THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

BENZODIAZEPINE ANXIOLYTICS

Deprescribing in older people: A clinical practice guideline

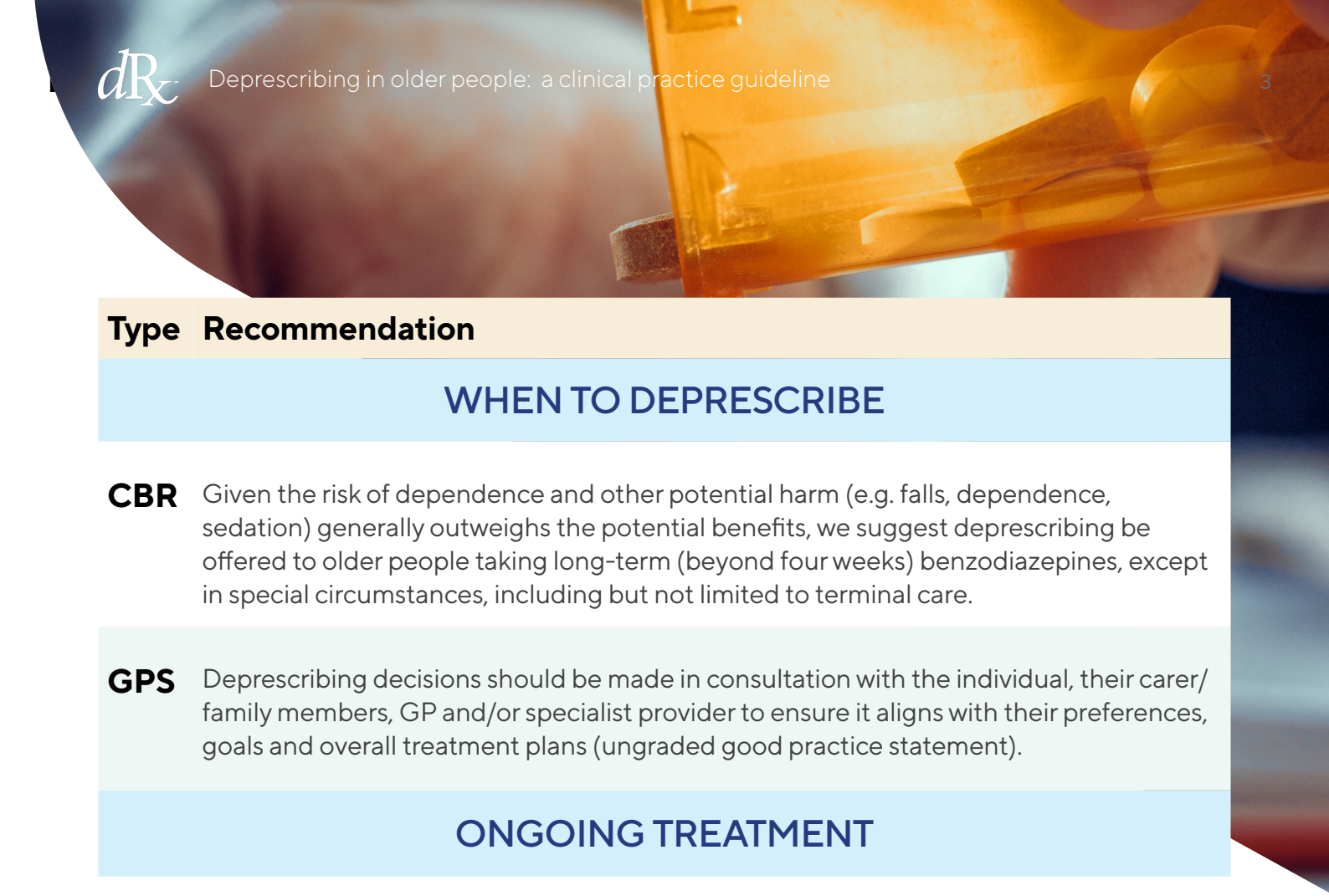
dRx™

BENZODIAZEPINE ANXIOLYTICS

Benzodiazepine derivatives used as anxiolytics include alprazolam, bromazepam, clobazam, diazepam*, lorazepam, oxazepam.

*Common Pharmaceutical Benefits Scheme medicines

Note: Please refer to the antiepileptics section for benzodiazepine derivatives used as antiepileptics (clonazepam, nitrazepam) and sedative hypnotics section for benzodiazepine derivatives used as sedative hypnotics (flunitrazepam, midazolam, nitrazepam, temazepam).



Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	Given the risk of dependence and other potential harm (e.g. falls, dependence, sedation) generally outweighs the potential benefits, we suggest deprescribing be offered to older people taking long-term (beyond four weeks) benzodiazepines, except in special circumstances, including but not limited to terminal care.
GPS	Deprescribing decisions should be made in consultation with the individual, their carer/family members, GP and/or specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	If deprescribing is unsuccessful despite multiple attempts with considerations for non-pharmacological options (e.g. action plan for recurrence of anxiety symptoms), intermittent or "as-required" dosing, we suggest maintaining the lowest effective dose, but we suggest reassessing the need for long-term therapy periodically.
	HOW TO DEPRESCRIBE
CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 25% every one to four weeks, ensuring the absence of withdrawal symptoms and/or symptoms indicative of relapse before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.

CBR, consensus-based recommendation; GPS, good practice statement

GPS Healthcare providers should consider and offer adequate non-pharmacological management options (e.g. psychological interventions for psychiatric disorders such as cognitive-behavioural therapy and relaxation techniques) during and after deprescribing (ungraded good practice statement).

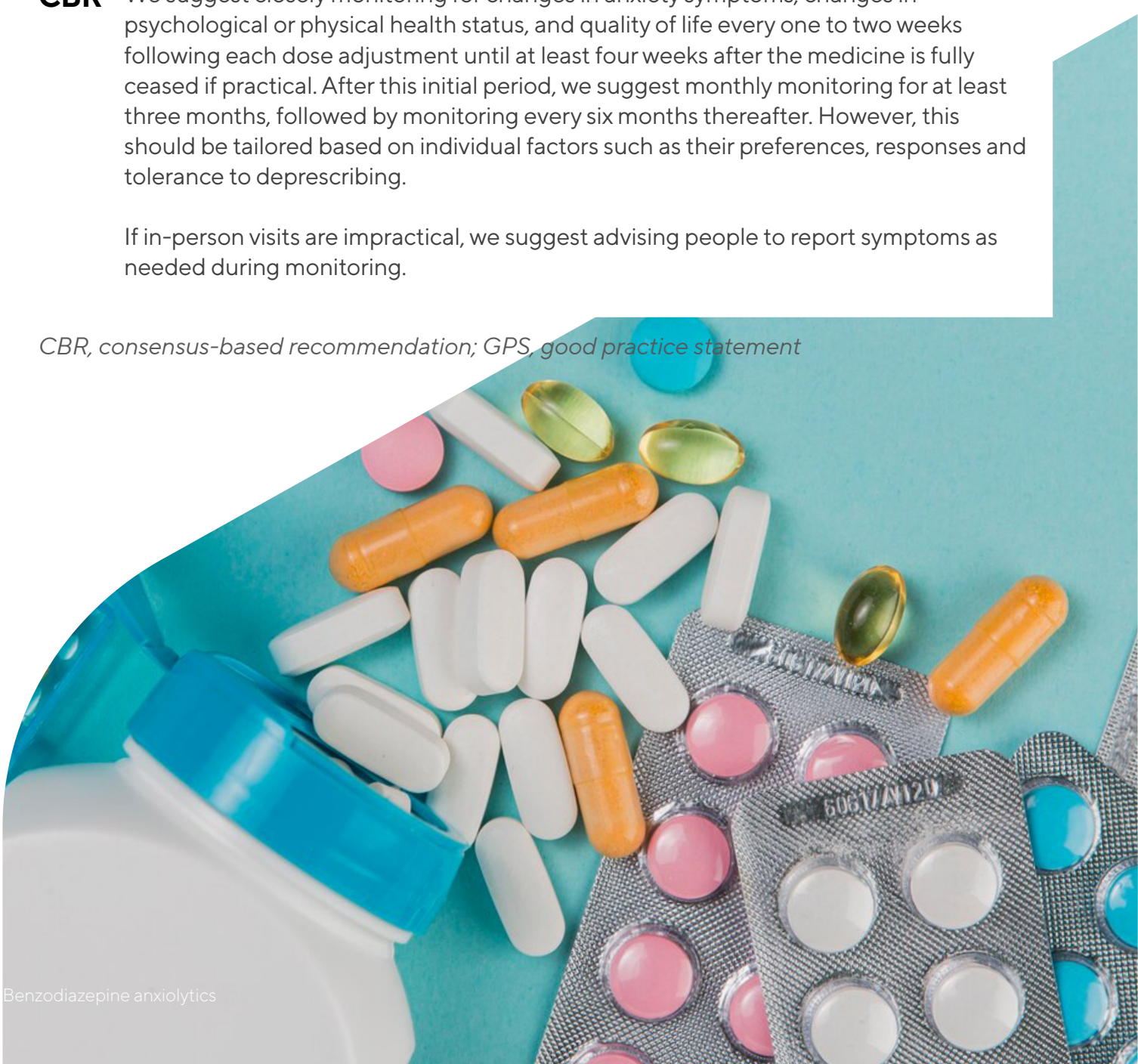
GPS Healthcare providers should consider and offer appropriate management strategies to the individual's families and care providers (e.g. verbal de-escalation, psychological intervention, increased staff-to-patient ratio, increased staff training in behaviour management) (ungraded good practice statement).

MONITORING

CBR We suggest closely monitoring for changes in anxiety symptoms, changes in psychological or physical health status, and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

If in-person visits are impractical, we suggest advising people to report symptoms as needed during monitoring.

CBR, consensus-based recommendation; GPS, good practice statement



Benzodiazepine anxiolytics

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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