NHS
Cumbria
Clinical Commissioning Group

HYPNOTICS

REDUCING & STOPPING

A Practice Guide

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Introduction

It is now well recognised that the long term use of hypnotics and anxiolytics by the majority of patients in general practice is not appropriate. The Committee on Safety of Medicines issued guidance in 1988 about the risks of the long term use of benzodiazepines. This guidance has resulted in very few new patients being prescribed long-term benzodiazepines by general practitioners.

The prescribing by general practitioners of hypnotics is being included in the **Department of Health QIPP (Quality Innovation Productivity & Prevention) national therapeutic indicators.**

Although prescribing data shows that there has been a reduction in the number of prescriptions and the quantity of benzodiazepines being prescribed, there still remain a large number of patients on regular repeat prescriptions of benzodiazepines that were initiated several years ago.

This practice guide provides practices in Cumbria a practical approach on how the number of patients on inappropriate long term **hypnotics** can be reduced (for further information on reduction and stopping anxiolytics not covered here refer to Welsh Education Pack). The methods described in this guide have been developed from the approaches that have been undertaken in various practices, both in Wales and locally.
(http://www.wales.nhs.uk/sites3/Documents/371/H&A%20Educational%20Pack%20website.pdf)

Hypnotics and Anxiolytics

Benzodiazepines

Mechanism of Action

All benzodiazepines act by enhancing the actions of a natural brain chemical, GABA (gamma-aminobutyric acid). GABA is a neurotransmitter, an agent which transmits messages from one brain cell (neuron) to another. The message that GABA transmits is an inhibitory one: it tells the neurons that it contacts to slow down or stop firing. Since about 40% of the millions of neurons all over the brain respond to GABA, this means that GABA has a general quietening influence on the brain: it is in some ways the body's natural hypnotic and tranquilliser.
A brief understanding of the mechanism of action is important to explain to patients the effect on the brain of taking this medication on a long-term.

Difference between benzodiazepines

Benzodiazepines with high potency and short elimination half lives are more likely to lead to problems with dependence e.g. lorazepam, oxazepam and loprazolam.
Those with long half lives can lead to residual effects into the following day e.g. nitrazepam.
Those with an intermediate half life cause least problems when used for a short period.

The effects of **long-term use** can

- Cause drowsiness and falls.
- Reduce a persons own coping skills.
- Impair judgement and dexterity.
- Increased the risk of experiencing a road traffic accident.
- Cause other effects include forgetfulness, confusion, depression, irritability, aggression, impulsivity and digestive problems.
- Result in dependence.

Dependence is often demonstrated in patients by a number of the following characteristics:

- They have taken benzodiazepines in prescribed "therapeutic" (usually low) doses for months or years.
- They have gradually become to "need" benzodiazepines to carry out normal, day-to-day activities.
- They have continued to take benzodiazepines although the original indication for prescription has resolved.

- They have difficulty in stopping the drug, or reducing dosage, because of withdrawal symptoms.
- If on short-acting benzodiazepines, they may develop anxiety symptoms between doses, or get craving for the next dose.
- They contact their doctor regularly to obtain repeat prescriptions.
- They become anxious if the next prescription is not readily available; they may carry their tablets around with them and may take an extra dose before an anticipated stressful event or a night in a strange bed.
- 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.

Systematic approach to reducing the number of patients in a practice on long term hypnotics

Can it be done?
It is relatively straightforward to withdraw most patients from long term hypnotic (and anxiolytics) if the problems linked to their long term use is explained to them and they feel that they will be supported through the withdrawal process.
A number of studies have shown that between 40 to 80% of patients can discontinue the benzodiazepine they have been taking for more than a year through a managed process.

All practice prescribers should

1. Agree to follow a practice protocol for prescribing Hypnotics and Anxiolytics (example - Appendix 1)
2. Agree to review **all** patients, but decide on a target group of patients and how to prioritise (e.g. younger, elderly, middle age, high dose)
3. Agree method of review most suitable to follow for the practice (e.g. medication to Acutes; ALL patients at once; few patients per GP per month). There are a number of approaches a practice can undertake to review these patients (discuss with Practice Medicines Optimisation Pharmacist)
    - If there are large numbers of patients that need to be reviewed then it may be appropriate to organise a separate clinic. There may be an opportunity for practices to be supported by other organisations (e.g. Partnership Trust, Unity).
    - By adding one of the patients to be reviewed at the end of each of the doctor's normal sessions. They will need a 15 minute appointment. This may be useful in practices with a number of GPs, so that they could all be involved.
    - By having the number of authorisations for repeat prescriptions of hypnotics (and anxiolytics) reduced to one or two months then the patient is asked to make an appointment to review only this medication.
    - As part of their usual medication review. This can be difficult as they may be on a number of medications which will all need time to be discussed. It may be an opportunity to give written information for a patient to take home and to then organise another appointment to discuss a reduction programme.
4. Agree most appropriate patient letter to adapt for the practice (Appendix 2 & Welsh pack p42 to 45)
5. Agree to provide information to patient
    - regarding concerns about hypnotics (and anxiolytics) and the need for gradual withdrawal (Appendix 3)
    - leaflets about self help techniques "Good Sleep Guide" and "Good Relaxation Guide" (Appendix 4)

This allows patients to be informed about the issues and allows them to start preparing for the proposed appointment. A copy of all this information should be given to each local community pharmacies in the area so that they are aware of the information patients may want to discuss.

Initial Appointment

1. Explain the reasons for the appointment
    - That long term use of this medication is not recommended.
    - Tolerance can develop.
    - Risk of rebound insomnia and withdrawal effects if stopped abruptly.
    - Risk of over-sedation and cognitive impairment seen as confusion and falls.
    - Risk of CNS depression.
    - Risk of physical and/or psychological dependence.
2. The need to address the cause of sleep disturbance.
    - Poor sleep hygiene.
    - Minor anxiety.
    - Pain control.
    - Depression.
    - Anxiety /panic attacks.
3. The need to undertake a gradual withdrawal process.
4. Support available from the practice throughout the process.
5. If at this initial appointment it is not appropriate to reduce their medication, the patient's prescription should be re-authorised for a period and another appointment made.
6. **Document in patients notes (8CR9 – Benzodiazepine Clinical Management Plan)**

Reduction Protocols for Hypnotics to Support Withdrawal

Experience locally from clinicians and practices that have successfully reviewed patients on long term hypnotics and anxiolytics is that the vast majority of patients can be withdrawn using the medication they are already taking. Standard reduction protocols often recommend converting patients medication to an equivalent dose of diazepam, however patients may prefer to try reducing their current medication rather than changing to another medication. (Please see Table 1 for dose equivalences to diazepam if conversion preferred).

- 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 or information about patient support groups.
- A copy of the protocol should be given to the patient and the patient's pharmacy. A copy should also be kept in the practice's records.

Examples of protocols (Appendix 5 & in Welsh Guide p63 -65)

Table 1. Differences between benzodiazepines and "Z" drugs (for insomnia)
(For all information regarding Anxiolytics refer to Welsh Education Pack)

Drug	Indication	Dose *	Half-life † (active metabolite)	Equivalent Dose §
Nitrazepam	Insomnia	5mg *nocte*	15-38 hours	5 mg
Temazepam	Insomnia	10-20 mg *nocte*	8-22 hours	10 mg
Loprazolam	Insomnia	1-2 mg *nocte*	6-12 hours	0.5-1 mg
Lormetazepam	Insomnia	0.5-1.5 mg *nocte*	10-12 hours	0.5-1 mg
Zopiclone	Insomnia	3.75 -7.5 mg *nocte*	5-6 hours	3.75 mg
Zolpidem	Insomnia	5-10 mg *nocte*	2-4 hours	10 mg
Zaleplon	Insomnia	5-10 mg *nocte*	2 hour	10mg

***** Generally use half an adult dose in elderly patients.
† Varies between individuals (e.g. prolonged in the elderly).
§ Equivalent dose to diazepam 5 mg.

Other Treatment Options for Insomnia
Benzo.org website http://www.benzo.org.uk/
Northumberland, Tyne&Wear NHS Foundation Trust Sleep Guide
http://www.ntw.nhs.uk/pic/leaflets/Sleeping%20Problems%20A4%202010.pdf
First Steps (Cumbria Partnership NHS Foundation Trust)
http://www.cumbriapartnership.nhs.uk/uploads/First%20Step/sleeping%20problems.pdf
– Sleeping Problems Self Help Guide (based on above material)
Sleep Diary - http://www.patient.co.uk/health/Sleep-Diary.htm

Sedating Antihistamines
Sedating antihistamines such as promethazine and diphenhydramine are available without a prescription for self treatment of occasional insomnia.
They have a **lack of good evidence,** slow onset of action and long duration, and the effect may diminish after a few days treatment.
Very occasionally they have been prescribed to patients during withdrawal process.

References:

Ashton H. Benzodiazepines: How they work and how to withdraw. School of Neurosciences Division of Psychiatry The Royal Victoria Infirmary Newcastle upon Tyne August 2002

Primary Care Guidelines for Medicines Liable to Misuse. Bridgend, Neath Port Talbot and Swansea Local Health Board 2002

Drug and Therapeutics Bulletin. What's wrong with prescribing hypnotics? DTB 2004; 42(112): 89-93

National Institute for Health and Clinical Excellence (NICE). Anxiety Full Guidance. Clinical Guideline (22) 2008

Clinical Knowledge Summaries Bezodiazepines/ Z drug Withdrawal National Liabary for Health June 2006 http://cks.library.nhs.uk/home

http://www.wales.nhs.uk/sites3/Documents/582/Guide_Hypnotics%20%26%20Anxiolytics%20Practice%20Guide_version02.pdf

Committee of Safety of Medicines. Current problems in pharmacovigilance. Jan 1988. Report No.: 21

Prescribing Protocol for Hypnotics and Anxiolytics

- 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 cohort of people who may need to be on a 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 regime (unless they fall into the exclusion criteria above), when they register with the practice.

Appendix 2 – Sample Letter

NHS
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Practice Name and Address

Dear Patient

Re: Sleeping and Anxiety Drugs.

There has been increasing concern about sleeping and anxiety drugs when they are taken for long periods of time. National guidelines state they should not be used for more than four weeks and then the 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 can only issue this medication on an acute prescription and, therefore, any sleeping and anxiety medicines have been removed 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 a medication review to discuss a very gradual and supported withdrawal. Medication for other conditions will not be affected.

We would be grateful if you could, therefore, come in to see your usual doctor or, alternatively, contact the surgery on …… to request a telephone consultation to discuss your tablets/capsules with us. The receptionists are aware of this letter and will help you as much as possible.

If you have any other queries or concerns, please contact the practice to discuss them. We enclose some information leaflets which you may find helpful.

Yours sincerely

Dr

Cumbria Clinical Commissioning Group

Sleeping and Anxiety Tablets - Information for Patients

Recently family doctors and all health care professionals have been concerned about the use of this kind of sedative medication when it is taken over long periods.

As Good Practice all doctors have been asked to review all patients currently prescribed sedative medication as a repeat prescription.

Research work done in this field has shown that all medication used as a sedative is not recommended to be used regularly and for long periods.

Sleeping and anxiety tablets used to be commonly taken. However, they have been shown to have problems, and are now not commonly prescribed. Possible problems with these tablets include:

- Drowsiness the next day. You may not be safe to drive or to operate machinery.
- Clumsiness and confusion in the night if you have to get up. For example, if you have had a sleeping tablet, you may fall over if you get up to go to the toilet in the night. (Older people who take sleeping tablets have an increased risk of breaking their hip.)
- Tolerance to sleeping tablets may develop if you take them regularly. This means that, in time, the usual dose has no effect. You then need a higher dose to help with sleep. In time, the higher dose then has no effect, and so on.
- Developing dependence (addiction) to sleeping and anxiety tablets,
- Suffering from withdrawal symptoms if the tablets are stopped suddenly so a slow withdrawal is needed.

If you would like discuss the best approach to reducing or stopping this medication please make an appointment to see the doctor.

Coming off benzodiazepines and "Z" drugs - a guide for patients

What are benzodiazepines and why are they used?

Benzodiazepines are a group of drugs which have been available since the early 1960's, and are used as sleeping tablets or to help with severe anxiety. "Z" drugs such as zolpidem, zopiclone and zaleplon are also used as sleeping tablets. Benzodiazepines and "Z" drugs are only available on prescription therefore they can only be legally prescribed at a pharmacy. In Britain, it is illegal to supply them in any other circumstances, including giving them away.

Benzodiazepines and "Z" drugs should only be taken for a short period of time (maximum of two to four weeks) to help cope with a crisis, or if taken for sleeplessness they should not be taken for more than one night in three (short-term use only). Both drug groups treat the symptoms of a condition and not the causes. However, their effectiveness is limited to about four weeks. You may feel you need to keep taking them despite any beneficial effect and if used continuously (more than six weeks), addiction may occur.

These tablets in combination with drinking or driving may be dangerous, as they are both nervous system depressants. Counselling and other non-drug treatments have proven to be more effective than drugs in many cases.

What are the effects of taking benzodiazepines?

Benzodiazepines act on the brain and may affect your memory and concentration. Other potential side-effects include tiredness and drowsiness.

Long-term benzodiazepine treatment is associated with a number of adverse effects and other complications. 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 excitability.

Complications related to long- term use include:

- depression
- reduction in coping skills
- tolerance and dependence.

How to stop taking benzodiazepines and "Z" drugs?

If you have been taking benzodiazepines to help you cope with a personal crisis, it may be advisable to wait until things settle down before starting to reduce the dose. The following tips may help once you have decided to withdraw:

- *You should not attempt to give them up completely all at once.* The rate at which a person should reduce his or her intake varies. It is important however, that once you have decided to withdraw that you make this a slow gradual process, as this often gives a better chance of long-term success. It is important that you take it at your own pace—one that feels right for you.

- *Consult your doctor or practice nurse/pharmacist.* They can give advice on the rate at which you should reduce the dose of the drug and help you to consider other ways of dealing with your worries/sleeping problems (e.g. anxiety management groups and counselling). Depending on which drug you are taking it may be easier to withdraw if you change to diazepam. Diazepam is available in 2, 5 and 10 mg tablets which make it easier to cut your dose down more slowly. Discuss the possibility of change with your doctor.
- *Don't go back!* When people begin to reduce their dose, they often become able to deal with normal day-to-day events and may feel much better. However, it is also usual to have a bad patch at some time during withdrawal. If this happens, stick with the current dose until you feel ready to reduce again; this may take several weeks, but try not to increase the dose.
- *Keep a written record.* Plan your withdrawal. Most people have found that about one to two weeks between reductions works for them but everyone finds their own level. Keeping a diary can help as it records your progress and achievements. This in itself will give you more confidence and encouragement to carry on.
- *Coping with withdrawal symptoms.* Not everyone experiences the same symptoms when withdrawing from benzodiazepines and "Z" drugs. Some may not experience any symptoms whereas some will suffer more than others:
    - *Panic attacks* are very common symptoms of withdrawal and understanding the cause is important. Panic attacks are usually brought on by the effects of adrenaline and rapid, shallow breathing or hyper-ventilation that results in palpitations, sweating, unsteady legs and trembling. Establishing control over breathing will help remove the feeling of fright.
    - *Anxiety* may be mistaken for the condition for which the drug was initially prescribed. Gradual drug withdrawal should help to minimise symptoms.
    - *Agoraphobia* ranges from being unable to go out on your own, to simply not wanting to go out despite being able to do so with effort. Usually, as withdrawal continues, agoraphobic feelings are reduced.
    - *Aches and pains* are very common during withdrawal from benzodiazepines and "Z" drugs. Doctors can prescribe painkillers to reduce these effects.
    - *Sleeping problems are* common during withdrawal, hence it is important to get some exercise as this helps encourage sleep. Try not to worry about lack of sleep—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 are very common during withdrawal and can be very distressing. Your doctor may be able to recommend a diet and indigestion remedies that may improve these symptoms which usually disappear after withdrawal is complete.
    - *Hot flushes and shivering*. The feeling of burning and extreme heat (sweating) is also common. In contrast, others suddenly feel cold.
    - *Sinus problems.* Many people suffer from inflamed mucous membranes which causes severe sinus discomfort.
    - *Vivid dreams and nightmares may occur* during withdrawal. This may be a good sign as before withdrawal most people do not dream (drug-induced sleep is 'dead' sleep). As withdrawal continues, dreaming returns 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.

Remember that the symptoms are not the disease – they show that you are progressing

With time they should all pass
You should not give up
Good luck!

THE GOOD SLEEP GUIDE

During the Evening

- Put the day to rest. Think it through. Tie up "loose ends" in your mind and plan ahead. A notebook may help.
- Take some light exercise early in the evening. Generally try to keep yourself fit.
- Wind down during the course of the evening. Do not do anything that is mentally demanding within 90 minutes of bedtime.
- Do not sleep or snooze in the armchair. Keep your sleep for bedtime.
- Do not drink too much coffee or tea and only have a light snack for supper. Do not drink alcohol to aid your sleep – it usually upsets sleep.
- Make sure your bed and bedroom are comfortable – not too cold and not too warm.

At Bedtime

- Go to bed when you are "sleepy tired" and not before.
- Do not read or watch TV in bed. Keep these activities for another room.
- Set the alarm for the same time every day – 7 days a week, at least until your sleep pattern settles down.
- Put the light out when you get into bed.
- Let yourself relax and tell yourself that "sleep will come when it's ready". Enjoy relaxing even if you don't at first fall asleep.
- Do not try to fall asleep. Sleep is not something you can switch on deliberately but if you try to switch it on you can switch it off!

If you have Problems getting to Sleep

- Remember that sleep problems are quite common and they are not as damaging as you might think. Try not to get upset or frustrated.
- If you are awake in bed for more than 20 minutes then get up and go into another room.
- Do something relaxing for a while and don't worry about tomorrow. People usually cope quite well even after a sleepless night. Go back to bed when you feel "sleepy tired".
- A good sleep pattern may take a number of weeks to establish. Be confident that you will achieve this in the end of the end by working through the "GOOD SLEEP GUIDE".

THE GOOD RELAXATION GUIDE

Dealing with Physical Tension

- Value times of relaxation. Think of them as essentials not extras. Give relaxation some of your time not just what's left over.
- Build relaxing things into your lifestyle every day and take your time. Don't rush. Don't try too hard.
- Learn a relaxation routine, but don't expect to learn without practice.
- There may be relaxation routines available, especially on audio tape. These help you to reduce muscle tension and to learn how to use your breathing to help you relax.
- Tension can show in many different ways – aches, stiffness, heart racing, perspiration, stomach churning, etc. Don't be worried about this.
- Keep fit. Physical exercise, such as a regular brisk walk or a swim, can help to relieve tension.

Dealing with Worry

- Accept that worry can be normal and that it can be useful. Some people worry more that others but everyone worries sometimes.
- Write down your concerns. Decide which ones are more important by rating each out of ten.
- Work out a plan of action for each problem.
- Share your worries. Your friends or your general practitioner can give you helpful advice.
- Doing crosswords, reading, taking up a hobby or an interest can all keep your mind active and positive. You can block out worrying thoughts by mentally repeating a comforting phrase.
- Practice enjoying quiet moments, e.g. sitting listening to relaxing music. Allow your mind to wander and try to picture yourself in pleasant, enjoyable situations.

Dealing with Difficult Situations

- Try to build your confidence. Try not to avoid circumstances where you feel more anxious. A step by step approach is best to help you face things and places which make you feel tense. Regular practice will help you overcome your anxiety.
- Make a written plan and decide how you are going to deal with difficult situations.
- Reward yourself for your successes. Tell others. We all need encouragement.
- Your symptoms may reduce as you face up to difficult situations. Keep trying and they should become less troublesome as your confidence grows.
- Everyone has good and bad days. Expect to have more good days as time goes on.
- Try to put together a programme based on all the elements in "The Good Relaxation Guide" that will meet the needs of your particular situation. Remember that expert guidance and advice is available if you need further help.

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Appendix 7 - 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 µg tablets/day	Number of 500 µg tablets/week
Starting dose	Lormetazepam 1.5 mg	3	21
Stage 1 (1-2 weeks)	Lormetazepam 1mg	2	14
Stage 2 (1-2 weeks)	Lormetazepam 500 µg	1	7
Stage 3 (1-2 weeks)	Lormetazepam 250 µg	½	4
Stage 4 (1-2 weeks)	Lormetazepam 250 µg *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. 5mg
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 and Zaleplon

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		

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