

DEPRESCRIBING GUIDE FOR **BENZODIAZEPINES** **AND Z DRUGS**

(including short-acting [e.g. alprazolam, oxazepam, temazepam] and intermediate/long-acting [e.g. diazepam, lorazepam, nitrazepam] benzodiazepines, and Z drugs [e.g. zopiclone, zolpidem])

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This guide provides deprescribing information that can be applied to written and/or verbal communication (in the form of “preferred language”) between clinicians, patients and/or carers. Adapt appropriately for individual patients.



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CONSIDER TWO STEPS WHEN DEPRESCRIBING:

1

Should I deprescribe?

2

How do I deprescribe?

STEP 1: SHOULD I DEPRESCRIBE? (PATIENT ASSESSMENT)

Deprescribing triggers:

- Inappropriate indication, no current indication, presence or risk of adverse events, drug interaction, drug-disease interaction, high drug burden index (DBI),¹ poor adherence, or patient preference.

1a) Is there a documented indication or symptoms supporting continued use?

Inappropriate indication for continued use:

- Long-term regular treatment of insomnia (beyond 2 weeks).
- Behavioural and psychological symptoms in dementia.

Do not deprescribe if:

- Used for severe anxiety or grief, before consulting the treating psychiatrist or psychologist.
- Used for acute alcohol withdrawal.
- An acute physical or mental condition is aggravating insomnia, consider waiting for it to resolve before starting to wean.

1b) Are there adverse effects?

Consider potential adverse effects:

- Falls, dizziness, light-headedness, headaches, ataxia, slurred speech, blurred vision, confusion, drowsiness, oversedation, nightmares, impaired concentration (e.g. increased risk of car accidents), or dependence.²

1c) Is this medication likely to cause more harm than benefit?

See [Evidence-based advice](#) for additional information on risks of harm and benefits of continued use.

1d) Does the patient/carer agree with the recommendation to deprescribe?

Following provision of information, discussion and shared-decision making, the patient or carer has communicated that they would like to proceed with or decline the deprescribing recommendation.

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

_____ is currently taking _____
(patient name) (drug name: e.g. temazepam 10mg daily)

for _____, and is currently experiencing/at risk of _____.
(indication: e.g. insomnia) (patient issue: e.g. adverse effects)

The _____ outweighs the _____ for continued use of _____.
(risk/benefit + rationale) (risk/benefit + rationale) (drug name: e.g. temazepam)

Discussed with _____ and _____ deprescribing recommendation.
(patient /carer name) (agreed/willing to trial/considering/declined)

STEP 2: HOW DO I DEPRESCRIBE? (RECOMMENDATION AND MANAGEMENT)

2a) How to wean

Key Points

- Establish a supportive and trusting relationship with the patient to engage in complex/sensitive discussions.
- Accompany weaning with commencement of relevant non-pharmacological therapy. See [Alternative management](#) recommendations.
- In general, wean gradually by 25% of the daily dose every 1-4 weeks.
- If reason for deprescribing is due to serious adverse effects, consider weaning faster.
- Substitution with other sedative medicines is not recommended as the same adverse effects and outcomes may occur.
- Provide advice to patient/carer on self-monitoring and what to do if symptoms re-occur.
- Organise appropriate follow up appointments with general practitioner (GP) (frequency determined by rate of weaning).

Initiation

Reduce dose slowly by 25-50% of the daily dose each week to month.

Adjustments depend on response

Adjust according to response (see [Monitoring](#) recommendations).

- Conversion to a long-acting benzodiazepine is not required if the patient is taking a short-acting benzodiazepine.
- If no withdrawal symptoms occur, continue to wean and stop.
- Consider slower weaning (e.g. 12.5%) when reducing to the final lowest dose. End treatment 2 weeks after administering the lowest dose.
- Consider alternate day dosing to aid with weaning if dosage forms are limited.

Adjustments in the case of recurrent symptoms

In the case of recurrent/withdrawal symptoms, revert to the previous lowest tolerated dose. Recommence weaning after 6-12 weeks at a lower weaning rate (e.g. 5-12.5% of daily dose each month) then stop.

(Based on recommendations in [References](#)²⁻¹⁰)

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

Recommend non-pharmacological replacement therapy to reduce reliance on benzodiazepines or Z drugs.

Recommend gradually reducing to _____ for _____ and reassess,
(drug: e.g. temazepam 7.5mg daily) (timeframe: e.g. 2 weeks)

then reduce to _____ for _____ and reassess,
(e.g. temazepam 5mg daily) (e.g. 2 weeks)

then reduce to _____ for _____ and reassess,
(e.g. temazepam 5mg/2.5mg daily on alternate days) (e.g. 2 weeks)

then reduce to _____ for _____ and reassess,
(e.g. temazepam 2.5mg daily) (e.g. 2 weeks)

then reduce to _____ for _____ and stop.
(e.g. temazepam 2.5mg on alternate days) (e.g. 2 weeks)

Follow up with GP _____ after discharge.
(e.g. fortnightly)

2b) Alternative management

Non-pharmacological support

Sleep hygiene; cognitive behavioural therapy; minimise use of caffeine and alcohol. For sleep hygiene advice, refer to [AMH Aged Care Companion-Insomnia].

Switching within drug class or consider alternative therapy

Drug substitution with other benzodiazepines and/or other sedatives is not recommended; especially in older people, due to poor evidence of benefit and high potential for harm.

In older patients, switching to long-acting benzodiazepines has not been shown to reduce the incidence of withdrawal symptoms and is no more effective than weaning short-acting benzodiazepines.

To consider other options, refer to [AMH- Benzodiazepines].

PREFERRED LANGUAGE:

Use **sleep hygiene practices** and **cognitive behavioural therapy** concurrently.

2c) Monitoring

Monitor short term (within 1-3 days)	Monitor long term (> 7 days)
<p>Monitor for withdrawal symptoms Symptoms can occur within 1-3 days of dose reduction.</p>	<p>Monitor for recurrence of symptoms Recurrence of previous or new symptoms (e.g. anxiety, depression) may occur within 1-2 weeks of dose reduction.</p>
<ul style="list-style-type: none"> Common withdrawal symptoms (e.g. irritability, anxiety, insomnia, and sweating) are usually mild, highly variable and can last up to 6-8 weeks. If severe symptoms (e.g. dysphoria, nightmares, memory impairment, hallucinations, hypertension, tachycardia, psychosis, tremors and seizures, profuse and persistent sweating, severe anxiety, or severe insomnia) occur, restart at the previous lowest effective dose. 	

PREFERRED LANGUAGE:

Within 1-3 days of dose reduction, monitor for **withdrawal symptoms** which can be **mild** (e.g. irritability, insomnia, sweating) or **severe** (e.g. dysphoria, nightmares, memory impairment, hallucinations, hypertension, tachycardia, psychosis, tremors and seizures, profuse and persistent sweating, severe anxiety, or severe insomnia).

Monitor for **recurrence** of symptoms within 1-2 weeks of dose reduction, including *anxiety or depression*.

Restart at the lowest effective dose with retriial weaning at 6-12 weeks.

EVIDENCE-BASED ADVICE

Effectiveness and safety

A meta-analysis estimated that 13 patients with insomnia needed to be treated (for 1-2 weeks) with a benzodiazepine or Z drug in order to obtain a benefit (number needed to treat [NNT] = 13); whereas 6 patients needed to be treated (from 7-28 nights) with a benzodiazepine or Z drug (compared with placebo) in order to suffer harm (number needed to harm [NNH] = 6).^{11,12}

A review of meta-analyses showed chronic benzodiazepine or Z drug use was strongly associated with an increased risk of falls in older people (relative risk [RR] range of 1.2-1.6 in people aged ≥ 65 years). This risk was greater in people aged ≥ 85 years (RR 3.6, 95% confidence interval [CI] 2.9-4.5).¹¹

The increased risk (13-50%) of hip fractures due to chronic benzodiazepine or Z drug use attributes to approximately 10% of the total burden of hip fractures.¹¹

Benzodiazepine or Z drugs can be successfully stopped in 27-80% of older patients. Improvements in balance and cognition can be seen in patients within 2-3 weeks of stopping a benzodiazepine or Z drug.¹¹

Over 90% of people would be willing to stop their medicines if recommended by their physician.¹³

Recommended duration of use

In general, the hypnotic benefits stop due to tolerance at approximately 2-4 weeks, and are then replaced by dependence. Their use may only increase sleep time by 23-25 minutes.¹¹

Limit drug treatment to short-term use. Benzodiazepines or Z drugs are associated with significant harm (e.g. falls, fractures, car accidents, withdrawal), and long-term use is not recommended, especially in older adults.

SUMMARISED PHRASING DURING HOSPITAL ADMISSION AND/OR AT DISCHARGE

When communicating deprescribing decisions to GPs at discharge, written and verbal communication should include information in the sequence of:

“Medicine, Intention, Rationale, Clear Plan (dose change, duration, follow up), Patient agreement”

PREFERRED LANGUAGE

(write in GP follow up plan and medication list):

_____ : _____ **due to** _____ **outweighing effects** _____
current medication (e.g. temazepam) stopped/ reduced with aim of stopping specific rationale (e.g. falls risk) of/on current indication (e.g. on chronic insomnia)

_____ **reduced to** _____ **for** _____, **then** _____. **Patient/Carer agreed.**
If weaning, old dose changed to new dose (e.g. temazepam 10mg nocte reduced to alternating 10mg/5mg) if weaning, time frame (e.g. 2 weeks) follow-up action (e.g. follow up with GP)

Refer to www.nswtag.org.au/deprescribing-tools/

Example:

Temazepam: reduced with aim of stopping due to falls risk outweighing effects on chronic insomnia.

Temazepam 10mg nocte reduced to alternating temazepam 10mg/5mg nocte for 2 weeks then follow up with GP. Patient agreed. Refer to www.nswtag.org.au/deprescribing-tools/



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