Hypnotic / Anxiolytic Dependence

Management

Primary Care management includes

- History of tablet use. Establish extent of problem and motivation to stop tablet use.
- Recognition of other possible drug/alcohol misuse and related high risk behaviour.
- Establish reasons for tablet use e.g. anxiety, insomnia, and address these with alternative therapies.
- Mental health history and physical examination as necessary.
- Relatively easy withdrawal from therapeutic dose tablets is possible in many people if the problems of continuing drug usage are explained to them. At least 50% of elderly benzodiazepine users would like to discontinue use *[King et al, 1990; Barter and Cormack, 1996]*. With help, 40% of people can come off hypnotics or anxiolytics without difficulty; 40% may have some difficulty; and the remainder may opt to remain on benzodiazepines.
- Withdrawal symptoms may occur if drugs are suddenly discontinued, even after taking benzodiazepines for short periods of time (3-14 days) *[MeReC, 1995]*. Short-acting benzodiazepines are more likely to lead to a withdrawal syndrome than long-acting drugs. Symptoms tend to occur shortly after abruptly stopping a benzodiazepine with a short half-life, or up to several days after stopping one with a long half-life. Rebound phenomena are not related to the particular drug prescribed, nor to the duration of prescribing *[The Scottish Office Home and Health Department Scottish Health Service Advisory Council, 1994]*.
- Commence withdrawal regimen with diazepam, prescribing doses according to Prodigy guidelines, reducing dose in fortnightly or monthly steps of no more than 10mg, until patient is free of dependence.

Specialist management includes

- When commencing a withdrawal regimen with a patient who is **dependent on doses of hypnotic or anxiolytic above therapeutic range (max. 30mg Diazepam -or equivalent- a day)**, a multidisciplinary approach is essential.
- Assess the most appropriate level of expertise required to manage the person, and refer or liaise appropriately (i.e. shared care, specialist care, specialist generalist care, or other forms of psychosocial care) [Gerada and Tighe, 1999].
- Once the assessment has been made, consideration should be given to the possibility that psychosocial rehabilitation may be required. In such circumstances, further assessment (Community Care Assessment) should be sought [Gerada and Tighe, 1999].

When to refer

Emergency [discuss with on-call specialist]

- Patients with severe withdrawal symptoms who have stopped anxiolytics / hypnotics abruptly contrary to advice.

Urgent out-patient referral [liaise with specialist and copy to CAS]

Patients motivated to begin withdrawal from anxiolytic/hypnotic dependence who fall into following categories:

- Current use over maximum therapeutic daily dosage (30mg Diazepam a day or equivalent dose of alternative).
- Co-existing misuse or dependence on other drugs or alcohol.
- Co-existing mental health disorder.

Refer to CAS

- Uncertainty of suitability for anxiolytic/hypnotic withdrawal regimen to be initiated in community.
- Bizarre or severe symptoms of dependence on therapeutic doses of anxiolytic/hypnotic.
- Bizarre or severe symptoms experienced during withdrawal regimen period.

Refer to RARC

- if the patient does not meet the referral criteria above consider referral to CAS requesting a RARC appointment.

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