Guidance For The Community Management Of Benzodiazepine And Z-Drug Dependence And Withdrawal In NHS Grampian

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Subject Guidance

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Policy application: NHS Grampian – Substance misuse

Purpose: This Guidance advises all staff in the community how to assess for dependence on benzodiazepines and z-drugs. It provides guidance on how to safely prescribe and withdraw benzodiazepines and z-drugs in dependent patients, along with advice and appropriate support.

Responsibilities for implementation:

Organisational: Management teams

Corporate: Senior Managers

Departmental: Substance misuse management team

Area: General practitioner practices

Policy statement: It is the responsibility of supervisory staff at all levels to ensure that their staff are working to the most up to date and relevant guidance, policies, protocols and procedures. By doing so, the quality of the services offered will be maintained, and the chances of staff making erroneous decisions which may affect patient, staff or visitor safety and comfort will be reduced. Supervisory staff at all levels must ensure that staff using this guidance act within their own level of competence.

Review: This policy will be reviewed at least every two years or sooner if current treatment recommendations change.
This document is also available in large print and other formats and languages, upon request. Please call NHS Grampian Corporate Communications on (01224) 551116 or (01224) 552245.

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Key Messages Summary

• Clinical services and General Practices should agree a practice prescribing policy for benzodiazepines and Z-drugs to ensure uniformity of practice between prescribers.

• Benzodiazepines and Z-drugs carry a risk of dependence, tolerance and withdrawal effects. They can put patients at increased risk of overdose, especially when combined with other depressant drugs such as methadone, heroin and alcohol.

• There is very little evidence to suggest that long-term substitute prescribing for dependence reduces harm. There is clear evidence that prescribing more than 30mg diazepam equivalent per day may cause harm.

• In practice short-term prescribing should be limited to a maximum of two weeks as signs of psychological and physical dependence can develop if prescribed for longer periods.

• For illicit (street sources/non prescribed) use, it is recommended that the patient’s benzodiazepine use be assessed over an approximate period of 3 months before dependence is confirmed and/or a substitute prescription of diazepam supplied. Exceptions to this rule should be decided on clinical presentation and discussed with the specialist substance misuse services.

• During this time monitor the patient’s pattern of use, encouraging patients to reduce current non-prescribed usage to therapeutic dose levels of 30mg diazepam equivalent per day or less. Prescribing should be considered as the last resort. Alternatives for anxiety management include non benzodiazepine pharmacotherapy and talking therapies.

• Provide patients with clear information on the risks of continuing benzodiazepine use and the potential for symptoms of withdrawal whilst undergoing a reducing regimen.

• Set realistic goals with the patient. Disagreement with the pace of reduction is likely to end in a poor outcome. Document the treatment plan in the patient notes.

• Gradual dose reduction is safer and likely to be more manageable to the patient than abrupt discontinuation.
• When prescribing remember that “Street” illicit benzodiazepines or Z-drugs may differ in constituents or strength.

• Whether prescribing for illicit or prescribed dependences, it is recommended that all benzodiazepines should be converted to the equivalent dose of Diazepam.

• Aim for the lowest dose of diazepam which controls symptoms of withdrawal (daily dose of between 10mg and 30mg) increasing to a maximum of 30 mg per day according to patient response.

• Diazepam should be prescribed in 2mg and 5mg strengths only preferably as daily dispense and no more than one weeks supply at a time. Diazepam 10mg tablets have a higher street value and should not be prescribed.

• If a patient is struggling with the reduction, hold the dose and reduction until the patient feels ready to continue. Do not increase the dose.
1. Introduction

This guidance outlines the recommended approach for the management of benzodiazepine and Z-drug* dependence and withdrawal within NHS Grampian. It aims to reduce the risks associated with benzodiazepines and Z-drugs by promoting safe prescribing.

*Z- drugs which include zaleplon, zolpidem and zopiclone are non benzodiazepine hypnotics, they carry the same risks and dependence problems as benzodiazepines.

There is a long history of both prescribed and illicit benzodiazepines/Z-drugs being misused with opioids, stimulants, alcohol and other drugs. There is little evidence to support the long-term prescribing of benzodiazepine/Z-drug for this client group.

In Scotland there has been a recent increase in the number of drug related deaths which have included a benzodiazepine, determined at toxicology. The National Drug Related Deaths Database (Scotland) Report 2012[^1] stated: “The drug most frequently found to be present in the body at death was diazepam (79%), followed by methadone (50%), heroin/morphine (48%), alcohol (47%) and anti-depressants (44%). Opioids (methadone, heroin, morphine or buprenorphine) were present in 80% of cases”.

2. Prescribing For Anxiety/Insomnia/Acute Requests

2.1. Anxiety and insomnia

Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic, or psychotic illness. The use of benzodiazepines to treat short-term ‘mild’ anxiety is inappropriate.

Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress.

Z drugs are indicated only for the short term management of severe insomnia that interferes with normal daily life, and should be prescribed for short periods of time only (up to two to four weeks for Zopiclone, Zolpidem and up to two weeks for Zaleplon).[^2] [^3]
In practice, it is recommended that short-term prescribing should be limited to a maximum of two weeks as signs of psychological and physical dependence can develop if prescribed for longer periods.

2.2. Acute requests for benzodiazepines

General practitioners should be alert to seemingly legitimate requests for supplies of benzodiazepines for any acute condition, e.g. back/muscular pain as this could just be a way of patients manipulating system. Practice staff should be trained to recognise and stop repeat acute requests for benzodiazepine prescriptions and refer patients back to GPs for further supplies where dependence/misuse is suspected.

3. Dependence, Tolerance and Withdrawal Effects

Benzodiazepines and Z-drugs carry a risk of dependence, tolerance and withdrawal effects. Tolerance to the anxiolytic and sedative effects of these groups of drugs typically occurs after a few weeks of regular use rendering them less effective for the management of the prescribed indication after this time. Tolerance to "episodic" amnesia does not develop and should be taken into account during consultations as patients may struggle with remembering recent events, the circumstances in which they occurred, and their sequence in time. This may impact on the efficacy of psychological interventions as patient recollection of consultations may be poor.

Dependence on even small doses of benzodiazepines/Z-drugs can result in anxiety, insomnia and other distressing withdrawal symptoms if the drug is stopped abruptly. Gradual dose reduction is preferable to abrupt discontinuation.¹⁴

4. Service/Practice Prescribing Policies

The substance misuse service would recommended that clinical services/General Practices formulate a practice prescribing policy for benzodiazepines and Z-drugs to ensure uniformity of practice between prescribers. This will help reduce the occurrence of patients selecting a prescriber on the basis of any personal prescribing policy. Where substance misuse CPNs (Community Psychiatric Nurses) are attached to a General Practice, they should be involved in the development of new, or update of existing, Practice policies on benzodiazepines. Practice pharmacists may be able to assist in identifying those patients receiving long-term prescriptions and use a variety of methods to reduce prescribing levels, e.g. letters with information and self-help for patients (see (3) in further reading section).

5. Assessment Of Benzodiazepine / Z-Drug Misuse and Dependence

5.1. Definition of dependence

DSM-IV “Definition of Dependence” states that the presence of three or more of the following 7 features, for a year or more would strongly indicate dependence.⁵
• **Tolerance:** a need for markedly increased amounts of the substance to achieve intoxication or desired effect or a markedly diminished effect with continued use of the same amount of the substance.

• **Withdrawal:** the characteristic withdrawal syndrome for the substance or taking the same (or a closely related) substance to relieve or avoid withdrawal symptoms.

  • The substance is often taken in larger amounts or over a longer period than was intended.
  • There is a persistent desire or unsuccessful efforts to cut down or control substance abuse.
  • A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.
  • Important social, occupational or recreational activities are given up or reduced because of substance use.
  • The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

It is essential that a full assessment is undertaken in order to identify dependence on a benzodiazepine.

5.2. **Establish type of dependency**

(i) Is drug prescribed or non-prescribed (illicit)?
(ii) If prescribed, what was the original indication?
(iii) Is the patient still experiencing symptoms of the original indication, e.g. stress or anxiety? Depending on timescales the prescribed drug may no longer be effective.
(iv) Note details of and reason(s) for any illicit use whether sole or in addition to prescribed use.

5.3. **Undertake full drug history**

The following points should be covered to assist diagnosis of dependence:

(i) Name of each drug taken, estimated daily dose, dosage interval, frequency of use and length of time taken for, e.g. months, years.
(ii) Co-morbid use of other drugs and/or alcohol. Benzodiazepines can lead to an unpredictable and exponential increase in risk of respiratory depression when taken with opioids and alcohol.
(iii) Time and duration of previous attempts at withdrawal and/or abstinence from benzodiazepines/Z-drugs.
(iv) History of previous severe withdrawal (including history of seizures) or post-withdrawal reaction.
(v) Concomitant severe medical or psychiatric illnesses.

5.4. **Check for Evidence of Benzodiazepine Dependence**

**Note the patient’s physical presentation** – drowsiness, disinhibition, dilation of pupils, and the frequency or consistency of presentation over several weeks.
For illicit use, it is recommended that the patient’s benzodiazepine use be assessed over a period of approximately 3 months before dependence is confirmed and/or a substitute prescription of diazepam supplied.

During this time Prescribers should make use of dependency questionnaires and drug diary sheets (Appendix 1 and 3) to monitor the patients pattern of use and level of dependence. Patients should be encouraged to reduce their benzodiazepine intake gradually over this time. It is important that binge episodes of heavy benzodiazepine use are not confused for a daily dependence. Urine sampling should be used to confirm presence of benzodiazepines on more than one occasion.

If there are exceptional circumstances, e.g. patient having withdrawal fits then prescribing can be considered at an earlier point but under specialist advice only.

5.5. Undertake urine/oral fluid drug testing

Note whether the presence or absence of benzodiazepines fits with the patient’s history, bear in mind that higher dosing will result in a longer duration of detection. Urine testing can also help identify other drugs of misuse and thus help decide if prescribing is appropriate or deemed too high risk, e.g. if a patient is regularly testing positive for cocaine and benzodiazepines, are they taking the benzodiazepines to deal with “come down effects” and therefore not dependent on them? In Grampian, neither oral fluid nor urine drug screening detects Z-drugs therefore dependence and compliance cannot be confirmed this way.

5.6. Dependence questionnaire/drug diary

The benzodiazepine dependence questionnaire (BDEPQ) is a self-report questionnaire which was developed to rate the severity of benzodiazepine dependence for people who use sleeping tablets or tranquillisers (benzodiazepines).

A BDEPQ may be a useful aid in some patients, particularly those who are not currently receiving a legitimate prescription. For elderly patients or those that may struggle with reading and writing it may help to go through the questionnaire with them, perhaps covering a section at each appointment.

Instead, of or additionally, patients should also be encouraged to record their daily benzodiazepine use in a drug diary which can assist accurate assessment. This process may help the patient to cut down quantities of the drug without the need for a prescription. It could also help those patients already in receipt of a prescription to identify triggers or times and reasons why they use benzodiazepines.

A link to the BDEPQ can be found below:
http://www.scotland.gov.uk/Publications/2003/05/17143/21912 (See Appendix 1, 2 and 3 respectively for self report BDEPQ NHS Grampian questionnaire, scoring sheet and drug diary).
5.7. Advice to patients around withdrawal symptoms

It is suggested that there are two phases in helping clients withdraw from benzodiazepine use.

**Phase One** - the key task is to provide clients with education about dependence and withdrawal. (See link for leaflet on benzodiazepine dependence and withdrawal [http://www.patient.co.uk/pdf/4638.pdf#](http://www.patient.co.uk/pdf/4638.pdf#)).

If the patient is fully aware of possible withdrawal effects and the length of time each effect may go on for, they may be more able to cope with them, particularly if they understand that steps can be taken to assist them to manage these symptoms. See Heather Ashton manual [http://www.benzo.org.uk/manual/bzcha03.htm](http://www.benzo.org.uk/manual/bzcha03.htm) for advice and practical tips.

**Phase Two** - the key task is to help clients deal with any negative symptoms that they experience as the drug is reduced. These symptoms may affect the client both physically and psychologically. However anxiety and panic are the most common symptoms experienced. Here the use of cognitive behavioural approaches is advocated.

6. Prior To Initiating A Reducing Regimen Consider Illicit Drug Use/Co-Morbid Conditions

6.1. Opioid dependent patients

Patients who are also prescribed a substitute prescription for opioid dependence should be maintained on a stable dose prior to considering benzodiazepine detoxification supported by urine drug screening, e.g. absence of other illicit drugs in the sample. Concurrent withdrawal from both medications is not recommended in a community setting. For patients whose other drug and alcohol misuse remains chaotic, the risk of overdose when introducing another respiratory depressant such as diazepam will greatly increase. Where opioid dependence is controlled it is easier to assess the need for and/or appropriateness of a benzodiazepine prescription.

Where required, advice should be sought from the Specialist Substance Misuse Service for support of more complex cases.

6.2. Alcohol dependent patients

Where patients exhibit a co-dependency on alcohol, the local specialist alcohol team should be consulted for advice prior to consideration of benzodiazepine withdrawal.

6.3. Co-existing mental health problems

It is important to take into account any mental health issues or conditions such as depression, schizophrenia or anxiety and any drugs already being prescribed for these. Drug interactions, respiratory depressant and sedative effects should be considered prior to commencing a benzodiazepine prescription. In these patient groups it would be appropriate to refer to the specialist service for assessment.
6.4. Illicit drug use

Illicit users should be motivated to reduce the dose of street benzodiazepine/Z-drug as much as possible. N.B “Street” illicit benzodiazepines or Z-drugs may differ in constituents or strength which should be taken into consideration when prescribing, e.g. patient may say that they are taking 200mg diazepam a day but an illicit supply could be much weaker than the quality assured products supplied via prescription.

In addition there are a number of New Psychoactive Substances without legal classification (legal highs), many of which are sold as benzodiazepine like compounds which may or may not exhibit similar effects to licensed benzodiazepines. There is potential that more people will develop dependence on such compounds in the future.

As a minimum patients should reduce current usage to therapeutic dose levels of 30mg diazepam equivalent per day or less. Prescribing should be considered as the last resort. By prescribing a benzodiazepine, prescribers may remove the principal motive for stopping use and may create dependency in the “intermittent” benzodiazepine/Z-drug user by giving them regular dosages.

7. Advice On Prescribing For Dependent Patients

Make sure the patient understands and is clear what the treatment plan is. It may be helpful for patient and prescriber to sign the agreed plan and record this. Starting a reducing regimen with an unwilling patient is unlikely to result in a successful outcome; however by encouraging and educating the patient on the benefits of reducing/stopping should help to engage patient in a reduction plan.

Evidence would suggest that a change in drug taking behaviour is more likely when an individual themselves is motivated to make such changes. Whilst it is often tempting to point out to an individual the problems their drug use is causing them, it may be helpful to build on what positive changes the individual hopes to achieve with this change. These frequently include improvements in physical and mental health, improved relationships, occupational performance and feeling of increased control over their lives. Reinforcing these positive long term goals may encourage the individual to move forward to make this change.

7.1. Initiating a reducing regimen

NB: It should be made clear at the outset that prescribing will be undertaken as a reducing regimen for a limited duration. Document the treatment plan in notes.

(i) Where a reducing regimen is deemed clinically appropriate, diazepam should be prescribed. Aim for the lowest dose which controls symptoms of withdrawal (daily dose of between 10mg and 30mg) increasing to a maximum of 30 mg per day according to patient response. Daily doses greater than 30mg are not recommended and may cause harm.
(ii) Benzodiazepines and Z-drugs should be converted to diazepam using the benzodiazepine dose equivalent chart (see Appendix 4). There is no justification for prescribing more than one benzodiazepine or Z-drug concurrently, except during the period of conversion. Substitute one dose of current benzodiazepine to diazepam at a time, usually starting with the evening or night-time dose. Replace the other doses, one by one, at intervals of a few days or a week until the total approximate equivalent dose is reached before starting the reduction. See Appendix 6 for zopiclone to diazepam conversion and withdrawal.

The long half-life of diazepam should enable the patient to take a single daily dose at night or a twice daily dose at most.

(iii) 10mg strength tablets of diazepam should not be prescribed as they have higher street value and are more likely to be diverted. Only 2mg and 5mg tablets should be prescribed. This has the additional benefit of allowing the patient to establish the lowest total dose required in a day.

(iv) Excessive supplies of medication on one prescription should be avoided. If a prescription is to be initiated this should initially be as a daily dispense arrangement. It is recommended that no more than one week’s supply should be prescribed to take away at a time and instalment dispensing (daily, three times per week, etc) should be used. This is especially important where patients have a history of drug or alcohol misuse or are co-prescribed an opioid substitute medication like methadone or buprenorphine product (e.g. Suboxone®).

7.2. Reducing regimen

(i) Aim to reduce in steps of approximately 10% to 20% of the daily dose every fortnight with patient consent. The rate of withdrawal is often determined by an individual’s capacity to tolerate symptoms.

(ii) If the patient is struggling with symptoms of withdrawal, halt the reduction and maintain the current dose until symptoms improve. Increases in dose are to be discouraged. Examples of reducing scale can be found in Appendix 6.

(iii) Set realistic goals with the patient. Disagreement with the pace of reduction is likely to end in a poor outcome. Document the treatment plan in the patient notes.

(iv) Check that other substances such as cannabis and alcohol are not being added in or increased in response to the benzodiazepine reduction.

(v) The time needed for complete withdrawal may vary from 4 weeks to a year or more.

(vi) Automatic repeat prescriptions are not recommended. Patients should be seen for ongoing assessment and support, before further supplies of benzodiazepines are issued.
8. **Additional Psychological Support**

Several agencies in Grampian are equipped to provide additional psychological support for benzodiazepine dependent patients. These include:

Drugs Action, Aberdeen 01224 557120

Northern Horizons, Turning Point Scotland, Peterhead 01779 470490

Studio 8, Elgin 01343 543792

In addition websites such as [http://www.benzo.org.uk/](http://www.benzo.org.uk/) have excellent links to patient forums and stories of recovery and withdrawal from benzodiazepines and excellent patient and professional advice and support on the subject.

9. **Contraindications, Cautions And Adverse Effects**

A full list of contraindications, cautions and side effects for each drug can be found in the British National Formulary [http://www.bnf.org/bnf/](http://www.bnf.org/bnf/).

9.1. **Pregnancy**

The Essential Guide to Problem Substance use During Pregnancy [10] states:

“There is no conclusive evidence that benzodiazepines cause congenital birth defects or other serious adverse effects on the developing fetus. However, an increased risk of low birth weight and preterm delivery has been reported and most studies have investigated low dose use, whereas many drug users report high dose intake. Whilst there have been some reports of facial abnormalities (i.e. cleft lip and palate) following high dose benzodiazepine use in early pregnancy, these findings have not been reliably reproduced.

Maternal use of benzodiazepines near term can also result in “floppy baby syndrome” where the newborn baby is lethargic, has reduced muscle tone and respiratory depression. Dependent benzodiazepine use by the mother is clearly associated with withdrawal symptoms in the newborn baby. Neonatal Abstinence Syndrome can be more severe and prolonged with benzodiazepines and the onset of withdrawal symptoms can be delayed, secondary to maternal opioid use”.

It is therefore generally recommended that use of benzodiazepines and Z-drugs are avoided in pregnancy unless there is a clear indication. However to reduce the risk of illicit use, those women who are dependent on benzodiazepines or Z-drugs should be stabilised on diazepam and where this can be tolerated without restarting illicit use, the dose reduced.

Recommended management for benzodiazepine use in pregnancy:

- **Outpatient:** GPs should liaise closely with the 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 the specialist antenatal clinic.

9.2. Breastfeeding

Diazepam and other benzodiazepines are excreted into breast milk, albeit at relatively low levels. Manufacturers’ advice on the use of diazepam whilst breastfeeding is to avoid if possible. There is a lack of research on benzodiazepine-dependent mothers who breastfeed, but if they wish to breastfeed, and the benefits are deemed to outweigh the risks they should be supported to do so. Potential risks include lethargy, sedation and poor suckling. Mothers should be advised to keep the dose of benzodiazepine as low as possible whilst breastfeeding and the infant should be monitored for signs of over-sedation and low milk intake/poor weight-gain. [10]

9.3. Hepatic impairment

In people with compromised hepatic function, long-acting agents are known to accumulate and metabolism will be slower necessitating prescribing of lower doses and closer monitoring. Benzodiazepines can precipitate coma in patients with hepatic impairment. The dose of Z-drugs should also be reduced if prescribing in these patients. Benzodiazepines and Z-drugs should be avoided in patients with severe disease [2] - seek specialist advice.

9.4. Renal impairment

Caution is necessary when prescribing benzodiazepines and Z-drugs to patients with severe renal impairment who can experience increased cerebral sensitivity to these drugs. Small doses should be used when initiating. [2]

9.5. Respiratory depression

Benzodiazepines and Z-drugs may cause respiratory depression which is exacerbated by the concomitant use of other CNS depressants such as alcohol and opioid drugs. Caution should be employed when prescribing benzodiazepines and Z-drugs in these instances. Patients should also be warned of the increased risks when mixing different respiratory depressants.

9.6. Driving history

It is the responsibility of the patient to inform the DVLA of any condition which may impair their ability to drive and the prescriber should inform patients of DVLA guidance. The DVLA has produced guidance regarding the professional responsibility of the prescriber available at: http://www.dft.gov.uk/dvla/medical/ataglance.aspx [11]
10. Consultation

Dr Steve Beason  Psychiatrist, NHSG Substance Misuse Service
Dr Carol Buchanan  GP with Special Interest in Substance Misuse
Dr Dheeraj Buruju  Speciality Registrar 4
Dr Bruce Davidson  Consultant Psychiatrist and Clinical Lead NHS Grampian (NHSG) Substance Misuse Service
Dr Alan Fraser  Sessional and out-of hours GP
Dr Fumen Gamba  Doctor, NHSG Substance Misuse Service
Dr Kevin Hinkley  GP with Special Interest in Substance Misuse
Mrs Eileen Howitt  Principal Pharmacist, Royal Cornhill Hospital
Dr Richard Legg  GP with Special Interest in Substance Misuse
Dr Iain Macaskill  Specialty Doctor, NHSG Substance Misuse Service
Dr Alison Mearns  GP with Special Interest in Substance Misuse
Ms Isobel Morison  Specialist pharmacist paediatrics/maternity
Andrew Robinson  Consultant Psychiatrist, NHSG Substance Misuse Service
Angie Wood  Nurse Consultant, NHSG Substance Misuse Service
Controlled Drug Pharmacists, NHS Grampian
CPN Clinical Leads, NHSG Substance Misuse Service
CPN Team Leads, NHSG Substance Misuse Service
NHS Grampian Mental Health Operational Medicines Management Group

11. References


5) The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)


12. Further Reading


2) The following web link to the NICE Clinical Knowledge summaries covers the assessment of a person who is being prescribed long-term benzodiazepines or Z-drugs, and offers advice on managing withdrawal of treatment. [http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal](http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal)

3) 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. 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.

4) General practitioners experiences and perceptions of benzodiazepine prescribing: systematic review and meta-synthesis – BMC Family Practice See link to paper below: [http://www.biomedcentral.com/1471-2296/14/191](http://www.biomedcentral.com/1471-2296/14/191)
Appendix 1 - NHSG Benzodiazepine Dependence Questionnaire (BDEPQ)

In the questions that follows you will be asked about your experience using medications known as sleeping pills, sedatives, hypnotics, ‘benzos’ or tranquillisers. These medications are also known by their trade names: valium, temazepam, nitrazepam (or mogadon), chlordiazepoxide (Librium); or by their nicknames such as ‘blues’, ‘moggies’, ‘tems’, ‘downers’.

When answering the questions please think only about your experiences over the last month. Place a tick or x in the box below the answer that best suits your experience in the last month.

1. In the last month, have you taken another sedative or tranquilliser as soon as the effects of the previous one began to wear off?
   NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

2. Have you taken sedatives, tranquillisers or sleeping pills in the last month because you like the way they make you feel?
   NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

3. In the last month, have you felt that you cannot face anything out of the ordinary without a sedative or tranquilliser?
   NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

4. Do you feel that you cannot get through the day without the help of your sedatives or tranquillisers?
   NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

5. Do you need to carry your sedatives or tranquillisers with you?
   NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

6. Have you tried to reduce the number of sedatives, tranquillisers or sleeping pills you take because they interfered with your life?
   A GREAT DEAL ☐ SOMEWHA __ A LITTLE ☐ NO ☐

7. Have you found that you needed to take more tranquillisers, sedatives or sleeping pills to get the same effect in the last month compared to when you first took them?
   NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

8. Do you need to take sedatives, tranquillisers or sleeping pills to deal with the problems in your life?
   NEVER ☐ SOMETIMES ☐ OFTEN ☐ EVERY DAY ☐
9. Do you feel terrible if you do not take a sedative, tranquilliser or sleeping pill?

EVERY DAY ☐ OFTEN ☐ SOMETIMES ☐ NEVER ☐

10a. In the last month, have you been worried that your doctor might not continue to prescribe the sedatives, tranquillisers or sleeping pills you are taking?

NEVER ☐ SOMETIMES ☐ OFTEN ☐ A LOT ☐

10b. How strong has this worry been?

MILD ☐ MODERATE ☐ SEVERE ☐

11. Could you stop taking sedatives, tranquillisers or sleeping pills tomorrow without any difficulties?

No, it would be impossible ☐
Perhaps, with a lot of difficulty ☐
Yes, with some difficulty ☐
Yes, without difficulty ☐

12. Do you count down the time until you can take your next sedative, tranquilliser or sleeping pill?

ALWAYS ☐ OFTEN ☐ SOMETIMES ☐ NEVER ☐

13a. Have you experienced relief when you have taken sedatives, tranquillisers or sleeping pills in the last month?

NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

13b. How strong is that relief?

MILD ☐ MODERATE ☐ INTENSE ☐

14a. In the last month, have you felt bad or sick as the effects of sedatives, tranquillisers or sleeping pills wore off?

Yes – Answer the next question ☐
No – Skip to question 15 ☐

14b. Have you taken another sedative, tranquilliser or sleeping pill to reduce these unpleasant after-effects?

NEVER ☐ SOMETIMES ☐ OFTEN ☐ ALWAYS ☐

15. In the last month, have you taken sedatives, tranquillisers or sleeping pills against the doctor’s advice or more frequently than recommended?

NEVER ☐ OCCASIONALLY ☐ SOMETIMES ☐ OFTEN ☐
16. Are you concerned about the number of sedatives, tranquillisers or sleeping pills you have taken in the last month?

- A GREAT DEAL ☐
- A LOT ☐
- A LITTLE ☐
- NOT AT ALL ☐

17. Have you taken more sedatives, tranquillisers or sleeping pills in one day than you planned to?

- EVERY DAY ☐
- OFTEN ☐
- SOMETIMES ☐
- NEVER ☐

18a Have you found the effects of sedatives, tranquillisers or sleeping pills pleasant?

- NEVER ☐
- SOMETIMES ☐
- OFTEN ☐
- ALWAYS ☐

18b. How strong is the pleasant feeling?

- MILD ☐
- MODERATE ☐
- INTENSE ☐

19. Have you taken sedatives, tranquillisers or sleeping pills for a longer period than you intended when you started?

- NEVER ☐
- SOMETIMES ☐
- OFTEN ☐
- A LOT ☐

20a. Have you felt tense or anxious as your prescription for sedatives, tranquillisers or sleeping pills began to run out?

- NEVER ☐
- SOMETIMES ☐
- OFTEN ☐
- EVERY TIME ☐

20b. How strong have these feelings been?

- MILD ☐
- MODERATE ☐
- SEVERE ☐

21a. Have you felt an urge or desire to take sedatives, tranquillisers or sleeping pills in the last month?

- NEVER ☐
- SOMETIMES ☐
- OFTEN ☐
- EVERY DAY ☐

21b. How strong is that urge or desire?

- MILD ☐
- MODERATE ☐
- INTENSE ☐

22. Have you taken sedatives, tranquillisers or sleeping pills in the last month when you did not really need them?

- NEVER ☐
- SOMETIMES ☐
- OFTEN ☐
- EVERY DAY ☐
Instructions: In the next set of questions please tick the box below next to the answer that matches what you think.

23. I feel powerless to prevent myself taking a sedative or tranquilliser when I am anxious, uptight or unhappy.

   STRONGLY □  DISAGREE    □  SOMEWHAT DISAGREE   □  SOMEWHAT AGREE    □  STRONGLY AGREE

24. I would not be able to handle my problems unless I take a sedative or tranquilliser.

   STRONGLY □  DISAGREE    □  SOMEWHAT DISAGREE   □  SOMEWHAT AGREE    □  STRONGLY AGREE

25. I get so upset over small arguments, that I need to take a sedative or tranquilliser.

   STRONGLY □  DISAGREE    □  SOMEWHAT DISAGREE   □  SOMEWHAT AGREE    □  STRONGLY AGREE

THANK YOU
Appendix 2 - Scoring The BDEPQ

SCORING INSTRUCTIONS:

Scoring the BDEPQ requires no more than basic clerical skills. The following steps describe how to calculate a total score and scores on the three subscales.

1. Score the items as follows:
   a. Score most items as 0 1 2 3
   b. Except items 2,5,6,9,12,16,17,24 and 25 which are reversed. Score these as 3 2 1 0.
   c. Score the second part (b) of 2-part items as 0 if the first part (a) is scored 0.
   d. Ignore item 14a
   e. Score item 11 as:
      3 No, it would be impossible
      2 Perhaps, but with a lot of difficulty
      1 Yes, with some difficulty
      0 Yes, without difficulty

2. Sum the items to give a total score.

3. Optionally calculate subscale scores as follows:
   a. GENERAL DEPENDENCE SUBSCALE: Sum items 1, 6, 7, 10a, 14b, 15, 16, 17, 19, 20a, 20b, 21a, and 22
   b. PLEASANT EFFECTS SUBSCALE: Sum items 2, 13a, 13b, 18a, 18b, and 21b
   c. PERCEIVED NEED SUBSCALE: Sum items 3, 4, 5, 8, 9, 11, 12, 23, 24, and 25

INTERPRETATION

In general higher scores are associated with greater risk of future withdrawal symptoms, of continued benzodiazepine use, and are more likely to be associated with ICD-10 diagnosis of benzodiazepine dependence.
## SCORING SHEET

<table>
<thead>
<tr>
<th>QUESTION No.</th>
<th>CIRCLE THE SCORE CORRESPONDING TO THE SUBJECT'S RESPONSE</th>
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<tr>
<td>1</td>
<td>0 1 2 3</td>
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<td>0 1 2 3</td>
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<td>6</td>
<td>3 2 1 0</td>
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<td>7</td>
<td>0 1 2 3</td>
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<tr>
<td>8</td>
<td>0 1 2 3</td>
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<tr>
<td>9</td>
<td>3 2 1 0</td>
</tr>
<tr>
<td>10a</td>
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<td>3 2 1 0</td>
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<td>0 1 2 3</td>
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<td>14a</td>
<td>Ignore</td>
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<tr>
<td>14b</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>15</td>
<td>0 1 2 3</td>
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<tr>
<td>16</td>
<td>3 2 1 0</td>
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<tr>
<td>17</td>
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<td>0 1 2 3</td>
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<td>21b</td>
<td>0 1 2 3</td>
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<tr>
<td>24</td>
<td>3 2 1 0</td>
</tr>
<tr>
<td>25</td>
<td>3 2 1 0</td>
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### TOTAL SCORE

**TOTAL**: 

### SUBSCALES:

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<th>16</th>
<th>17</th>
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**TOTAL**

#### PLEASANT EFFECTS

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<th>13b</th>
<th>18a</th>
<th>18b</th>
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**TOTAL**

#### PERCEIVED NEED

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<th>4</th>
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<th>8</th>
<th>9</th>
<th>11</th>
<th>12</th>
<th>23</th>
<th>24</th>
<th>25</th>
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<td>TOTAL</td>
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</table>

**TOTAL**
Appendix 3 - NHSG Drug Diary

<table>
<thead>
<tr>
<th>Date and time</th>
<th>What did I use and how much?</th>
<th>What triggered me to use?</th>
<th>How was I feeling before I used?</th>
<th>Any consequences of taking drug? (good or bad)</th>
</tr>
</thead>
<tbody>
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<td></td>
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Appendix 4 - Diazepam Equivalent Table, All Doses Equivalent To Diazepam 10mg Tablets.

Table adapted from Heather Ashton [13]

- **Half-life**: time taken for blood concentration to fall to half its peak value after a single dose. Half-life of active metabolite shown in square brackets. This time may vary considerably between individuals.

<table>
<thead>
<tr>
<th>Benzodiazepines⁵</th>
<th>Half-life (hrs)* [active metabolite]</th>
<th>Approximately Equivalent Oral Dosages (milligrams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam</td>
<td>6-12</td>
<td>0.5</td>
</tr>
<tr>
<td>Chlordiazepoxide</td>
<td>5-30 [36-200]</td>
<td>25</td>
</tr>
<tr>
<td>Clobazam</td>
<td>12-60</td>
<td>20</td>
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<tr>
<td>Clonazepam</td>
<td>18-50</td>
<td>0.5</td>
</tr>
<tr>
<td>Clorazepate</td>
<td>[36-200]</td>
<td>15</td>
</tr>
<tr>
<td>Diazepam</td>
<td>20-100 [36-200]</td>
<td>10</td>
</tr>
<tr>
<td>Flunitrazepam</td>
<td>18-26 [36-200]</td>
<td>1</td>
</tr>
<tr>
<td>Flurazepam</td>
<td>[40-250]</td>
<td>15-30</td>
</tr>
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<td>Loprazolam</td>
<td>6-12</td>
<td>1-2</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>10-20</td>
<td>1</td>
</tr>
<tr>
<td>Lormetazepam)</td>
<td>10-12</td>
<td>1-2</td>
</tr>
<tr>
<td>Nitrazepam</td>
<td>15-38</td>
<td>10</td>
</tr>
<tr>
<td>Oxazepam</td>
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<tr>
<td>Temazepam</td>
<td>8-22</td>
<td>20</td>
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<tr>
<td>Non-benzodiazepines with similar effects</td>
<td></td>
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</tr>
<tr>
<td>Zaleplon</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Zolpidem</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Zopiclone</td>
<td>5-6</td>
<td>15</td>
</tr>
<tr>
<td>Eszopiclone</td>
<td>6 (9 in elderly)</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix 5 - Treatment Algorithm Only Valid In Conjunction With NHSG Benzodiazepine Guidance

General principles that should be ongoing throughout any reduction regimen
- Teach HEALTHY coping techniques appropriate to patient
- Address underlying 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

Patient taking benzodiazepine or z-drug?

Prescribed

Is prescribed indication still appropriate?

YES

Continue prescription with regular review

NO

Pause reduction until ready to continue. Do not increase dose. Consider 3rd sector referral for psychological support.

Patient able to continue reduction without a prescription?

YES

Convert to diazepam and prescribe (max daily dose 30mg)

Reduce dose by 10-20% per fortnight according to patient response

Patient struggling with dose reduction?

YES

Support patient to reduce intake. Consider referral to 3rd sector for additional psychological support

NO

CONTINUE REDUCTION UNTIL COMPLETE
(time needed for withdrawal can vary from about 4 weeks to a year or more)

Illicit

Monitor for 3 months: advise patient to reduce daily dose by 10-20% per fortnight

Patient dependent?

YES

NO

CONTINUE REDUCTION UNTIL COMPLETE
(time needed for withdrawal can vary from about 4 weeks to a year or more)
Appendix 6 - Sample Reducing Regimen

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 REGIMEN : STARTING AT 30MG DAILY

<table>
<thead>
<tr>
<th></th>
<th>MORNING</th>
<th>AFTER-NOON</th>
<th>NIGHT</th>
<th>TOTAL FOR DAY</th>
<th>GP USE: TABS PER WEEK</th>
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<tbody>
<tr>
<td>STARTING DOSE</td>
<td>10mg</td>
<td>10mg</td>
<td>10mg</td>
<td>30mg</td>
<td>42 x 5mg</td>
</tr>
<tr>
<td>STAGE 1 2 WEEKS</td>
<td>8mg</td>
<td>8mg</td>
<td>8mg</td>
<td>24mg</td>
<td>84 X 2mg</td>
</tr>
<tr>
<td>2 2 WEEKS</td>
<td>6mg</td>
<td>6mg</td>
<td>8mg</td>
<td>20mg</td>
<td>70 X 2mg</td>
</tr>
<tr>
<td>3 2 WEEKS</td>
<td>6mg</td>
<td>6mg</td>
<td>6mg</td>
<td>18mg</td>
<td>63 X 2mg</td>
</tr>
<tr>
<td>4 2 WEEKS</td>
<td>4mg</td>
<td>6mg</td>
<td>6mg</td>
<td>16mg</td>
<td>56 X 2mg</td>
</tr>
<tr>
<td>5 2 WEEKS</td>
<td>4mg</td>
<td>4mg</td>
<td>6mg</td>
<td>14mg</td>
<td>49 X 2mg</td>
</tr>
<tr>
<td>6 2 WEEKS</td>
<td>4mg</td>
<td>4mg</td>
<td>4mg</td>
<td>12mg</td>
<td>42 X 2mg</td>
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<td>7 2 WEEKS</td>
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<td>4mg</td>
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<td>10mg</td>
<td>35 X 2mg</td>
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<tr>
<td>8 2 WEEKS</td>
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<td>2mg</td>
<td>4mg</td>
<td>8mg</td>
<td>28 X 2mg</td>
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<td>9 2 WEEKS</td>
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<td>2mg</td>
<td>4mg</td>
<td>14 X 2mg</td>
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<tr>
<td>11 2 WEEKS</td>
<td>0</td>
<td>0</td>
<td>2mg</td>
<td>2mg</td>
<td>7 X 2mg</td>
</tr>
</tbody>
</table>

SOME GROUND RULES
This is intended to be a slow process. Do not try to rush it.
If struggling take an extra week or two 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 support/encourage you.
Consult your GP regularly, especially if you experience any fainting, fits, and depression or panic attacks.

WITHDRAWAL FROM Zopiclone 15mg with diazepam substitution
(15mg Zopiclone approx. equivalent to 10mg diazepam)

<table>
<thead>
<tr>
<th></th>
<th>Night Time</th>
<th>Equivalent diazepam dose</th>
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</thead>
<tbody>
<tr>
<td>Starting dose</td>
<td>Zopiclone 15mg</td>
<td>10mg</td>
</tr>
<tr>
<td>Stage 1 (1 week)</td>
<td>Zopiclone 7.5mg Diazepam 5mg</td>
<td>10mg</td>
</tr>
<tr>
<td>Stage 2 (1 week)</td>
<td>Stop Zopiclone Diazepam 10mg</td>
<td>10mg</td>
</tr>
<tr>
<td>Stage 3 (1-2 weeks)</td>
<td>Diazepam 9mg</td>
<td>9mg</td>
</tr>
<tr>
<td>Stage 4 (1-2 weeks)</td>
<td>Diazepam 8mg</td>
<td>8mg</td>
</tr>
</tbody>
</table>

Then continue reducing diazepam by 1mg every 1-2 weeks.