NHS Grampian

GUIDANCE FOR PRESCRIBING AND WITHDRAWAL OF BENZODIAZEPINES & HYPNOTICS IN GENERAL PRACTICE

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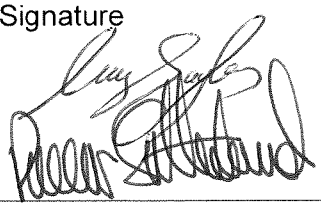
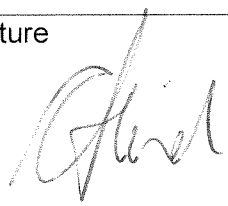
Signature 	Signature	Signature 

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Purpose: The purpose of the following information and guidance is to disseminate the lessons learned in the specialist unit in order that a greater attention to rigour in assessment and a more holistic approach to treatment can reduce the reliance on maintenance prescribing of benzodiazepines.

Responsibilities for implementation:

Departmental: Heads of Service / Clinical Leads
Area: General Practitioners

Review: This policy will be reviewed every two years or sooner if current treatment recommendations change.

This policy is also available in large print and on computer disk. Other formats can be supplied on request.

Please call the Pharmacy Medicines Unit on 01224 556525 or 556088 for a copy.

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October 2006

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GUIDANCE FOR PRESCRIBING AND WITHDRAWAL OF BENZODIAZEPINES & HYPNOTICS IN GENERAL PRACTICE

INTRODUCTION

The purpose of the following information and guidance is to disseminate the lessons learned in the specialist unit in order that a greater attention to rigour in assessment and a more holistic approach to treatment can reduce the reliance on maintenance prescribing of benzodiazepines. It is further intended that the damaging effects of long-term anxiolytics use will be detected, acknowledged, treated, and prevented from recurring in the future.

The recommendations for practice and the statistics quoted in this text are derived mainly from the most recently published Cochrane Reviews and the Database of Abstracts of Reviews of Effectiveness (DARE, 2003). Recommendations are included from the Protocol for the Treatment of Benzodiazepine Withdrawal, which was developed by recognised expert, Professor Heather Ashton (University of Newcastle, 2002). This publication is available to download free from the Internet at www.benzo.org.uk, an invaluable website for professionals and patients alike. Recommendations from the Royal College of General Practitioners and the Royal College of Psychiatrists are also included.

OPENING STATEMENTS

The National Performance Assessment Framework for NHS Scotland takes account of anxiolytic and hypnotic prescribing and it is a national priority to reduce this within each Health Board Area.

The British National Formulary (BNF) and Committee on Safety of Medicines (CSM) provide clear guidance on the indications for these drugs.

Changes in the controlled drug regulations HDL (2006) 27 recommend that prescriptions for benzodiazepines should be limited to a quantity necessary for up to 30 days clinical need.

Dependence upon prescribed benzodiazepines is now recognised as a major clinical problem.

THERE ARE NO LICENSED INDICATIONS FOR THE PRESCRIPTION OF BENZODIAZEPINES FOR MORE THAN 2 TO 4 WEEKS

CSM ADVICE makes it clear that:

i. Benzodiazepines are indicated for the short-term relief (2 – 4 weeks only) of ANXIETY that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness.
ii. The use of benzodiazepines to treat short-term ‘mild’ anxiety is inappropriate and unsuitable.
iii. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress (BNF Section 4.1).

Key points to consider in relation to prescribing

- There are no licensed indications for prescribing benzodiazepines for more than 2-4 weeks.
- Dependence on even small doses of benzodiazepines can result in anxiety, insomnia and other distressing withdrawal symptoms if the drug is stopped abruptly.
- Benzodiazepines are not indicated or advised for the treatment of opiate addiction.
- Older people are more sensitive to the CNS side effects of benzodiazepines, such as confusion, amnesia, ataxia and hangover effects and are therefore at an increased risk of falls. Benzodiazepines can increase the risks of road traffic accidents, increase toxicity with alcohol and suicide risk.
- Known opiate addicts have a high chance of becoming dependent on benzodiazepines.

Prescribing indications

- Prevention of dependence by appropriate initial prescribing is the most desirable situation.
- The British National Formulary lists the following indications for the prescribing of benzodiazepines:

• Short term use in anxiety or insomnia. • As an adjunct in alcohol withdrawal. • Status epilepticus. • Febrile convulsions. • Muscle spasm. • Perioperative use.

SECTION 1

ASSESSMENT OF BENZODIAZEPINE DEPENDENCE

Benzodiazepines are potentially addictive drugs; physical and psychological dependence can develop within weeks of regular use. Benzodiazepines are increasingly used in conjunction with other substances of abuse. They are used in this context to increase the "kick" obtained from opiates, and to alleviate the withdrawal symptoms of other drugs of abuse such as cocaine, amphetamines and alcohol.

Main Principles of Assessment

- Early detection and intervention are important factors in successful outcomes.
- Prescribers should be able to recognise the risk or potential for benzodiazepine dependence in all diagnostic groups (psychiatric AND non-psychiatric cases) and age groups.
- Patients known to be opiate addicted, or known to use other illicit drugs, have a high chance of using and becoming dependent on very high doses of benzodiazepines.
- Confirmation of a diagnosis of dependence should be backed up with a positive urinary drugs screen for benzodiazepines and regular laboratory testing thereafter.
- Assessing motivation to change is an essential component in the management of dependency.
- Screening for benzodiazepine misuse should include measures to regularly review repeat prescriptions for tranquillisers and hypnotic medication.

ACTUAL ASSESSMENT

i. Check for Evidence of Benzodiazepine Dependence

- Note the patient's physical presentation – drowsiness, disinhibition, dilation of pupils, and note the frequency or consistency of presentation over several weeks.
- It is recommended that the patient's benzodiazepine use be assessed over a 3-month period before a diagnosis of dependency is made unless there is compelling evidence at an earlier point.

ii. Try to Establish the PATTERN of Benzodiazepine usage:

- Date of onset of benzodiazepine usage and which drug(s).
- Date of onset of dependency and frequency of usage.
- Average daily dose and dose intervals.
- Duration of any successful withdrawal from benzodiazepines.
- If yes to above, longest period of abstinence.

N.B. Street or illicit sources of benzodiazepines may be different strengths from prescribed sources. The former are often weaker and this should be remembered when prescribing.

iii. Establish TYPE of Dependency:

There are three main types of Benzodiazepine dependence that are recognised; these include "Therapeutic dose dependence", "Prescribed high dose dependence" and "Recreational high dose abuse and dependence".

The type of dependency must be established – the following questions can aid this process:

- Are the benzodiazepines prescribed or non-prescribed?
- If prescribed what is the indication for the Benzodiazepine?
- Is there any additional non-prescribed use?
- Patients reason for taking non-prescribed benzodiazepines

a) Therapeutic Dose Dependence.
People who have developed dependence on therapeutic doses of prescribed benzodiazepines.

Characteristics of Therapeutic Dose Dependence

- They have taken benzodiazepines in prescribed low doses for months or years.
- They have gradually come to "need" benzodiazepines in order to carry out their normal activities of daily living.
- They have continued to take their medication even though the original indication for it has disappeared.
- They experience withdrawal symptoms when they try to reduce or stop the drugs.
- They may contact the practice frequently to request repeat prescriptions.
- They experience anxiety if the next prescription is not ready or easily obtainable.
- They may have increased the dosage since the original prescription.
- They may have anxiety symptoms, panics, agoraphobia, insomnia, depression and increasing physical symptoms despite continuing to take benzodiazepines.

ASHTON (2002**)**

b) Prescribed High Dose Dependence, e.g. 30mg Diazepam or more

A minority of patients who start on prescribed benzodiazepines begin to "require" ever-larger doses.

Characteristics of Prescribed High Dose Dependence

- They may try to persuade their doctor to escalate the doses and/or the number of tablets on the prescription.
- On reaching the prescriber's limits they may present at hospitals or register at further practices to obtain more tablets.
- They may combine Benzodiazepine misuse with excessive alcohol consumption or with other sedative drugs.
- They tend to be highly anxious, depressed and may have a personality disorder.
- They tend not to use illicit drugs, but may obtain benzodiazepines from "street" sources, which may include a relative's or acquaintances continuing, unnecessary, prescribed benzodiazepines.

c) Recreational High Dose Abuse and Dependence

High dose dependence in this category may develop as polydrug abusers attempt to increase the intensity and duration of the "kick" they get out of illicit drugs – especially opiates – and to cope with the withdrawal symptoms and stimulating effects of others such as cocaine or amphetamine and alcohol.

Characteristics of Recreational High Dose Abuse & Dependence

- A very high tolerance develops, making it difficult to detect the actual scale of drug consumption.
- Users may be taking well in excess of 100mgs daily in a single dose. Doses of up to 1,000mgs are occasionally reported in clinical practice.
- There may be a concurrent alcohol problem, and the user may have been introduced to benzodiazepines during previous alcohol detoxification.

iv. Detail any history of previous severe withdrawal (including history of seizures) or post-withdrawal reaction.

v. Concomitant severe medical or psychiatric illness.

vi. Co-morbid use of other drugs and alcohol.

vii. Driving history:

Patients should be reminded of DVLA guidelines.

"*The non-prescribed use of these drugs and/or the use of supra-therapeutic dosage, whether in a substance withdrawal/maintenance programme or otherwise, constitutes misuse/dependency for licensing purposes.*

The prescribed use of these drugs at therapeutic doses (BNF), without evidence of impairment, does not amount to misuse/dependency for licensing purposes (although clinically dependence may exist).

Persistent misuse of, or dependency on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum one year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required. In addition favourable Consultant or Specialist report may be required on reapplication."

viii. Establish level of motivation to change.

ix. Urine drug testing as appropriate

Note whether the presence or absence of benzodiazepines in the urine fits with the patient's history, bear in mind that higher dosing will result in a longer duration of detection.

SECTION 2

MANAGEMENT OF BENZODIAZEPINE & HYPNOTIC WITHDRAWAL

Withdrawal of benzodiazepines should be gradual because abrupt withdrawal may produce confusion, toxic psychosis, convulsions, or a condition resembling delirium tremens. Any new patients presenting with benzodiazepine dependence should have a full assessment and be monitored for 3 months before a prescription is supplied if appropriate. When a decision is made to prescribe benzodiazepines it is recommended that the lowest possible dose for the relief of symptoms be used (max 30mg diazepam daily, a review within 2 weeks is recommended). Care should also be taken with the amount of tablets supplied and the STRENGTH of tablet required. Bear in mind that diversion into the black market can have surprising sources, and that 10mg tabs ('blues') are more highly prized than 5mg or 2mg denominations. Daily or weekly dispensing may be more appropriate in some cases than allowing a 28-day supply.

BENZODIAZEPINE REDUCTION

The process of reduction following prolonged use of benzodiazepines can be difficult and protracted, usually involving many months of reducing doses. Patients embarking on a reduction programme need to be motivated, well supported and adequately prepared with accurate information about what to expect.

i. General principles for benzodiazepine dose reduction

- Set realistic goals with the patient. Disagreement with the pace of reduction is likely to end in a poor outcome.
- Aim to reduce in steps of about 10-20% of the daily dose every fortnight with patient consent. If withdrawal symptoms occur, maintain the dose until symptoms improve (BNF).
- Allow for some periods of stabilisation of dose when things get difficult, but discourage any increase in doses, which may be interpreted as backsliding.
- Check that other substances such as cannabis and alcohol are not being added in or increased as a result of the Benzodiazepine reduction.
- Always convert the medication being misused to an equivalent dose of diazepam, including hypnotic medications (refer to Appendix 1, 2, 3, 4 and 5). There is no justification for using 2 different types of benzodiazepines.
- Do not allow excessive supply of medication on one prescription, use weekly or daily dispensing as appropriate. Use 2mg and 5mg diazepam tablets only, so that the patient can try to establish the lowest total dose required in a day.
- Time needed for complete withdrawal varies from 4 weeks to a year or more.
- Examples of reducing scales can be found in appendices 1,2, 3, 4 and 5.

ii. Half-Life Of Benzodiazepines and Their Diazepam Equivalents

The effects of most benzodiazepines wear off within a few hours. However, when prescribing, the half-life is important, as the drug will continue to exert subtle effects as long as it is present in the body. Shorter acting benzodiazepines e.g. lorazepam are eliminated quickly, causing peaks and troughs of concentration, therefore making them unsuitable for managing withdrawal.

To manage withdrawal from benzodiazepine dependence most smoothly it is recommended to convert the drug(s) being used to the equivalent dose of diazepam, a longer-acting benzodiazepine.

iii. Table of Diazepam 5mg Equivalents

NAME OF DRUG	Dose equivalent to 5mg Diazepam	Half-life (range)	Duration of detectability*
Diazepam	5mg	32 hrs (21-50)	36-200 hrs
Chlordiazepoxide	15mg	12 hrs(6-30)	36-200 hrs
Lorazepam	0.5mg	12 hrs (8-25)	-
Oxazepam	15mg	8hrs (5-15)	-
Temazepam	10mg	5-11 hrs	8-22 hrs
Nitrazepam	5mg	18-36 hrs. Elderly 40+ hrs	36-200
Flunitrazepam (Rohypnol®)	0.5mg	18-26 hrs	36-200
Zopiclone†	7.5mg	5-6 hrs	-
Zolpidem†	10mg	2 hrs	-
Zalepon†	10mg	2 hrs	-

**This time varies considerably between individuals*

† These drugs are chemically different from benzodiazepines but have the same effects on the body and act by the same mechanisms.

iv. Management of polydrug dependence e.g. opiates, cocaine and benzodiazepines

- Opiate use should be stabilised first - with methadone if appropriate – taking into consideration the increased risk of overdose and poorer clinical outcome if concomitant benzodiazepine misuse is present.
- Users should be encouraged and supported in reducing their illicit benzodiazepine use to a level that prevents withdrawal but is not associated with significant intoxication. In most cases users should continue to reduce use to zero without benzodiazepine prescribing.
- The user has made progress in controlling illicit benzodiazepine misuse i.e. not appearing intoxicated, improvement in other measures of stability.
- There should be an agreement with the patient, which includes expectations for attendance, monitoring, and compliance with adjunct treatments.
- If a reduction regime is offered, the following conditions are recommended:
  - Use diazepam only
  - Dispense in daily instalments (only to be waived if there is a bona fide reason such as full-time employment and/or good record of compliance)
  - Reduce to zero over a planned period
  - Specify doses (up to max 30mg diazepam daily)
  - 5mg or 2mg tablets only
  - Written reduction plan, mutually agreed between keyworker, patient and prescriber
- If contact is broken by non-compliance, benzodiazepine prescribing should cease.

v. Prescribing in pregnancy

Sudden cessation of benzodiazepine use during pregnancy is potentially hazardous for both mother and foetus, including the risk of convulsions. Benzodiazepines may cause long lasting and difficult-to-control withdrawal symptoms in the neonate, so any reduction in the level of use is to be encouraged. The three-month assessment period before prescribing benzodiazepines does not apply in cases of pregnancy.

Recommended management for benzodiazepine use in pregnancy:

- **Outpatient**: GPs should liase closely with obstetrician involved with the care of the patient who is benzodiazepine dependent in order to determine individual management. Follow this policy, speeding up reduction if possible by reducing the interval of reductions to weekly.

- **In-Patient:** Aberdeen Maternity Hospital under joint care of consultant obstetrician and SMS antenatal clinic.

NOTES ON ALCOHOL DETOXIFICATION USING CHLORDIAZEPOXIDE

- Community detoxification is an effective and safe treatment for patients with mild to moderate withdrawal symptoms.
- Where community detoxification is offered, it should be delivered using protocols specifying daily monitoring of breath alcohol level and withdrawal symptoms.
- Medication may not be necessary if the:
  - Patient reports consumption is less than 15 units daily (for men) or 10 units daily (women), and neither recent withdrawal symptoms nor drinking to prevent withdrawals.
  - Patient has no alcohol on breath test, and no withdrawal signs or symptoms
- For patients managed in the community, chlordiazepoxide is the preferred benzodiazepine. (SIGN Guideline 74: Management of harmful drinking and alcohol dependence in primary care, 2003)
- Benzodiazepines may be used in Primary Care to manage alcohol withdrawal symptoms, but for a maximum period of 7 days.

7 Day Alcohol Detoxification Regime Using Chlordiazepoxide				
DAY	MORNING	LUNCHTIME	6PM	BEDTIME
1	30mg	30mg	30mg	30mg
2	20mg	20mg	20mg	20mg
3	15mg	15mg	15mg	15mg
4	10mg	10mg	10mg	10mg
5	10mg	5mg	5mg	10mg
6	5mg	5mg	5mg	5mg
7	5mg	0	0	5mg

SECTION 3

SUGGESTIONS FOR CLINICAL PRACTICE IN PRIMARY CARE

i. Practice Policy:

Consider the development and implementation of a practice policy for the prescribing and management of patients on benzodiazepines. The aim would be to ensure a consistent approach to prescribing within the practice supporting the requirements of clinical governance.

Key points to incorporate into a practice policy

- Indications for prescribing benzodiazepines, incorporating details of formulary drugs and dose regime.
- Specify situations when a prescription may be added to repeat prescribing system, ensuring this is authorised and recorded by a GP. Detail this in the practice repeat prescribing policy. Administration staff must be trained to identify excessive prescription requests for benzodiazepines and refer to GP accordingly.
- Identify a system for review of short-term prescriptions, e.g. discharge letters, ensuring therapy is discontinued as planned.
- It is now recommended that any prescription is limited to a quantity necessary for up to 30 days clinical need.
- Prescribers must ensure patients on repeat prescriptions are reviewed frequently, at least annually.
- Assessment for benzodiazepine addiction.
- Management of benzodiazepine addiction, incorporating the following points:
    - Confirmation through urine testing over a period of time.
    - Prescribing should not exceed a dose of 30mg daily.
    - Indefinite long-term maintenance therapy is not a recognised treatment plan.
    - Agree reduction plan and record discussions regularly.
    - Avoid the use of 10mg tablets, only prescribe 2mg or 5mg.
    - Consider daily or weekly dispensing when appropriate.
    - Use of a benzodiazepine reducing regime to avoid abrupt withdrawal.
- Management of addiction in pregnancy.
- Alcohol withdrawal.
- Consider displaying patient information on benzodiazepines in the waiting area.
- Select and use, when appropriate, patient information leaflets to reinforce advice and education given to patients on topics such as dependence, tolerance, or withdrawal.
- CHP and practice pharmacists can support the development of practice policies.

ii. Evidence relating to GP initiated action to reduce benzodiazepine prescribing

a) Writing to the Patient

A study set out to assess the effect of a letter from the general practitioner, suggesting a reduction in the use of benzodiazepines, and whether the impact of the letter could be increased by the addition of information on how to tackle drug reduction. (n = 209; mean age 69 – range 34 – 102 years). After 6 months consumption had reduced to two thirds of the original intake. 18% of subjects received NO prescriptions at all during the monitoring period. Ref.: Cormack, M & Sweeney, K. 1994. Evaluation of an easy, cost-effective strategy for cutting Benzodiazepine use in general practice. British Journal of General Practice, 44 (378) 5-8.

b) Brief Intervention

This study indicates that some chronic users of benzodiazepines can successfully reduce their intake with simple advice from the GP and a self-help booklet. This approach required no extra clinic visits, and resulted in positive mental health change.
Ref.: Bashir, K. King, M. Ashworth, M. 1994. Controlled evaluation of brief intervention by general practitioners to reduce chronic use of benzodiazepines. British Journal of General Practice, 44 (386); 408-412.

c) Education

A randomised-controlled trial studied the effect of an educational visit (by a doctor or pharmacist) on Benzodiazepine prescribing. The overall Benzodiazepine prescribing rate fell by 23.7%, that is from 4.93 to 3.76 prescriptions per 100 encounters. Anxiety and insomnia diagnosis rates also declined from 4.68 to 3.76 per 100 encounters. The intervention had a strong effect in reducing initial prescriptions.
Ref.: de Burgh, S.Mant, A. MAttick, R. 1995. A controlled trial of educational visiting to improve Benzodiazepine prescribing in general practice. Australian Journal of Public Health, 19 (2) 142-148

d) Psychological Interventions

Several studies have illustrated the benefits of non-pharmacological approaches to managing insomnia and anxiety. Techniques include:

- Stimulus control
- Sleep restriction
- Progressive muscular relaxation
- Sleep hygiene education
- Paradoxical intention (stop trying to sleep, focus on staying awake)
- Cognitive behavioural therapy
- Altering dysfunctional beliefs about sleeplessness
- Changing maladaptive sleep

Ashton (2003) advocates the deployment of community nurses and pharmacists to assist GPs in managing withdrawal at dedicated clinics, and setting up self-help groups

iii. Patient Information Leaflets on Benzodiazepines

These can be downloaded from the Internet www.prodigy.NHS.uk, go to Patient Information Leaflets, click on 'B' for benzodiazepines and the following leaflets will be displayed: 'Benzodiazepines and Z drugs' and 'Stopping Long-Term Benzodiazepines'.

For a wealth of further information on benzodiazepines, support groups etc see www.benzo.org.uk

REFERENCES AND FURTHER READING

Guidelines:

Ashton, H. 2002. Benzodiazepines: how they work & how to withdraw. University of Newcastle. Free at www.benzo.org.uk

British National Formulary. Guidance on management of benzodiazepine dependence: http://www.bnf.org

CMO's update no.37, Department of Health, January 2004. Benzodiazepines warning. http://www.dh.gov.uk/assetRoot/04/07/01/76/04070176.pdf

MeReC briefing, issue no.17, April 2002. Update on benzodiazepine and non-benzodiazepine hypnotics.

Prodigy: hypnotic and anxiolytic dependence and insomnia. www.prodigy.nhs.uk

Royal College of Psychiatrists, 1997. Benzodiazepines: risks, benefits or dependence (remains under review, 2004)

The Scottish Office Department of Health: 1999. Drug misuse and dependence – guidelines on clinical management HMSO.

General references:

Meikl, J. 2004. Cut down on tranquilliser prescriptions, GPs warned. The Guardian, Feb 11, 2004

Garfield, S. 2003. Unhappy anniversary. Valium's 40th birthday. The Observer, Feb 2, 2003

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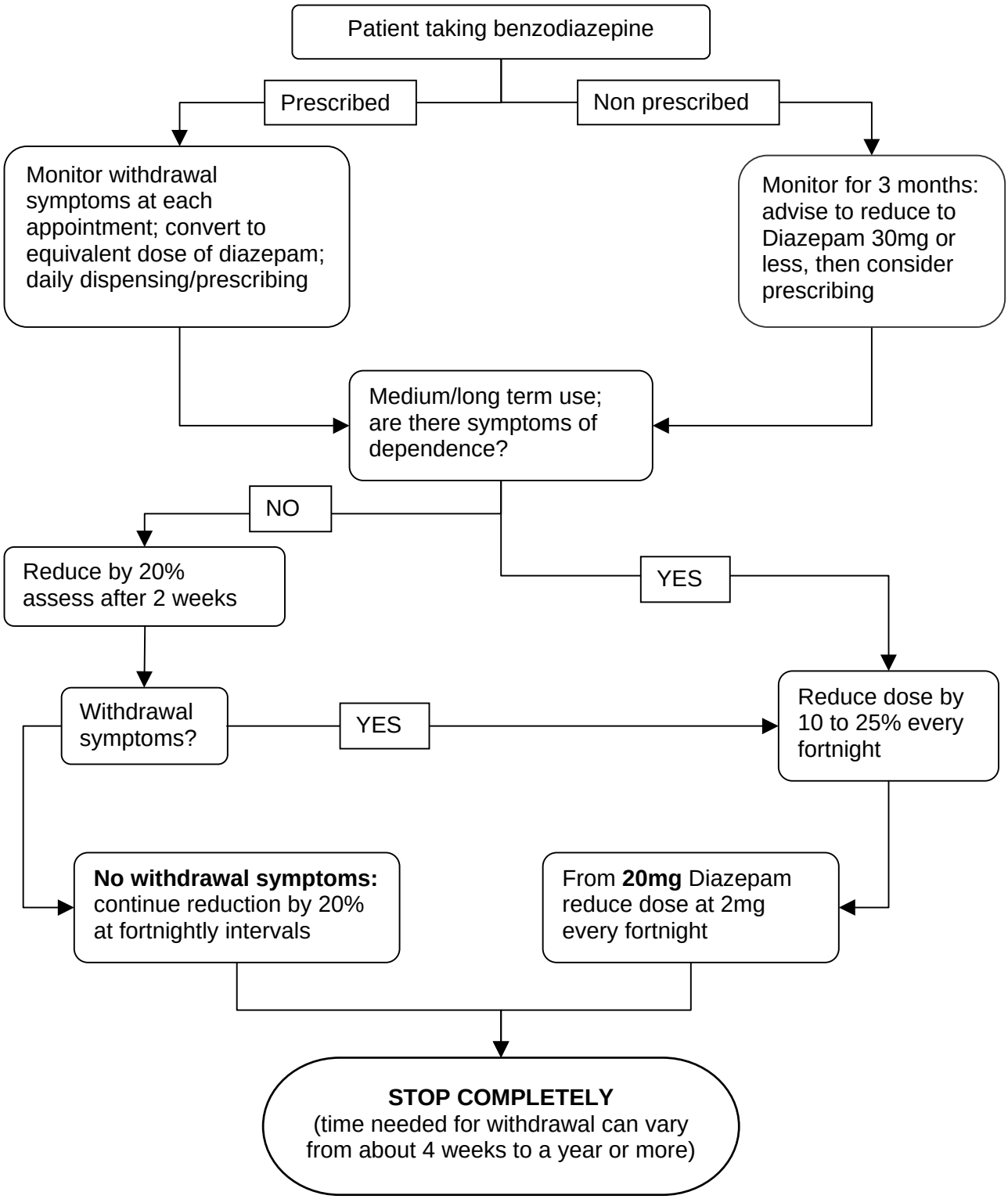
*Special thanks to Brian Smith for all his early work on this guide, who sadly is no longer with us.

Widespread consultation has been undertaken to include GPs, CHP pharmacists, Mental Health Service, and Substance Misuse Staff.

Appendix 1: ALGORITHM FOR BENZODIAZEPINE REDUCTION

General principles that should be ongoing throughout any reduction regimen

- Teach HEALTHY coping techniques appropriate to patient
- Address SLEEP HYGIENE issues
- Address any underlying PSYCHOLOGICAL PROBLEMS
- If withdrawal symptoms occur, maintain at same dose until symptoms improve and reduce in small steps; It is better to reduce slowly than too quickly



Appendix 2: PATIENT INFORMATION
RECOMMENDED REDUCING REGIME FROM 30mg

NOTES:

- Stages 1-5 might be manageable with one week between reductions, but the later stages are better taken over 2 weeks.
- A mixture of 5mg and 2mg tablets will be required. If intermediate reductions of 1mg are required, halve the 2mg (scored) tablet.

DIAZEPAM REDUCING REGIME: STARTING AT 30MG DAILY						
		MORNING	AFTERNOON	NIGHT	TOTAL FOR DAY	GP USE: TABS PER WEEK
STARTING DOSE		10mg	10mg	10mg	30mg	42 x 5mg
STAGE 1	2 WEEKS	8mg	8mg	8mg	24mg	84 X 2mg
2	2 WEEKS	6mg	6mg	8mg	20mg	70 X 2mg
3	2 WEEKS	6mg	6mg	6mg	18mg	63 x 2mg
4	2 WEEKS	4mg	6mg	6mg	16mg	56 x 2mg
5	2 WEEKS	4mg	4mg	6mg	14mg	49 x 2mg
6	2 WEEKS	4mg	4mg	4mg	12mg	42 x 2mg
7	2 WEEKS	2mg	4mg	4mg	10mg	35 x 2mg
8	2 WEEKS	2mg	2mg	4mg	8mg	28 x 2mg
9	2 WEEKS	2mg	2mg	2mg	6mg	21 x 2mg
10	2 WEEKS	2mg	0	2mg	4mg	14 x 2mg
11	2 WEEKS	0	0	2mg	2mg	7 x 2mg
TOTAL = AT LEAST 22 WEEKS						

SOME GROUND RULES

*** This is intended to be a slow process. Do not try to speed it up in any way**

*** If you are struggling take an extra week to complete a stage rather than going backwards by increasing the dose.**

*** Tell a friend or partner what you are aiming for so that they can encourage you**

*** Consult your GP regularly, and if you experience any fainting, fits, depression or panic attacks**

Appendix 3: PATIENT INFORMATION
RECOMMENDED REDUCING REGIME FROM 80mg to 30mg

IT IS UNLIKELY THAT THESE DOSES WILL BE PRESCRIBED FOR YOU.
The following reducing plan is to assist you in reducing your own illicit benzodiazepine use.

DIAZEPAM REDUCING REGIME: STARTING AT 80MG DAILY						
		MORNING	MIDDAY	AFTERNOON	NIGHT	TOTAL FOR DAY
STARTING DOSE		20mg	20mg	20mg	20mg	80mg
STAGE 1	2 WEEKS	20mg	20mg	15mg	20mg	75mg
2	2 WEEKS	20mg	15 mg	15mg	20mg	70mg
3	2 WEEKS	15mg	15mg	15mg	20mg	65mg
4	2 WEEKS	15mg	15mg	10mg	20mg	60mg
5	2 WEEKS	15mg	10mg	10mg	20mg	55mg
6	2 WEEKS	10mg	10mg	10mg	20mg	50mg
7	2 WEEKS	10mg	10mg	5mg	20mg	45mg
8	2 WEEKS	10mg	5mg	5mg	20mg	40mg
9	2 WEEKS	10mg	5mg	5mg	15mg	35mg
10	2 WEEKS	5mg	5mg	5mg	15mg	30mg
TOTAL = AT LEAST 20 WEEKS		WELL DONE. NOW FOLLOW THE SLOWER REDUCTION FROM 30mg				

SOME GROUND RULES

*** This is intended to be a slow process. Do not try to speed it up in any way**

*** If you are struggling take an extra week to complete a stage rather than going backwards by increasing the dose.**

***Tell a friend or partner what you are aiming for so that they can encourage you**

***Consult your GP regularly, and if you experience any fainting, fits, depression or panic attacks**

NOTE: THESE ARE GUIDELINES FOR HELPING YOU TO REDUCE YOUR OWN BENZODIAZEPINE USE. IT IS UNLIKELY THAT A DOCTOR WOULD PRESCRIBE THE AMOUNT OF DIAZEPAM DESCRIBED ABOVE.

Appendix 4: PATIENT INFORMATION
RECOMMENDED REDUCING REGIME FROM 200mg to 80mg

UNDER NO CIRCUMSTANCES WILL THESE DOSES BE PRESCRIBED FOR YOU
The following reducing plan is to assist you in reducing your own illicit benzodiazepine use.

DIAZEPAM REDUCING PLAN STARTING AT 200mg						
		MORNING	MIDDAY	AFTERNOON	NIGHT	TOTAL FOR DAY
STARTING DOSE		50mg	50mg	50mg	50mg	200mg
STAGE 1	2 WEEKS	50mg	40mg	40mg	50mg	180mg
2	2 WEEKS	40mg	40mg	30mg	50mg	160mg
3	2 WEEKS	40mg	30mg	30mg	40mg	140mg
4	2 WEEKS	30mg	30mg	20mg	40mg	120mg
5	2 WEEKS	30mg	20mg	20mg	40mg	110mg
6	2 WEEKS	30mg	20mg	20mg	30mg	100mg
7	2 WEEKS	20mg	20mg	20mg	30mg	90mg
8	2 WEEKS	20mg	20mg	20mg	20mg	80mg
TOTAL 16 WEEKS AT LEAST		WELL DONE. NOW FOLLOW THE SLOWER REDUCTION FROM 80MG				

SOME GROUND RULES

*** This is intended to be a slow process. Do not try to speed it up in any way**

*** If you are struggling take an extra week to complete a stage rather than going backwards by increasing the dose.**

***Tell a friend or partner what you are aiming for so that they can encourage you**

***Consult your GP regularly, and if you experience any fainting, fits, depression or panic attacks**

NOTE: THESE ARE GUIDELINES FOR HELPING YOU TO REDUCE YOUR OWN BENZODIAZEPINE USE. IT IS UNLIKELY THAT A DOCTOR WOULD PRESCRIBE THE AMOUNT OF DIAZEPAM DESCRIBED ABOVE.

Appendix 5: WITHDRAWAL FROM ZOPICLONE 15MG WITH DIAZEPAM SUBSTITUTION

(15mg Zopiclone is approx. equivalent to 10mg diazepam)

	Night Time	Equivalent diazepam dose
Starting dose	Zopiclone 15mg	10mg
Stage 1 (1 week)	Zopiclone 7.5mg Diazepam 5mg	10mg
Stage 2 (1 week)	**Stop** Zopiclone Diazepam 10mg	10mg
Stage 3 (1-2 weeks)	Diazepam 9mg	9mg
Stage 4 (1-2 weeks)	Diazepam 8mg	8mg
Then continue reducing diazepam by 1mg every 1-2 weeks		