Benzodiazepine Withdrawal Management

These toolkits are derived from the QLD Alcohol and Drug Withdrawal Clinical Practice Guidelines 2012.
Medical Addiction specialists will be able to offer additional expert opinion based upon current evidence.

insight
Centre for alcohol and other drug training and workforce development

1 SCREENING

Severity of Dependence SDS Scale

Record the answer that best represents the consumer's personal feelings towards their benzodiazepine use over the previous twelve months.				
Did you ever think your benzodiazepines use was out of control?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
Did the prospect of not using benzodiazepines make you anxious or worried?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
How much did you worry about your use of benzodiazepines?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
Did you wish you could stop using benzodiazepines?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
How difficult would you find it to stop or go without benzodiazepines?	Never or almost never (0)	Sometimes (1)	Often (2)	Always or nearly always (3)
Benzodiazepines > 7 indicates dependence (Cuevas C, Sanz E, de la Fuente J, Padilla J, Berenguer J. 2000).				Total /15

2 ASSESSMENT

Perform Comprehensive Assessment

1. **Consumption history:** Average daily intake (higher doses increase severity of dependence), frequency of use (number of doses per day?), duration of use - months or years, type of benzodiazepine used (short – or long-acting), history of severity of withdrawal symptoms, means of obtaining the benzodiazepine (prescribed, 'doctor shopping', fraudulently?), other drug use? day/time of last use
   Visit QScript to investigate prescribing history (**https://www.qscript.health.qld.gov.au/**)
2. **Biopsychosocial history:** Medical and psychiatric conditions, social history and collateral relating to presentation
3. **Investigations:** Bloods (eLFTS, FBC) Urine drug screen, Blood Borne Virus screen
4. **Physical examination:** Neurological observations, assess for IV use (patency and health of veins - assess for cellulitis/ infected access sites)

3 MONITORING

Convert Diazapam Equivalents

Generic name	Trade name	Time to peak concentration	Elimination half-life#	Equivalent dose**	
Diazepam	Antenex, Ducene, Valium, Valpam	30-90 mins	Biphasic: rapid phase half-life 3 hours; elimination half-life 20-48 hours	5mg	
Alprazolam	Alprax, Xanax*, Kalma	1 hour	6-25 hours	0.5-1mg	
Clonazepam	Paxam, Rivotril	2-3 hours	22-54 hours	0.5mg	
Flunitrazepam	Hypnodorm	1-2 hours	20-30 hours	1-2mg	
Lorazepam	Ativan	2 hours	12-16 hours	1mg	
Nitrazepam	Alodorm, Mogadon	2 hours	16-48 hours	2.5-5mg	
Oxazepam	Alepam, Murelax, Serepax	2-3 hours	4-15 hours	15-30mg	
Temazepam	Euphypnos, Normison, Temaze, Temtabs	30-60 minutes after tablets, 2 hours after capsules	5-15 hours	10-20 mg	
Zopiclone ***	Imovane	1.75 hours	5.5 hours	7.5mg	(note: not full benzodiazepines, so not directly equivalent)
Zolpidem ***	Stilnox	0.5 -3hours	2.5 hours	10mg	

Based on manufacturer's product information; #elimination half-life: time for plasma concentration to decrease by 50%;*Xanax no longer produced and most likely counterfeit,**Equiv dose approximate to 5mg diazepam, ***Added for information only

4 MONITORING

Benzodiazepine Withdrawal Scale CIWA-B

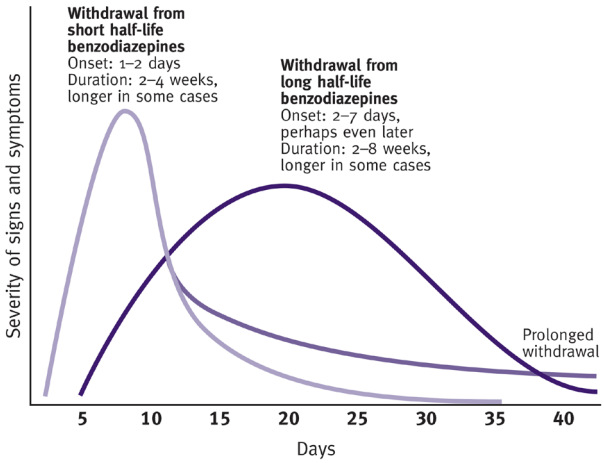
- Implement and monitor CIWA-B, using as a guide to monitor withdrawal trends as a compliment to to clinical assessment during dosage reduction
- *Inpatient only- for stabilisation and significant dose reudction:* Commence at fourth hourly and reduce as scores settle
- Use objective data and clinical judgement to guide management

Symptoms

Common: Anxiety; Insomnia; Restlessness; Agitation; Irritability; Poor concentration; Poor memory; Depression; Muscle tension; Aches and twitching; Nightmares; Agoraphobia; Feelings of unreality; Depersonalisation; Panic attacks; Nausea; Dry retching; Decreased appetite; Weight loss; Sweating; Lethargy; Increased sensory perception; Aches and pains; Headaches; Palpitations; Tremor; Blurred vision; Increased temperature; Ataxia; Menstrual changes

Uncommon: Delusions; Paranoia; Hallucinations; Seizures; Persistent tinnitus; Confusion

Course of Withdrawal



Adapted from Frank L, Pead J, (1995). *New Concepts in Drug Withdrawal: a resource handbook.* Victoria. Reproduced with permission.

5 TREATMENT

Reduction regieme

Rate of benzodiazepine withdrawal should be individualised and flexible. Rates may need to be slowed further towards the end of tapering

Example regieme - Rapid withdrawal	
Daily dose of 40-80mg diazepam	Reduce by 5mg / week
Daily dose of < 40mg diazepam	Reduce by 2.5mg / week
Example regieme - Slow withdrawal	
Daily dose of 40-80mg diazepam	Reduce by 10mg / week
Daily dose of <40mg diazepam	Reduce by 5mg / week
Poly substance use / high doses (*inpatient only*)	
Stabilise on a long-acting benzodiazepine (preferrably diazepam), at a dose about 40% of their regular intake before admission (or 80mg/day whichever is lower). Reduction and withdrawal should follow	

Supportive Pharamcotherapies

Symptoms	Supportive Pharmacotherapies
Sleep Problems	Promethazine
Hallucinations Mood disturbances	Olanzapine (low dose e.g. 2.5mg while symptoms persist titrated against symptoms
Stomach pains Physical pain Nausea	Hyoscine butylbromide Paracetamol, NSAIDS Metoclopramide, promethazine

Psychotheraputic interventions

Anxiety, sleeping disorders and other concurrent psychological problems are common and must be treated throughout withdrwawl regieme

Psychosocial Interventions

- Progressive muscle relaxation
- Relaxation (app or CD)
- Sensory Approaches
- Challenging irrational beliefs
- Physical activity /exercise
- Relaxation strategies, breathing and meditation techniques
- CBT and mindfulness approaches
- Stress management
- Mood management
- Coping strategies
- Activity scheduling
- Timetabling pleasant activities
- Anger management
- Sleep hygiene
- Solution-focused brief therapies (SFBT)
- Motivational Interviewing techniques
- Decisional balance
- Readiness /confidence to change ruler
- Psychoeducation
- Goal-setting
- Nutrition and hydration

Variances to Standard Withdrawal Protocols

- Do not prescribe benzodiazepines for patients on methadone or buprenorphine programs without consultation with treating physician.
- View QScript record to check whether they are obtaining prescriptions from other doctors
  https://www.qscript.health.qld.gov.au/
- Consider cross tolerance with alcohol – perform full alcohol and drug assessment
- Caution diazepam use in hepatic/renal dysfunction - Consider oxazepam as alternative.

Alcohol and Drug Clinical Advisory Service: 1800 290 928 08:00 - 23:00 / 7 days (for clinician only)

6 FOLLOW UP

Post-Withdrawal Treatment Options

Relapse Prevention	Adis 24/7 Alcohol and Drug Support 1800 177 833 adis.health.qld.gov.au Individual counselling Self-help groups (AA, NA, Smart Recovery) Residential rehabilitation Family Drug Support (FDS) - 1300 368 186