HAUTE AUTORITÉ DE SANTÉ

Guidance Leaflet
Discontinuation of benzodiazepines and related medicinal products: procedure for the doctor providing outpatient treatment

June 2015

Introduction

The aim is to reduce the long-term prescription of benzodiazepines (BZD) and related medicinal products[1] for anxiety disorders and insomnia[2] because the benefit-risk relationship is unfavourable.

Despite prescriptions being of limited duration[3], it has been observed that usage may extend over several months, or even several years. However, beyond a few weeks, the risks of adverse effects increase: daytime drowsiness, falls, accidents, memory impairment, etc., as also does the risk of dependence.

1. Derivatives of the imidazopyridine group, derivatives of the cyclopyrrolone group.
2. BZDs used in the treatment of neurological diseases because of their antispasmodic and myorelaxant properties are outside the scope of this Guidance Leaflet.
3. - ranging from some days (including the dose-tapering phase) for occasional severe insomnia to 4 weeks (including the dose-tapering phase) for transient severe insomnia;
   - from 8 to 12 weeks (including the dose-tapering phase) for the symptomatic treatment of severe and/or incapacitating anxiety disorder.

Key points

- → Every prescription of BZD or related medicinal products must comply with the indications and the treatment durations specified in the Marketing Authorisation (MA).
- → The indications for the prescription of BZD and for the continuation of the prescription must be evaluated on a case-by-case basis and according to the patient's medical, psychological and social circumstances.
- → The side effects and ways in which to discontinue the treatment must be explained to the patient when treatment is initiated.
- → Discontinuation must always be gradual, over a period of few weeks to several months [in the case of chronic treatment].
- → If the goal of the procedure is discontinuation, achieving a reduction in the dose must already be considered to be a favourable result.

General principles for the prescription of benzodiazepines

Comply with the indications and anticipate discontinuation

→ The prescription of BZD or related medicinal products should be limited to the validated indications and the durations of prescription specified in the MA should be observed.[4]

→ When initiating treatment, the duration of the treatment, risks associated with the treatment, particularly the risk of dependence, and the methods of discontinuation due to these risks should be explained to the patient.

→ Discontinuation should be considered each time there is a request for the treatment to be renewed.

→ Every patient who has been treated daily for more than 30 days should be offered a strategy for discontinuation of BZD or related medicinal products.

Assess dependence and prepare for discontinuation

→ Individuals are considered as able[5] to discontinue BZD if they:

- desire this, are compliant and motivated;
- have appropriate social support (social inclusion, presence of a helpful environment);
- no history of complications on discontinuation of medicinal products;
- can be regularly reviewed.

→ The patient should be assured that he or she is an active participant in the discontinuation process, particularly in choosing a rate that suits. The discontinuation process may take from 3 months to 1 year, or longer if necessary.

→ At the moment of starting the discontinuation process, the practitioner should:

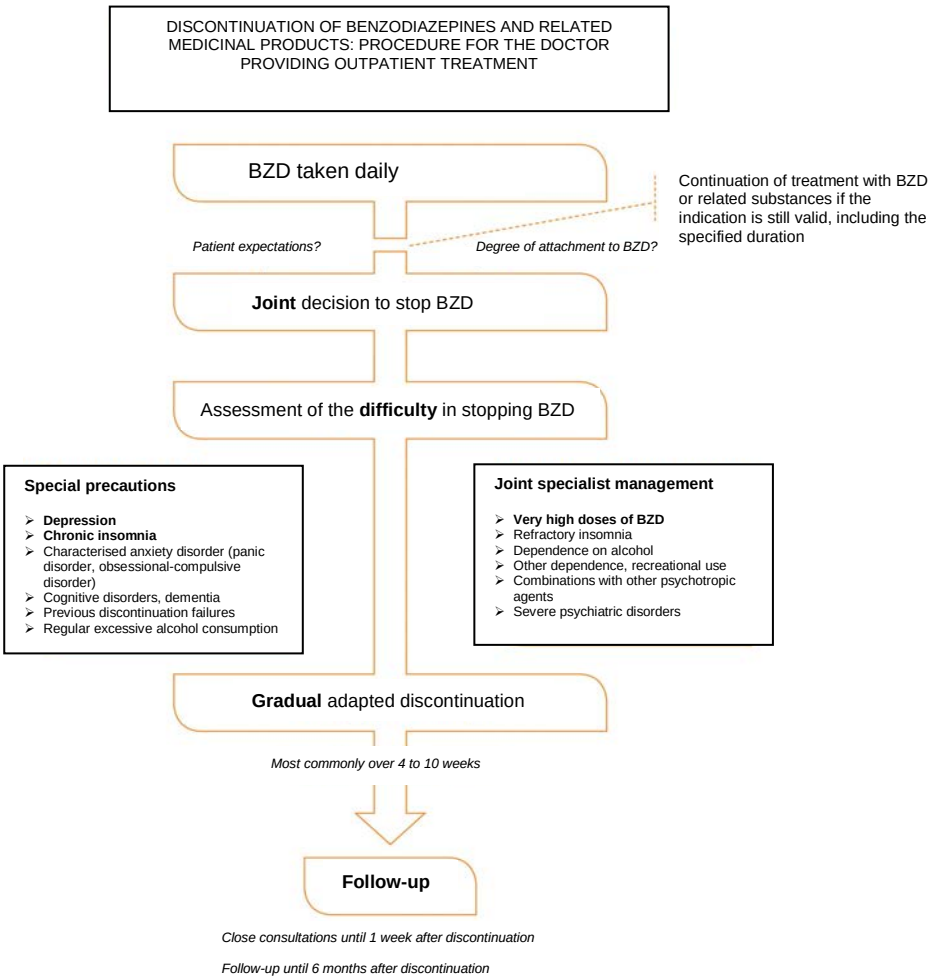
- assess the patient's expectations and degree of "attachment" to benzodiazepines in order to reach a joint decision and evaluate prognostic factors. The practitioner may use the items in the ECAB questionnaire (cognitive scale for benzodiazepine attachment, see tools) as a basis;
- distinguish situations requiring a special strategy (depression, chronic or excessive use, drug users, etc.).

→ If the suggestion to discontinue benzodiazepines is not accepted by the patient, the information should be provided again during a subsequent consultation.

→ Regardless of the strategy chosen, with or without specialist management, discontinuation must always be gradual, over a period ranging from a few weeks (most commonly 4 to 10 weeks) to several months (long duration of use, high doses).

→ The aim of the procedure is to stop benzodiazepine use. However, a reduction in dose is a favourable result.

4. see Website of French National Agency for Medicines and Health Products Safety.
5. see NICE Clinical Knowledge Summaries: Benzodiazepine and z-drug withdrawal, July 2013.



Management by the general practitioner

1) Short intervention

→ A first intervention by the regular doctor may be offered, particularly to patients who are dependent on a therapeutic dose or to elderly subjects.

→ This intervention may be offered to the patient in one of two ways: oral information during a consultation or written, reasoned and personalised information given to the patient by the doctor.

→ It is followed by a specific consultation focusing on the ways of discontinuing the BZD.

2) Consultation on discontinuation

→ During this consultation, the practitioner should:

- inform the patient about the BZD being used: name of the substance, anxiolytic and sedative properties;
- present the risks of long-term BZD use, prioritising them according to the patient's age and activity level: impaired memory, decreased reflexes and concentration, risk of dependence, risk of falls, suspicion of dementia, etc.;
- present the benefits of discontinuation, even of simply reducing the dose;
- inform the patients about the symptoms that may appear during discontinuation of BZD;
- inform the patient about non-pharmaceutical alternatives: relaxation, etc.;
- inform the other doctors in charge of an intercurrent disease of the existence of the withdrawal.

2) Consultation on discontinuation (continued)

→ It may also be useful to suggest keeping a sleep diary and/or a dose-reduction calendar (with a record of unusual symptoms).

→ If the patient wishes it, the doctor may involve the patient's family and healthcare professionals in the discontinuation process.

→ In agreement with the patient, a multiprofessional protocol may be established for the BZD withdrawal, bringing together the prescribing regular doctor, the specialist if one is involved in follow-up of the disease, the pharmacist, and the patient's nurse and family. This protocol will define the role of each participant, the use of documents for messages, the monitoring of the withdrawal, the protocol for information sharing, the level of warning signs and the manners in which information is circulated.

3) Follow-up after discontinuation

Frequency of monitoring

→ The frequency of monitoring depends on the patient and on the manner of follow-up chosen. New secure communication tools facilitate exchanges between healthcare professionals and thus the follow-up of these patients.

→ In the case of patients with several risk factors for failure or withdrawal syndrome, or those for whom discontinuation proves difficult, the follow-up protocol should be reinforced and adapted (daily call, dispensing of small quantities in agreement with the pharmacist, remote monitoring of compliance, etc.).

→ Regardless of the frequency of follow-up established, it is useful for the patient to have the option of telephone contact with the practitioner and/or other healthcare professionals.

Follow-up consultation

→ Follow-up consultations during dose reduction enable the following:

- analysis of symptoms associated with the discontinuation or of other new symptoms;
- assessment of adherence to the discontinuation protocol and encouragement of the patient to ask questions;
- investigation of any increase in the consumption of alcohol, tobacco or other psychoactive substances;
- measurement of the dose reduction (collection of unused tablets) and giving positive reinforcement as regards the dose reduction.

→ If the patient finds that the reduction is too rapid or has symptoms relating to discontinuation, the rate of the dose reduction should be slowed down or the period of use of each successive dose level should be extended; if the symptoms are severe, a return should be made to the previous dose.

Psychological support from the regular doctor or another professional (psychiatrist, psychologist, addiction specialist, etc.) may be necessary, particularly in certain cases: anxiety disorder, depression, major stress factors, discontinuation implemented over a long period.

Monitoring after discontinuation

→ In the short term, a consultation 3 to 7 days after the last dose should be offered to patients who have succeeded discontinuing a BZD in order to evaluate the symptoms associated with the discontinuation and to information the patient about rebound insomnia and/or anxiety disorder. The suggestion should be made that the patient returns the other boxes of BZD in his or her possession to the community pharmacist in order to limit the risk of resumption of use of the product or of a family member using it.

→ In the medium term, follow-up should be offered, in particular during the first 6 months following the discontinuation (period where the risk of a re-start is highest). It is useful for the patient to have the option of telephone contact with the doctor.

Joint specialist management

In cases of very high doses of BZD, refractory insomnia, alcohol dependence, another dependence, recreational use, combinations with other psychotropic agents, severe psychiatric disorders.

The discontinuation of BZD includes an assessment of the dependence and type of consumption and will determine how the patient is managed.

The opinion of a specialist (psychiatrist, addiction specialist, psychologist, etc.) or referral for specialist management should be considered in the following cases:

- history of alcoholism or other dependence,
- severe concomitant diseases, psychiatric disorders or personality disorders,
- history of abandoning withdrawal from medicinal products.

Discontinuation with substitution using diazepam may be considered in certain cases after checking hepatic function: difficulties with discontinuation due to strong dependence, history of abandoning withdrawal from medicinal products, consumption of short-acting substances which have a potent effect or cannot easily be reduced, concomitant use of several BZDs.

Withdrawal syndrome

Assessment

→ The discontinuation must be gradual to minimise the effects of withdrawal.

Management

→ **If non-serious symptoms appear during the phase of reduction of BZDs or related medicinal products**, the patient should return to the previous dose level and subsequent reduction should be done more gradually.

→ **If non-serious symptoms appear after the complete discontinuation of BZDs or related medicinal products**, the patient should, in particular, not restart the treatment. In most cases, information and psychological support make it possible to wait until the symptoms have disappeared.

→ **If the symptoms are more severe or persistent,** a diagnostic re-assessment is needed for specific management of a precisely diagnosed condition (depression, anxiety disorder, confirmed insomnia, etc.).

→ **If the patient has serious symptoms of BZD withdrawal syndrome (confusion, hallucinations, impaired alertness, seizures, coma)**, he or she should be admitted to hospital for symptomatic treatment.

A set of tools is available on the HAS website.

- ECAB questionnaire (cognitive scale for benzodiazepine attachment)
- Symptoms reported during BZD discontinuation
- Letter with information from the regular doctor
- Calendar to monitor the discontinuation
- Sleep-wake diary

As part of its “Prescription médicamenteuse pour le sujet âgé” [“Medical prescription for elderly subjects”] (PMSA) programme, HAS makes available to doctors a set of tools for the improvement and assessment of prescribing practices with respect to elderly patients.

All HAS publications are available for download at
www.has-sante.fr