinks, such as coffee, tea, energy drinks and cola, for at least six hours before going to bed because they may keep you awake.

Avoid alcoholic drinks altogether. These can affect the quality of your sleep, and can also worsen any unwanted effects of benzodiazepines and z-drugs, particularly when you first start treatment.

What else can I do to help my anxiety?
A healthy lifestyle, with exercise, a healthy diet and a good sleep pattern can help to reduce your anxiety. Self-help tools such as relaxation and mindfulness are also available. Try to avoid using alcohol or nicotine to manage anxiety.

Counselling and other psychological therapies are available for anxiety. Your doctor can refer you for therapies as part of NHS treatment.

Other medicines (not benzodiazepines) are sometimes used to treat anxiety. These include selective serotonin reuptake inhibitors such as sertraline and escitalopram. Remember that all medicines can have unwanted effects (side effects), and you should discuss the risks and benefits of any treatment with your doctor.

Combining some of the different approaches mentioned above might be an effective way to manage your anxiety.

Where can I find further information?
Please ask your doctor, pharmacist or nurse for leaflets about sleeping tablets, relaxation and how to get a good night's sleep.

Organisations such as Mind (www.mind.org.uk) and the National Centre for Mental Health (www.ncmh.info) have several resources available on their websites, including information about anxiety and insomnia, and the medicines used to treat them.

1b) Welsh – Meddyginiaethau ar gyfer pryder ac insomnia

Mae'r crynodeb hwn ar gyfer pobl sy'n cael bensodiasepinau (diazepam, chlordiazepoxide, loprazolam, lorazepam, lormetazepam, nitrazepam, temazepam) ar bresgripsiwn neu bobl sydd â phresgripsiwn ar gyfer zolpidem neu zopiclone, y cyfeirir atynt weithiau fel "cyffuriau z".

Ar gyfer beth y defnyddir bensodiasepinau a chyffuriau z?
Mae bensodiasepinau a chyffuriau z yn cael effaith tawelol ar eich ymennydd. Gallant eich cynorthwyo i reoli cyfnod byr o straen difrifol (pryder) neu fethu cysgu (insomnia), sy'n effeithio ar eich lles (ansawdd bywyd). Gall bensodiasepinau gael eu presgripsiynu ar gyfer pryder neu insomnia; presgripsiynir cyffuriau z ar gyfer insomnia.

Beth yw sgileffeithiau bensodiasepinau a chyffuriau z?
Fel pob meddyginiaeth, gall bensodiasepinau a chyffuriau z gael rhai effeithiau amhleserus neu ddigroeso (sgileffeithiau).

Gallant achosi problemau megis:

- cysgadrwydd a phenysgafnder
- dryswch a phroblemau gyda'r cof
- cwympo, yn arbennig ymhlith cleifion hŷn

Oherwydd y mathau hyn o effeithiau digroeso, cysylltir bensodiasepinau a chyffuriau z gyda risg gynyddol o ddamweiniau ar y ffyrdd, neu ddamweiniau gyda pheiriannau gwaith. Mae'n anghyfreithlon gyrru os ydych yn cymryd un o'r meddyginiaethau hyn ac mae'n effeithio ar eich gyrru. Peidiwch â gyrru, na defnyddio peiriannau, os ydych dan effaith y meddyginiaethau hyn.

Gall cymryd bensodiasepinau a chyffuriau z am gyfnodau hir achosi rhai problemau ychwanegol. Mae'r rhain yn cynnwys:

- yr effeithiau'n dechrau gwanhau (a elwir weithiau'n 'oddefiad');
- symptomau'n dychwelyd pan fyddwch yn rhoi gorau i'r driniaeth
- effeithiau diddyfnu pan fyddwch yn rhoi'r gorau i driniaeth, yn arbennig os byddwch yn rhoi'r gorau iddi yn sydyn.

Am y rhesymau hyn dim ond am gyfnodau byr o amser (hyd at 2 wythnos) y dylid defnyddio bensodiasepinau a chyffuriau z fel arfer.

Am faint o amser y cymerir bensodiasepinau a chyffuriau z fel arfer?
Caiff y cyffuriau hyn eu presgripsiynu fel arfer ar gyfer triniaeth tymor byr am bryder difrifol neu insomnia. Fel arfer bydd eich meddyg yn presgripsiynu'r meddyginiaethau hyn am ddim rhagor na dwy wythnos o driniaeth.

Efallai y cynigir apwyntiad dilyn i fyny i chi rhag ofn eich bod angen cefnogaeth bellach, triniaeth amgen, neu atgyfeiriad (er enghraifft, i dîm all drefnu triniaethau ymlacio).

Weithiau efallai y bydd pobl wedi cael eu trin â'r meddyginiaethau hyn am gyfnod hwy na dwy wythnos. Os ydych chi'n un o'r rheini, dylech sgwrsio â'ch meddyg ynglŷn ag a yw'r feddyginiaeth yn dal i'ch helpu, neu a ddylech geisio rhoi'r gorau i gymryd y feddyginiaeth a bresgripsiynwyd i chi yn raddol.

Os ydych wedi bod yn cymryd bensodiasepin neu gyffur z am gyfnod hir, **ni ddylech** roi'r gorau i'w gymryd heb sgwrsio ynglŷn â hyn gyda'ch meddyg yn gyntaf.

Rhoi'r gorau i bensodiasepinau a chyffuriau z
Gall rhoi'r gorau i driniaeth yn rhy gyflym achosi symptomau diddyfnu, yn arbennig os ydych wedi bod yn cymryd y meddyginiaethau hyn am amser hir. Gallai symptomau diddyfnu gynnwys symptomau tebyg i'r ffliw, pryder, insomnia, hunllefau a theimlo'n bigog. Os ydych chi'n ystyried rhoi'r gorau i gymryd eich bensodiasepin neu gyffur z, sgwrsiwch â'ch meddyg cyn gwneud hynny.

Os ydych chi a'ch meddyg yn penderfynu bod rhoi'r gorau i'r driniaeth yn iawn i chi, bydd hyn fel arfer yn digwydd mewn camau, drwy leihau'n raddol y swm rydych yn ei gymryd. Caiff y ddos ei lleihau fel arfer bob un i ddwy wythnos, yn seiliedig ar sut rydych yn teimlo. Yn dibynnu ar y ddos rydych yn ei chymryd, gallai rhoi'r gorau i driniaeth ddigwydd dros nifer o wythnosau, nifer o fisoedd, neu hyd yn oed blwyddyn neu fwy.

Beth arall allaf i ei wneud i helpu gyda fy insomnia?
Ceisiwch greu patrwm cysgu rheolaidd. Ceisiwch fynd i'r gwely a deffro yr un adeg bob dydd, a pheidiwch â chysgu yn ystod y dydd.

Gwnewch yn siŵr bod eich ystafell wely yn dywyll, tawel a digyffro, gyda gwely cyfforddus, a cheisiwch gael gwared ar unrhyw ddyfeisiau trydanol megis teledu. Ceisiwch beidio â defnyddio eich ystafell wely i weithio.

Gall gwneud newidiadau i'ch ffordd o fyw helpu i wella eich cwsg. Ceisiwch ymlacio cyn mynd i'r gwely, ac osgowch ymarfer corff egnïol ac ysgogiad meddyliol yn hwyr yn y nos. Gallai gwrando ar gerddoriaeth ymlaciol, darllen llyfr neu gael bath cynnes eich helpu i ymlacio cyn mynd i'r gwely. Osgowch nicotin a diodydd caffein, fel coffi, te, diodydd egni a cola, am o leiaf chwe awr cyn mynd i'r gwely oherwydd gallant eich cadw'n effro.

Osgowch ddiodydd alcoholaidd yn llwyr. Gall y rhain effeithio ar ansawdd eich cwsg, a gallant hefyd waethygu unrhyw effeithiau digroeso bensodiasepinau a chyffuriau z, yn arbennig pan fyddwch yn dechrau triniaeth am y tro cyntaf.

Beth arall allaf i ei wneud i helpu gyda fy mhryder?
Gall ffordd o fyw iach, gydag ymarfer corff, diet iach a phatrwm cysgu da helpu i leihau eich pryder. Mae dulliau hunangymorth megis ymlacio ac ymwybyddiaeth fyfyriol hefyd ar gael. Ceisiwch osgoi defnyddio alcohol neu nicotin i reoli pryder.

Mae cwnsela a therapïau seicolegol eraill ar gael ar gyfer pryder. Gall eich meddyg eich atgyfeirio ar gyfer therapïau fel rhan o driniaeth y GIG.

Weithiau defnyddir meddyginiaethau eraill (dim bensodiasepinau) i drin pryder. Mae'r rhain yn cynnwys atalwyr ailddderbyn serotonin dethol megis sertraline ac escitalopram. Cofiwch y gall pob meddyginiaeth gael effeithiau digroeso (sgileffeithiau), a dylech drafod risgiau a manteision unrhyw driniaeth gyda'ch meddyg.

Gallai cyfuno rhai o'r gwahanol ddulliau a grybwyllir uchod fod yn ffordd effeithiol i reoli eich pryder.

Lle gallaf gael rhagor o wybodaeth?
Holwch eich meddyg, fferyllydd neu nyrs am daflenni ynglŷn â thabledi cysgu, ymlacio a sut i gael noson dda o gwsg.

Mae gan sefydliadau fel Mind (www.mind.org.uk) a'r Ganolfan Genedlaethol ar gyfer Iechyd Meddwl (www.ncmh.info) lawer o adnoddau ar eu gwefannau, yn cynnwys gwybodaeth am bryder ac insomnia, a'r meddyginiaethau a ddefnyddir i'w trin.

APPENDIX 2. ASSESSMENT TOOLS

2a) Sleep assessment tool

ALL INFORMATION PROVIDED IS TREATED AS CONFIDENTIAL

Name:……

Tel No:……..**Date of birth:**…….

About your sleep

How many hours sleep do you get each night?

Less than 2 hours	2–4 hours	4–6 hours	6 or more hours

During the last month how many times have you felt refreshed when you wake up in the morning?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

During a typical month do you get good quality deep sleep, or is your mind still alert during sleep?

Always good quality	Mostly good quality	Equal amount of good and poor quality	Mostly poor quality	Always poor quality

During the last month how often have you had difficulty sleeping because:

a. You could not get to sleep within 30 minutes?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

b. You wake up in the middle of the night or early morning?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

c. You have to get up to use the bathroom?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

d. You snore, gasp for air, or stop breathing?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

e. You kick or thrash about while asleep?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

f. You are in pain?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

g. The room is too light, noisy, hot or cold?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

Please list any other reasons:

……

How often did these reasons affect your sleep in the last month?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

How many times during the last month have you had difficulty staying awake whilst driving, eating or engaging in social activity?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

How often do you sleep during the day?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

During the last month have you taken any stimulants (e.g. nicotine, caffeine, amphetamine, decongestants) after 6 pm?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

Are you taking any other medicines? Please list:

……

About your sleep medication

How long have you been taking benzodiazepines or z-drugs?

2 months or less	2–6 months	6–12 months	1–5 years	More than 5 yrs

During the last month how often have you taken benzodiazepines or z-drugs?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

Do you take any additional remedies to help you sleep (e.g. Nytol™, herbal remedies, alcohol)? Please list:

……..

During the last month how often have you taken an additional remedy?

Not in the last month	Less than once a week	Once or twice a week	Three or more times a week

2b) Sleep condition indicator (SCI)

Item	Score				
	4	3	2	1	0
Thinking about a typical night in the last month…					
1…..how long does it take you to fall asleep?	0–15 min	16–30 min	31–45 min	46–60 min	≥ 61 min
2….if you then wake up during the night, how long are you awake for in total (add all the wakenings up)	0–15 min	16–30 min	31–45 min	46–60 min	≥ 61 min
3….how many nights a week do you have a problem with your sleep?	0–1	2	3	4	5–7
4….how would you rate your sleep quality?	Very good	Good	Average	Poor	Very poor
Thinking about the past month, to what extent has poor sleep…					
5….affected your mood, energy, or relationships?	Not at all	A little	Some-what	Much	Very much
6….affected your concentration, productivity, or ability to stay awake?	Not at all	A little	Some-what	Much	Very much
7….troubled you in general?	Not at all	A little	Some-what	Much	Very much
Finally…					
8….how long have you had a problem with your sleep?	I don't have a problem / < 1 mo	1–2 mo	3–6 mo	7–12 mo	> 1 year

Scoring instructions:

- Add the item scores to obtain the SCI total (minimum 0, maximum 32)
- A higher score means better sleep
- Scores can be converted to 0–10 format (minimum 0, maximum 10) by dividing total by 3.2
- Items scores in grey area represent threshold criteria for Insomnia Disorder*

*Source: Espie CA, Kyle SD, Hames P, *et al*. The Sleep Condition Indicator: a clinical screening tool to evaluate insomnia disorder. *BMJ Open.* 2014;4:e004183

2c) Generalised anxiety disorder assessment (GAD 7)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				
Total score (add your column scores)				

Scoring instructions:
Scores of 5, 10 and 15 are taken as the cut-off points for mild, moderate and severe anxiety respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.*

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
[ ]	[ ]	[ ]	[ ]

For information on diagnosis of anxiety and depression please refer to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The NICE guideline on Generalised anxiety disorder and panic disorder in adults, adopted the DSM diagnostic criteria, and used this definition when considering their treatment recommendations.

* Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A Brief Measure for Assessing Generalized Anxiety Disorder. *Arch Intern Med.* 2006;166:1092-1097.

2d) Sleep diary

INSTRUCTIONS – Keep diary for 2 weeks

1. Write the date and type of day: **W**ork, **D**ay **O**ff, **H**oliday
2. Put the letter '**C**' in the box when you have coffee, tea or cola. Put '**M**' when you take any medicine. Put '**A**' when you drink alcohol. Put '**E**' when you exercise.
3. Put a line (****) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you have a nap during the day.
5. Leave boxes un-shaded to show when you wake up at night and when you are awake during the day.

Sample entry below: *On Monday when I was in work, I jogged on my lunch break at 1pm, had a glass of wine with dinner at 6pm, fell asleep watching TV from 7 to 8pm, went to bed at 10pm, fell asleep around 11pm, woke up and couldn't go back to sleep at about 4am, went back to sleep from 5 to 7am, and had a coffee and medicine at 7am.*[*]

Date	Day	12 pm	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am
Example	W		E					A				\									C M				

Date	Day	12 pm	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am

[*]Source: American Academy of Sleep Medicine. Sleep Diary www.sleepeducation.org/docs/default-document-library/sleep-diary.pdf?sfvrsn=2

2e) Anxiety diary

Use this diary to keep a note of when and where you feel anxious. You only need to make a brief entry, and record how anxious you are feeling using the anxiety scale. The scale is marked from 1 to 10; 1 indicates you are very slightly anxious, 5 is moderately anxious, and 10 is extremely anxious, or the most anxious you've ever been.

Filling in the chart will help figure out the cause of your anxiety, and whether there are specific times of the day or week that relate to more severe anxiety episodes. This will help us choose the best way to deal with your anxiety problem.

Your name ……………………………………………………………………………………..

Day, date and time	Where are you?	What are you doing?	Anxiety scale									
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10
			1	2	3	4	5	6	7	8	9	10

APPENDIX 3. INFORMATION FOR PATIENTS

3a) English - The good sleep guide

Establish a regular sleep pattern

- Set the alarm for the same time every morning for seven days a week, at least until your sleep pattern settles down.
- Get up at the same time every day, even if you did not fall asleep until late.
- Do not sleep during the day.

During the evening

- Ensure you 'put the day to rest'. Think it through and use a notebook if necessary. Tie up "loose ends" in your mind and plan ahead.
- Try to keep yourself fit by performing light exercise in the late afternoon or early evening (later than this can disturb your sleep).
- Have a regular routine before sleep, whereby you wind down during the course of the evening and avoid anything that is mentally demanding within 90 minutes of bedtime.
- Keep your sleep for bedtime (i.e. avoid falling asleep or snoozing in the armchair).
- Do not drink too much caffeinated substances (e.g. coffee, tea and certain soft drinks) and only have a light snack for supper. Try decaffeinated milk-based or herbal beverages.
- Do not drink alcohol to aid your sleep. It may help you fall asleep, but you will almost certainly wake up during the night.
- Make sure your bed is comfortable and the bedroom is not too cold (but not too warm) and is quiet (use earplugs if necessary).

At bedtime

- Go to bed when you are 'sleepy tired' and not before.
- Avoid activities in the bedroom that keep you awake. Do not read, watch television, use electronic devices, or work in bed.
- Turn the lights off when you get into bed.
- Relax and tell yourself that 'sleep will come when it's ready'. Enjoy relaxing even if you don't fall asleep at first.
- Do not *try* to fall asleep. Sleep cannot be switched on deliberately but attempting to do so may switch it off!

If you have problems getting to sleep

- Try not to get upset or frustrated as sleep problems are quite common and they are not as damaging as you might think.
- If you are awake in bed for more than 20 minutes, get up and go into another room.
- Do something relaxing for a while and don't worry about tomorrow. Read, watch television or listen to quiet music (in another room) and after a while you should feel tired enough to go to bed again.
- Remember that people usually cope quite well even after a sleepless night. Only return to bed when you feel "sleepy tired".
- Establishing a good sleep pattern may take a number of weeks; however, you should remain confident that you *will* achieve it by working through this guide.

3b) Welsh - Y canllaw cysgu'n dda

Sefydlu patrwm cysgu rheolaidd

- Gosodwch y larwm ar gyfer yr un amser bob bore, saith diwrnod yr wythnos, o leiaf hyd nes bod eich patrwm cysgu yn setlo.
- Codwch yr un amser bob dydd, hyd yn oed os na lwyddoch i fynd i gysgu nes yn hwyr.
- Peidiwch â chysgu yn ystod y dydd.

Gyda'r hwyr

- Gwnewch yn siŵr eich bod yn 'gorffen eich diwrnod'. Dadansoddwch ef a defnyddiwch lyfr nodiadau os oes angen. Cwblhewch unrhyw beth sydd heb ei ddatrys yn eich meddwl a chynlluniwch ymlaen.
- Ceisiwch gadw eich hun yn heini drwy wneud ymarferion ysgafn yn hwyr yn y prynhawn neu'n gynnar gyda'r hwyr (gall eu gwneud yn hwyrach na hyn amharu ar eich cwsg).
- Lluniwch drefn arferol cyn cysgu, lle byddwch yn dechrau ymlacio yn ystod y noson ac osgowch unrhyw beth sy'n golygu llawer o feddwl o fewn 90 munud i'ch amser gwely.
- Cadwch eich cwsg ar gyfer amser gwely (h.y. peidiwch â mynd i gysgu neu bendwmpian mewn cadair).
- Peidiwch ag yfed gormod o ddiodydd â chaffein ynddynt (e.e. coffi, te a rhai diodydd ysgafn) a bwytewch fyrbryd ysgafn yn unig i swper. Rhowch gynnig ar ddiodydd sydd â sail llaeth iddynt neu ddiodydd llysieuol.
- Peidiwch ag yfed alcohol i'ch helpu i gysgu. Efallai y bydd yn eich helpu i syrthio i gysgu, ond byddwch bron yn siŵr o ddeffro yn ystod y nos.
- Gwnewch yn siŵr bod eich gwely'n gyfforddus ac nad yw'r ystafell wely'n rhy oer (ond nid chwaith yn rhy gynnes) a'i bod yn dawel (defnyddiwch blygiau clust os oes angen).

Amser gwely

- Ewch i'r gwely pan fyddwch yn 'gysglyd flinedig' ac nid cyn hynny.
- Osgowch weithgareddau sy'n eich cadw'n effro yn yr ystafell wely. Peidiwch â darllen, gwylio'r teledu, defnyddio dyfeisiau electronig na gweithio yn y gwely.
- Diffoddwch y goleuadau pan fyddwch yn mynd i mewn i'r gwely.
- Ymlaciwch a dywedwch wrth eich hun y 'daw cwsg pan fydd yn barod'. Mwynhewch ymlacio hyd yn oed os nad ydych yn syrthio i gysgu i ddechrau.
- Peidiwch â *cheisio* syrthio i gysgu. Ni ellir gorfodi cwsg ond gall ceisio gwneud hynny ei atal!

Os cewch broblemau'n mynd i gysgu

- Ceisiwch beidio â digalonni neu fynd yn rhwystredig gan fod problemau cysgu yn eithaf cyffredin ac nid ydynt mor niweidiol ag yr ydych yn ei feddwl.
- Os ydych yn effro yn eich gwely am fwy nag 20 munud, codwch ac ewch i ystafell arall.
- Gwnewch rywbeth ymlaciol am ychydig a pheidiwch â phoeni am yfory. Darllenwch, gwyliwch y teledu neu gwrandewch ar gerddoriaeth dawel (mewn ystafell arall) ac wedi ychydig fe ddylech deimlo wedi blino digon i ddychwelyd i'r gwely.
- Cofiwch fod pobl fel arfer yn ymdopi'n weddol dda hyd yn oed ar ôl noson ddigwsg. Dychwelwch i'r gwely dim ond pan fyddwch yn teimlo'n "gysglyd flinedig".
- Gall sefydlu patrwm cysgu da gymryd ychydig wythnosau; fodd bynnag, dylech barhau'n hyderus y *byddwch yn* llwyddo drwy weithio drwy'r canllaw hwn.

3c) English - The good relaxation guide

Dealing with physical tension

- Finding and dedicating time to relax is essential. Give relaxation some of your time, not just what's left over.
- Incorporate relaxing activities into your lifestyle. Do not rush tasks or try too hard to resolve issues.
- Adopt a relaxation routine, but do not expect to learn without practice.
- Relaxation routines are available (audio recordings) which help to relieve muscle tension and teach appropriate breathing exercises.
- Try not to worry about tension symptoms, such as aches, stiffness, increased heart rate, perspiration, stomach churning, etc.
- Keep fit and try adhering to a physical exercise regime. Regular brisk walks or swimming can help relieve tension.

Dealing with worry

- Accept that worrying is normal and on occasion it may be useful.
- Write down your concerns and decide which ones are more important using a rating system (i.e. marks out of ten).
- Work out a plan of action for each problem.
- Share your worries with friends, relatives or your GP, as they may provide helpful advice.
- Mentally repeating a comforting phrase may help block out worrying thoughts. Similarly, reading, crosswords, hobbies and interests may all help keep your mind active and positive.
- Enjoy quiet moments (e.g. sit and listen to relaxing music). Allow your mind to wander and try to picture yourself in pleasant situations.

Dealing with difficult situations

- Build your confidence by accepting and confronting circumstances that make you feel more anxious. Adopt a step-by-step approach to help face things and places which make you feel tense. Regular practice will help you overcome these issues.
- Write a plan and decide how you are going to deal with difficult situations.
- For further encouragement, reward yourself and share with others when you overcome difficult situations.
- As you face difficult situations your confidence will grow and your anxiety symptoms should become less troublesome.
- Everyone has good and bad days. Expect more good days as time goes on.
- Try to put together a programme incorporating all the elements presented in 'The Good relaxation guide' that meets the needs of your particular situation. Remember that expert guidance and advice is available if you need further help.

3d) Welsh - Y canllaw ymlacio da

Ymdopi â thensiwn corfforol

- Mae dod o hyd i, a neilltuo, amser i ymlacio yn hollbwysig. Clustnodwch amser i ymlacio, nid dim ond yr amser sydd dros ben.
- Cynhwyswch weithgareddau ymlacio yn eich ffordd o fyw. Peidiwch â brysio tasgau ac ymdrechu'n rhy galed i ddatrys problemau.
- Datblygwch drefn ymlacio, ond peidiwch â disgwyl dysgu heb ymarfer.
- Mae ffyrdd o ymlacio ar gael (recordiadau sain) sy'n cynorthwyo i leihau tensiwn yn y cyhyrau a datblygu ymarferion anadlu priodol.
- Ceisiwch beidio â phryderu am symptomau tensiwn, megis poenau, stiffrwydd, cynnydd yng nghuriad y galon, chwysu, stumog yn troi ac ati.
- Cadwch yn heini a cheisiwch gadw at drefn ymarfer corff arferol. Gall mynd am dro a cherdded yn gyflym neu nofio yn rheolaidd helpu i leihau tensiwn.

Ymdopi â phryder

- Derbyniwch fod pryder yn rhywbeth arferol ac weithiau gall fod yn ddefnyddiol.
- Cofnodwch eich pryderon a phenderfynwch pa rai sydd fwyaf pwysig gan ddefnyddio system raddio (h.y. marciau allan o ddeg).
- Lluniwch gynllun i ymdrin â phob problem.
- Rhannwch eich pryderon gyda ffrindiau, perthnasau neu eich meddyg teulu, gan y gallai fod ganddynt gyngor defnyddiol.
- Gallai ailadrodd ymadrodd cysurlon yn eich meddwl helpu i gadw meddyliau pryderus draw. Yn yr un modd, gallai darllen, gwneud croeseiriau, ymgolli mewn hobïau neu ddiddordebau gadw eich meddwl yn brysur ac yn gadarnhaol.
- Mwynhewch eiliadau tawel (e.e. eistedd a gwrando ar gerddoriaeth ymlaciol). Gadewch i'ch meddwl grwydro a cheisiwch ddychmygu eich hun mewn sefyllfaoedd pleserus.

Ymdopi â sefyllfaoedd anodd

- Cynyddwch eich hyder drwy dderbyn a wynebu sefyllfaoedd a allai eich gwneud yn fwy gofidus. Defnyddiwch ddull cam wrth gam er mwyn helpu i wynebu pethau a lleoedd sy'n gwneud i chi deimlo dan straen. Bydd ymarfer yn rheolaidd yn eich helpu i oresgyn y materion hyn.
- Ysgrifennwch gynllun a phenderfynwch sut yr ydych yn mynd i ddelio â sefyllfaoedd anodd.
- I gael anogaeth bellach, gwobrwywch eich hun a rhannwch gydag eraill adegau pan fyddwch yn goresgyn sefyllfaoedd anodd.
- Wrth i chi wynebu sefyllfaoedd anodd bydd eich hyder yn cynyddu a dylai eich symptomau gofid beri llai o bryder i chi.
- Bydd pawb yn cael diwrnodau da a rhai sydd ddim cystal. Gydag amser gallwch ddisgwyl mwy o'r rhai da.
- Ceisiwch lunio rhaglen sy'n cynnwys yr holl elfennau a gyflwynir yn y 'Y canllaw ymlacio da' sy'n diwallu anghenion eich sefyllfa benodol chi. Cofiwch fod arweiniad a chyngor arbenigol ar gael os bydd angen rhagor o gymorth arnoch.

3e) English - Example of a letter to be given to patients newly prescribed a hypnotic or anxiolytic

Dear ……..

You have been prescribed a short course of ……by your doctor. This medicine can help you cope with short periods of severe stress or sleeplessness; however, it is *not* intended for long-term treatment in order to avoid drug dependence.

Your GP will initially prescribe this drug for a maximum of 14 days. You may be offered a follow-up appointment in case you need support, alternative treatment or referral (for example to a team who can arrange relaxation treatments).

Taking this drug for more than 14 to 28 days may lead to problems, such as:

- depression, reduced ability to handle situations, and addiction;
- an increase in accidents on the road, and with work machinery;
- an increase in falls.

Long-term treatment often makes sleep difficulties worse and may even make it difficult to discontinue drug use, so please *do not* ask for further supplies when these run out. Try to sleep without taking a tablet one, two or three nights a week. Avoid caffeinated drinks such as coffee, tea, Red Bull and cola after 3 pm as these may keep you awake, and avoid late-night physical and mental stimulation. In addition, avoid alcoholic drinks when taking a benzodiazepine, particularly when first starting treatment.

Do not drive or operate machinery while under the effects of these drugs

There are leaflets available that can give you further advice about sleeping tablets, relaxation and how to get a good night's sleep. Please ask your doctor, pharmacist or nurse.

3f) Welsh - Enghraifft o lythyr i'w roi i gleifion sydd newydd gael presgripsiwn ar gyfer cyffur hypnotig neu gyffur lleihau gorbryder

Annwyl ……..

Presgripsiynwyd cwrs byr o …… i chi gan eich meddyg. Gall y feddyginiaeth hon eich cynorthwyo i ymdopi â chyfnodau byr o straen difrifol neu fethu cysgu; fodd bynnag, *ni* fwriedir iddi fod yn driniaeth hirdymor er mwyn osgoi dibyniaeth ar y cyffur.

I gychwyn bydd eich meddyg teulu yn presgripsiynu'r cyffur hwn am ddim mwy na 14 diwrnod. Efallai y cynigir apwyntiad dilynol i chi rhag ofn bod angen cefnogaeth, triniaeth amgen neu atgyfeiriad (er enghraifft at dîm a fydd yn gallu trefnu triniaethau ymlacio) arnoch.

Gall cymryd y cyffur hwn am dros 14 i 28 diwrnod arwain at broblemau megis:

- iselder, methu delio cystal â sefyllfaoedd, a chaethiwed i'r cyffur
- cynnydd mewn damweiniau ar y ffyrdd, ac wrth weithio â pheiriannau
- cynnydd mewn achosion o gwympo

Bydd triniaeth hirdymor yn aml yn gwaethygu trafferthion cysgu a gallai hyd yn oed ei gwneud hi'n anodd rhoi'r gorau i ddefnyddio'r cyffur, felly *peidiwch* â gofyn am ragor o gyflenwad pan ddaw'r rhain i ben. Ceisiwch gysgu heb gymryd tabled ar un, dwy neu dair noson yr wythnos. Osgowch ddiodydd caffein megis te, coffi, Red Bull a cola wedi 3pm gan y gallai'r rhain eich cadw ar ddihun, ac osgowch ysgogiadau corfforol a meddyliol gyda'r hwyr. Hefyd, osgowch ddiodydd alcoholaidd pan fyddwch yn cymryd bensodiasepin, yn arbennig pan fyddwch yn dechrau triniaeth am y tro cyntaf.

Peidiwch â gyrru na gweithio peiriannau pan fyddwch dan effeithiau'r cyffuriau hyn.

Mae taflenni ar gael a allai roi rhagor o gyngor i chi am dabledi cysgu, ymlacio a sut i gael noson dda o gwsg. Holwch eich i'ch meddyg, fferyllydd neu nyrs.

APPENDIX 4. GUIDES FOR HEALTHCARE PROFESSIONALS

4a) Example of secondary care guidelines on the prescribing of anxiolytics and hypnotics

- On admission to hospital, establish if the patient is a regular or occasional user of benzodiazepines or z-drugs. Alternatively, determine whether hypnotic and/or anxiolytic treatment has been newly initiated upon admission.
- Regular users should not have their treatment stopped suddenly.
- Before a hospital patient is prescribed a hypnotic there should be an accurate diagnosis and any treatable causes of insomnia should be addressed first (e.g. pain, urinary frequency, breathing difficulties, depression, mania, substance misuse, etc).
- Discuss with the patient the benefits and principles of good sleep hygiene, avoiding the use of hypnotics and anxiolytics, and the possibility of dosage reduction.
- Review the timing of regular medication (i.e. sedating medication at night, alerting medication in the morning).
- Hospital patients requiring hypnotics should have them prescribed on the 'as required' (PRN) side of the prescription chart (unless the patient was admitted on regular doses of night sedation). Ideally the prescriber should specify the earliest time and the maximum number of consecutive nights that a hypnotic should be given, or provide more specific instructions (e.g. every 2nd/3rd night if the patient is not asleep one hour after retiring to bed).
- Any prescription should be for the lowest effective dose and shortest duration possible (no longer than four weeks), and patients should be advised of the short term nature of treatment at initiation.
- If prescribing newly initiated hypnotics for a regular period (increasing the risk of dependence), the consultant should document this in the patient's medical notes.
- Nurses should use the following guidelines when administering a hypnotic during the patient's hospital stay:
  - Administer if the patient has been unable to sleep for one hour after retiring to bed and is requesting it.
  - Administer after 11.30 pm as long as the patient has had an opportunity to fall asleep, but administer before 1.00 am to prevent hangover effects next morning.
  - Do not administer for more than two consecutive nights (without seeking medical review).
- Regularly review the progress of hypnotic treatment during the patient's hospital stay and discontinue as soon as possible.
- Hypnotics and anxiolytics newly initiated in hospital should *not* be prescribed on discharge unless an explicit withdrawal regimen is indicated. Withdrawal regimens may be required if the patient has taken the hypnotic/anxiolytic continuously for more than six weeks as an in-patient.
- In rare cases where newly initiated anxiolytic or hypnotic treatment is continued after discharge, the GP should receive details about why the treatment was initiated, the expected treatment duration, details of any dose reduction regimen and what information has been given to the patient or carer.
- An example of where it may be appropriate to discharge a patient home on hypnotic or anxiolytic treatment includes patients receiving palliative care.

- Any patient prescribed for an ‘as required’ hypnotic should have their prescription cancelled if no dose has been administered in the previous two weeks. Pharmacy staff should have the authority to cancel such prescriptions.
- All ‘as required’ hypnotic prescriptions should be regularly reviewed (e.g. at weekly ward rounds) to assess the frequency and appropriateness of usage.
- If non-recommended long-term use is envisaged (i.e. more than four weeks) consent needs to be obtained regarding the use outside the product licence.

4b) Example of a GP practice prescribing policy for benzodiazepines and z-drugs

GPs in this practice will prescribe hypnotics and anxiolytics (benzodiazepines and z-drugs) in line with national and locally developed guidelines:

- First-line treatment should be non-pharmacological measures.
- Where benzodiazepine or z-drug treatment is indicated, first-line options should be:
  - Anxiolytic: diazepam
  - Hypnotic: zopiclone
- For patients who have not received these drugs regularly, GPs will only prescribe hypnotics and anxiolytics for a maximum of 14 days and at the lowest effective dose. They will only be prescribed if the GP feels that the condition is severe, disabling and subjecting the patient to extreme distress and/or for those where other interventions have not been successful. The following guidance published by NICE will apply:
  - The indication for starting a hypnotic or anxiolytic will be documented.
  - Other possible causes of sleep disturbance will be recorded (e.g. pain, dyspnoea, depression) and treated appropriately.
  - All patients will receive advice on non-drug therapies for anxiety and insomnia.
  - Patients will be advised on the potential problems of dependence (i.e. addiction).
  - A second prescription will not be issued without a follow-up visit to the GP.
  - Benzodiazepines or z-drugs should *not* be taken for more than 2–4 weeks (including tapering off).
- Patients who are already on a regular benzodiazepine or z-drug prescription will be assessed and, if appropriate, counselled for a withdrawal scheme with the aim to gradually reduce drug dosage to zero.
- Patients who are unable or unwilling to reduce drug dosage via a managed withdrawal scheme (or who use more than one drug of abuse, or who are dependent on alcohol) may be referred to the substance misuse service in their area.
- Prescriptions for hypnotics and anxiolytics should not be routinely available on repeat. However, the practice accepts that there may be a small minority of people who need to be on a small maintenance dose of a benzodiazepine. Examples are people:
  - with severe mental health problems under care of a psychiatrist;
  - on benzodiazepines for treatment of epilepsy;
  - who are seriously or terminally ill.
- Lost prescriptions will not be replaced.
- Patients will be allocated a ‘usual doctor’ and will only deal with this person.
- If a patient takes higher doses than prescribed, and runs out of medication before the next prescription is due, they will not be prescribed extra tablets.
- The practice will undertake a regular review and audit of the prescribing practice of benzodiazepines and z-drugs to ensure compliance with national and local guidelines.
- Temporary residents should note that:
  - patients not currently on an anxiolytic or hypnotic will be treated according to NICE guidelines and the practice policy
  - regular users will not receive prescriptions without proof of dosage, frequency and date of last prescription; this can be obtained from the patient’s surgery. If they remain with the practice for more than two weeks, they should enter the reducing scheme and the policy should be followed as for a registered patient.
- Any new patients currently on hypnotics or anxiolytics will be informed that they will be placed on a withdrawal regimen (unless they fall into the exclusion criteria above), when they register with the practice.

4c) Example of GP practice guidelines for initiating hypnotics and anxiolytics

- Establish current sleep/anxiety patterns with the help of sleep/anxiety diaries (Appendices 2d and 2e).
- Address any treatable causes of insomnia/anxiety:
  - Review concomitant drug therapy.
  - Review the timing of regular medication (e.g. sedating medication at night, alerting medication in the morning).
- Consider non-drug treatment options first:
  - Give advice (verbally or using patient information leaflets) on non-drug treatments, and record in medical notes whether or not an anxiolytic or hypnotic is prescribed.
- When hypnotics or anxiolytics *must* be used:
  - use lowest effective dose.
  - use for a short period only. All prescriptions for hypnotics and anxiolytics issued to new patients should be for a maximum of two weeks.
  - ensure that no prescriptions for hypnotics or anxiolytics are on repeat.
  - encourage intermittent use rather than continual use.
  - note that hypnotics started in hospital should not usually be continued in primary care.
  - document indication.
- Provide patients with information (Appendices 3e and 3f) and self-help leaflets (Appendices 3a, 3b, 3c and 3d) at the time of initial drug supply. Advise about the potential for dependence (addiction), falls and driving impairment, and document in records.
- Explain that the prescription will not be repeated. Patients will be seen by a GP before a second prescription is issued.
- In elderly patients prescribe with caution and start at a lower dose. Monitor the response as:
  - unpredictable drug metabolism and interactions may make patients more sensitive to these medicines.
  - there may be an increased risk of ‘hangover’ effect due to prolonged half-life.
  - there may be an increased risk of ataxia and confusion, therefore causing an increase in falls.
- Use clinical judgement to assess the risks/benefits of withdrawal for individual patients.

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.

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** _____

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

Review of original patients after 6 months

Practice _____ **Date** _____

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

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.

2. **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.

3. **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.

4. **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.

5. **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.
2. **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.

3. **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.

4. **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.

5. **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 am y 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	21 x 10 mg 7 x 5 mg
Stage 8 (1–2 weeks)	Diazepam 30 mg	3 x 10 mg	21 x 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		