CHAPTER 12: BENZODIAZEPINE WITHDRAWAL
12 BENZODIAZEPINES

These Guidelines provide a comprehensive approach to withdrawal care. The use of prescribing guidelines outlined below will be supported by a comprehensive clinical assessment.

Benzodiazepines are a class of psychoactive drugs commonly used in the treatment of anxiety disorders and insomnia. Benzodiazepines are also administered as supportive pharmacotherapies in alcohol and other drug withdrawal.

Dependence on benzodiazepines can occur within weeks or months (Denis et al., 2006). Individuals dependent on high doses of benzodiazepines may ‘doctor shop’ or obtain the medication illegally in order to support their use.

Benzodiazepine withdrawal clients generally fall into two categories:

- Those who use benzodiazepines exclusively for therapeutic purposes
- Those who use benzodiazepines erratically, in high doses, and with other drugs

In delivering benzodiazepine withdrawal services to clients, clinicians should consider:

- Setting
- Withdrawal syndrome and potential complications
- Assessment
- Withdrawal care planning
- Withdrawal care
- Planning for post-withdrawal
- Special needs groups

Each of these considerations is examined below.

12.1 Benzodiazepine withdrawal settings

The most appropriate setting for an individual seeking benzodiazepine withdrawal will be informed by a thorough clinical assessment.

The most appropriate setting for an individual seeking benzodiazepine withdrawal should be determined via a thorough clinical assessment. For individuals with a high daily dose of benzodiazepines, who are elderly or use benzodiazepines in conjunction with alcohol, an inpatient setting is most appropriate. Consideration should also be given to the likelihood of a longer period of withdrawal care for these clients.

In some settings, such as hospitals, psychiatric facilities, prisons and police watch-houses, individuals may experience an unplanned benzodiazepine withdrawal. Staff in such settings will be familiar with, and alert to, the signs of benzodiazepine withdrawal in order to respond in a timely and appropriate manner.

Evidence of the onset of withdrawal symptoms and frequent or unusual requests for pain management should be considered potential indicators of benzodiazepine withdrawal.

The best withdrawal care facilitates step-up and step-down care, according to client need.

Access to stepped care allows clients whose needs warrant greater withdrawal care to be transferred to a more intensive withdrawal setting. Alternately, stepped care allows those for whom need is reducing to be stepped down to less intensive care.

12.2 Benzodiazepine withdrawal syndrome

The withdrawal syndrome for mono-dependent benzodiazepine users can vary from relatively mild to extremely uncomfortable or painful, however it is rarely life threatening. The potential risks of polydrug dependence and drug substitution should be considered in withdrawal assessment and the withdrawal
management plan. Polydrug users should be managed by specialist AOD services due to the risk of seizures upon sudden cessation of use.

Withdrawal typically occurs within two days of ceasing short-acting benzodiazepines (e.g. oxazepam), and between two and ten days after ceasing long-acting benzodiazepines (e.g. diazepam). However, the onset of benzodiazepine withdrawal may be as late as three weeks after cessation of drugs with a long half-life (Saunders & Yang, 2002b). Withdrawal from benzodiazepines with a short half-life tends to be more severe than from benzodiazepines with a long half-life. Withdrawal is often protracted and may extend over a number of weeks or months.

Benzodiazepine withdrawal symptoms include:

- Anxiety
- Depression
- Diarrhoea, constipation, bloating
- Insomnia
- Irritability
- Muscle aches
- Poor concentration and memory
- Restlessness
- Less commonly, perceptual disturbances and panic attacks
- Occasionally, seizures and symptoms of psychosis (NSW Department of Health, 2008a)

As shown in figure 5 below, the symptoms and duration of a benzodiazepine withdrawal vary. The amount and frequency of dose reduction is the most important factor affecting severity of the withdrawal syndrome. Additional contributing factors include:

- Polydrug dependence
- A history of seizures
- A history of underlying anxiety, depression or trauma
- High daily benzodiazepine doses
- Unclear daily doses (due to doctor shopping/illegal purchase)

Figure 1: Symptoms and duration of benzodiazepine withdrawal

Source: NSW Health (2008, p.30)
12.3 Benzodiazepine withdrawal assessment

Clinicians should be familiar with the general principles of assessment (refer section Error! Reference source not found.).

During withdrawal assessment, clinical staff will be alert to signs of client impairment.

A thorough assessment of benzodiazepine-dependent clients is critical in determining the most appropriate withdrawal care. Assessment is, however, largely dependent on the capacity of clients to provide relevant information. Recent benzodiazepine use may limit clients’ capacity to share and absorb accurate assessment information.

For impaired clients, all services should:

- As soon as possible, identify the most recent drug type, dose and time consumed (to inform medical intervention in the event of an overdose)
- Implement regular clinical observations of the client at frequent intervals at first then decreasing over time as evidence of impairment subsides
- Revisit the assessment when acute impairment has passed

The most consistent feature of benzodiazepine withdrawal is that its course can vary among individuals. Therefore, flexible, responsive and individualised assessment and treatment planning is critical.

Benzodiazepine withdrawal clients commonly experience a concurrent physical and/or psychosocial problem, such as anxiety or a sleeping disorder. This concern is typically a driver of benzodiazepine misuse and must be addressed during withdrawal care.

Assessment should seek to identify the user category into which a benzodiazepine client falls. Among therapeutically-dependent clients, the potential re-emergence of the physical and/or psychosocial problem for which they were self-medicating will require a planned response such as a non-prescription medication alternative.

Polydrug users who consume large quantities of benzodiazepines in a short period of time also require particular attention. Experienced clinicians should be consulted in relation to the potential risks of benzodiazepine stabilisation versus discontinuation. Stabilisation carries a risk of overdose due to decreased levels of substance tolerance, while discontinuing dosing risks seizure associated with sudden cessation of use. Given these potential risks, dosing changes should be informed by established regimes in combination with clinical expertise.

12.4 Withdrawal care planning

Information obtained during assessment will inform the withdrawal care plan.

The withdrawal care plan documents:

- Likely severity of withdrawal based on previous history of complicated withdrawal
- Risks associated with substance use, such as overdose history
- The client’s motivation for withdrawal care, where this is a planned withdrawal presentation
- The client’s goals during withdrawal care i.e. withdrawal, maintenance, reduction or substitution
- Potential barriers that may impact on achieving the client’s withdrawal goals
- Available support to enhance the likelihood of success
- A post-withdrawal plan, including relapse prevention and linkages to external support networks to address the client’s psychosocial needs
- Inclusion of family/significant others where appropriate

Given that benzodiazepine withdrawal can occur over an extended period of time, psychosocial support and continuing care are key elements of a withdrawal management plan. Remaining flexible throughout the course of treatment is also essential due to the varied nature of the withdrawal syndrome amongst benzodiazepine clients. The development of an individualised withdrawal care plan that can be revised over the course of treatment is of most benefit to clients.
12.5 Withdrawal care

Benzodiazepine-dependent clients may experience mild, moderate or severe withdrawal. Clinical withdrawal symptoms upon treatment presentation generally inform dosing and reduction regimes. In cases of protracted withdrawal, substitution pharmacotherapy should be maintained at a fixed dose until the person feels able to continue reduction.

All benzodiazepine withdrawal care is predicated on the provision of ongoing and objective monitoring in the initial stages of a client’s presentation to withdrawal care. Monitoring should occur at regular intervals, the frequency of which is dependent on the severity of the withdrawal syndrome.

It is noted that mono-dependent benzodiazepine clients are the focus of existing literature on benzodiazepine withdrawal regimes. Ideally benzodiazepines should be avoided or used very cautiously in polydrug users and those on methadone or buprenorphine.

Table 13, below, outlines the recommended dosing regimen for therapeutic benzodiazepine clients.

Table 2, which follows, provides a conversion table for benzodiazepine/diazepam transfer.

Table 1: Outpatient dosing regimen for therapeutic benzodiazepine users (as at March 2009)

<table>
<thead>
<tr>
<th>Client type/setting</th>
<th>Withdrawal goal</th>
<th>Recommended regime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic users (regular dose of a long-acting benzodiazepine) in outpatient withdrawal</td>
<td>Reduction or stabilisation</td>
<td>Tapered withdrawal • Convert the patient to diazepam and reduce by 10% every 1–2 weeks • When dose is at around 5 mg, reduce by 1 mg • Provide ongoing review, support and reassurance • Manage therapeutic issues underlying the benzodiazepine dependence • Supervised pick-up of doses should be based on a management plan in conjunction with a community prescribing doctor</td>
</tr>
</tbody>
</table>

Source: Key informant interviews; CEAG

Table 2: Conversion table for benzodiazepine/diazepam transfer (as at March 2009)

<table>
<thead>
<tr>
<th>Benzodiazepine (brand name)</th>
<th>Approximate equivalent to 5 mg diazepam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam (Xanax, Kalma)</td>
<td>0.5 mg</td>
</tr>
<tr>
<td>Oxazepam (Serepax, Murelax)</td>
<td>30 mg</td>
</tr>
<tr>
<td>Clonazepam (Rivotril)</td>
<td>0.5 mg</td>
</tr>
<tr>
<td>Nitrazepam (Mogadon, Aldorm)</td>
<td>5 mg</td>
</tr>
<tr>
<td>Flunitrazepam (Hypnodorm)</td>
<td>1 mg</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>0.5 mg</td>
</tr>
</tbody>
</table>

Source: Adapted from Ashton (2005)

Clients who consume larger quantities of benzodiazepines within a short period of time generally do not require a slow tapering benzodiazepine regimen. Low doses of benzodiazepines for a few days may be sufficient to manage anxiety. Adjunct therapy and natural supplements may also assist.
12.5.1 Symptomatic medications

A range of symptomatic medications is appropriate for use in benzodiazepine withdrawal.

Table 3 outlines symptomatic medications suitable for use in managing benzodiazepine withdrawal.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Symptomatic medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedation</td>
<td>Tricyclic antidepressants (TACs) (b) may be used but may lower the seizure threshold</td>
</tr>
<tr>
<td>Histories of multiple seizures</td>
<td>Anticonvulsants (b)</td>
</tr>
<tr>
<td>Physical symptoms such as tremors</td>
<td>Beta-blockers (b)</td>
</tr>
</tbody>
</table>

a) NSW Department of Health (2008a)  
b) Murray et al. (2002)

General principles and guidelines for coping with, and relaxing during, benzodiazepine withdrawal may also assist some clients withdrawing from benzodiazepines (Appendix 5).

12.5.2 Benzodiazepine withdrawal scales

Withdrawal from benzodiazepines may be monitored using the Benzodiazepine Withdrawal Symptom Questionnaire (BWSQ) (Appendix 8) (Tyrer et al., 1990). The BWSQ is a 20-item self-report, validated questionnaire (Couvee & Zitman, 2002).

The Clinical Institute Withdrawal Assessment Scale-Benzo-diazepines (CIWA-B) (Appendix 9) is a 22-item instrument designed to assess and monitor the type and severity of symptoms of benzodiazepine withdrawal (Busto et al., 1989). Although the CIWA-B is commonly used within AOD treatment settings (Saunders & Yang, 2002b), its psychometric properties have not been extensively evaluated.

Note: Withdrawal scales should not be solely relied upon to monitor complicated withdrawal as they may lack the sensitivity to detect progression to serious illness. Withdrawal monitoring should always include close clinical observation and judgement.

12.5.3 Cognitive behavioural therapy

Cognitive Behavioural Therapy (CBT) is an effective adjunct to a tapered medication regimen in some benzodiazepine patients (Morin et al., 2004). It is also an appropriate way of linking clients into ongoing, post-withdrawal care.

12.5.4 Psychosocial support

*Psychosocial interventions complement the medical management of benzodiazepine withdrawal symptoms and will be available at all withdrawal services.*

The overarching principles of supportive care are fundamental to the provision of a holistic model of withdrawal care. Psychosocial interventions should explore:

- Client goals, including any change in these goals over time
- Perceived barriers to achieving an individual’s goals of withdrawal care
- An individual’s beliefs about withdrawal care
- Appropriate interventions and support services
- Longer term support strategies for clients whose benzodiazepine withdrawal results in the re-emergence of symptoms for which they were originally prescribed benzodiazepine medication

12.5.5 Planning for post-withdrawal

*Post-withdrawal support is an essential component of the treatment continuum for benzodiazepine-dependent clients.*

Planning for post-withdrawal should:
Commence at the assessment phase of withdrawal care
Support the client’s goals, which may pertain to accommodation, child protection, domestic violence and legal support
Support client access to post-withdrawal services that provide ongoing support and advocacy
Involve family/significant others in post-withdrawal care, as appropriate, to help implement the client’s post-withdrawal plan

12.6 Special needs groups

12.6.1 Clients with chronic physical illness and the elderly
The elderly and those with chronic comorbid physical illness are likely to experience benzodiazepine withdrawal toxicity. This is typically due to poor metabolism and physical frailty. The impact of multiple drug regimes should be closely monitored by withdrawal clinicians.

12.6.2 Pregnant women
Pregnant women should undertake a gradual, supervised reduction of benzodiazepines, rather than abrupt withdrawal (NSW Department of Health, 2008b).

12.6.3 Clients with a dual diagnosis
Clients for whom a psychiatric condition emerges during benzodiazepine withdrawal will receive care that addresses their specific needs.
Specifically, they will be:
- Linked with appropriate mental health services
- Encouraged to continue to seek mental health support beyond withdrawal care
- Monitored for symptoms such as agitations during withdrawal and managed appropriately.

12.6.4 Families/significant others
Consideration will be given to the needs of family/significant others in contact with a benzodiazepine-dependent person during outpatient withdrawal or reduction.
Where appropriate, information will be provided to family/significant others regarding the withdrawal process and support services such as Directline and/or Lifeline.

12.6.5 Young people
Young people presenting to AOD services will be linked with youth-specific services, where available.
As outlined above (section Error! Reference source not found.), young people may present with varying psychosocial factors contributing to their drug use which impact upon their long-term plan for recovery. It is important to be mindful of the potential differences in treatment approach and care when commencing withdrawal care. Ongoing contact with, and adjunct support from, youth-specific workers throughout withdrawal care can promote more positive experiences for the young person.
For further detailed information related to the withdrawal care of young benzodiazepine users, please refer to the YSAS Clinical Practice Guidelines (YSAS, 2008).
12.7 Recommended reading


