Standard of Practice

Prescribing Benzodiazepines & Z-Drugs

(including Zopiclone & other drugs)

Initial Approval: September 25, 2020 **Effective Date: November 1, 2020**

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All registrants must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

PREAMBLE

This Standard establishes the standard of practice and ethical requirements of all registrants in relation to prescribing benzodiazepines and/or Z-Drugs for maximum safety for all patients whether in the community or in a health care facility. **This Standard does not apply to the use of these drugs in the treatment of cancer, palliative and end-of-life patients, seizure disorders, bipolar/psychotic disorder, and acute alcohol withdrawal*.** Medical evidence of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs is altered over time, so prescribing these drugs must be in accordance with current medical knowledge. This Standard recognizes that in prescribing benzodiazepines and/or Z-Drugs each registrant exercises their clinical judgment, which is to be that of a registrant acting reasonably in the circumstances with current medical knowledge.

*If prescribing for any of these conditions please include the medical condition on the prescription for the awareness of the pharmacist for dispensing purposes.

STANDARD OF PRACTICE

1. GENERAL

1.1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first (i.e., Cognitive Behaviour Therapy, improved sleep habits, elimination of caffeine, etc.) if available, and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

1.2. To mitigate risk of harm the registrant must use reasonable efforts to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN. This will mitigate the risk of harmful drug interactions and combinations and will prevent patients from obtaining prescriptions from multiple providers.

1.3. Registrants must prescribe the lowest effective dosage of benzodiazepines or Z- Drugs for the shortest possible duration and only exceed the maximum recommended dosage in exceptional circumstances and document this.

1.4. Long term use must be supported by current clinical evidence. Benzodiazepines and Z-Drugs may be appropriate for certain uncommon indications.

1.5. Discuss the following with the patient and document it in the medical record:
- 1.5.1. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;
- 1.5.2. Non-pharmacological therapies;
- 1.5.3. The modest benefit of long-term benzodiazepines and Z-Drugs;
- 1.5.4. Risks associated with treatment; and
- 1.5.5. The impairment caused by these drugs, particularly the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired.

1.6. Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba and should be avoided and/or replaced.

1.7. Registrants must carefully consider all concurrent medical conditions in the context of decisions to prescribe or continue to prescribe these medications:
- 1.7.1. Heart failure, obesity, sleep apnea, chronic lung disease, alcohol and substance use disorders and renal or hepatic insufficiency and other chronic conditions or pregnancy compound the risk of these medications in unique ways.
- 1.7.2. Patients must be regularly screened for the presence or emergence of mental health disorders (particularly mood and substance use disorders) which may complicate management.

1.8. In the course of managing patient care on these drugs (particularly while tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient's care needs. Appropriate care management can include referral to a physician with expertise and can include slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal. Periodically attempt a trial of slow tapering (and if possible, collaborate with a trusted pharmacist identified by the patient). Use tapering guidelines and equivalency tables referred to in the Contextual Information attached to this Standard of Practice. Appropriate care management does not include abruptly discontinuing or an ultra rapid decrease of these drugs after long term use. Where tapering is not feasible, if there is documented benefit to the patient outweighing the potential harms, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is difficult, though possible.

1.9. Combining benzodiazepines and/or Z-Drugs with themselves or with other medications compounds risk of harm:

1.9.1. If prescribing benzodiazepines and/or Z-Drugs, physicians must consider potential drug interactions with prescribed, over the counter, and recreational psychoactive substances including alcohol, opioids, gabapentin, and other benzodiazepines, dimenhydrinate and diphenhydramine, and document their advice to patients to avoid these;

1.9.2. If patients with complex care needs are receiving multiple sedating medications, the physician must consider seeking the opinion of relevant consultants such as psychiatrists, pain specialists, addiction medicine specialists, pharmacists, and others to work toward a collaborative medication regimen that minimizes risk as much as possible.

1.9.3. Only in exceptional circumstances prescribe opioids together with benzodiazepines and/or Z-Drugs. Patients must be informed of the increased risk of death with this combination, and the discussion documented.

1.9.4. Only in exceptional circumstances prescribe two or more benzodiazepines and/or Z-Drugs concurrently unless in the context of a taper.

1.10. Registrants must be aware of and comply with statutory reporting duties in the context of disease or disability, including a treatment regimen, that is expected to cause impairment to any relevant authorities (e.g. the MPI Registrar of Motor Vehicles).

2. PRESCRIPTION WRITING

2.1. Explicit instructions must be provided to the patient regarding appropriate use, quantity, and number of days the supply is intended to last. A dispensing interval, indicating the number of days the supply is anticipated to last, must be noted on the prescription (e.g. dispense X tablets every Y days).

2.2. Only write a prescription for a maximum of three months, with dispensing to be authorized for no more than a one-month supply unless it is for infrequent use. On an exceptional basis, registrants may authorize a dispensing interval of up to three months for patients:
  2.2.1. in remote communities; and
  2.2.2. travelling, if the patient has been on a stable long-term prescription.

3. OLDER ADULT PATIENTS – ADDITIONAL

3.1. For older adult patients recognize that new starts of benzodiazepines and Z-Drugs must be carried out with extreme caution and not be used as first choice for insomnia, agitation, or delirium, nor for managing behaviours arising from dementia and delirium.

3.2. Ensure that dosing takes into consideration declining renal, hepatic and cognitive function and polypharmacy in older adult patients.

3.3. In prescribing for older adult patients, the registrant must recognize and discuss with the patient additional risks, including but not limited to:
  3.3.1. Falls and subsequent fractures related to sedation, confusion, drowsiness and postural instability;
  3.3.2. Impairment of psychomotor skills, judgment, and coordination increases the risk of motor vehicle and other accidents;
  3.3.3. Negative effects on cognition, memory, delirium and a possible link to cognitive decline and dementia.

4. APPLICABLE DRUGS FOR THIS STANDARD

Benzodiazepines		Z-Drugs
Alprazolam (Xanax®)	Lorazepam (Ativan®)	Eszopiclone
Bromazepam (Lectopam®)	Midazolam (Versed®)	Zolpidem
Chlordiazepoxide (Librium®)	Nitrazepam (Mogadon®)	Zopiclone
Clobazam *to be started by Neurologists only	Oxazepam (Serax®)	
	Potassium-Clorazepate	
Clonazepam (Rivotril®)	Temazepam (Restoril®)	
Diazepam (Valium®)	Triazolam (Halcion®)	
Flurazepam (Dalmane®)		

See next page for Contextual Information and Resources

CONTEXTUAL INFORMATION & RESOURCES

Prescribing Benzodiazepines & Z-Drugs (including Zopiclone & other drugs)

The Contextual Information and Resources are provided to support registrants in implementing this Standard of Practice. The Contextual Information and Resources do not define this Standard of Practice, nor should it be interpreted as legal advice. It is not compulsory, unlike a Standard of Practice. The Contextual Information and Resources are dynamic and may be edited or updated for clarity, new developments, or new resources at any time.

Background

Medical evidence of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs has altered over time, so prescribing these drugs must be in accordance with current medical knowledge. Drugs of dependence have important therapeutic uses, but there is a need to ensure the supply of these medicines is clinically appropriate. In the past two decades clinical guidelines have recommended against long-term use of benzodiazepines and Z-Drugs. The conditions where benzodiazepines are most commonly prescribed (anxiety and insomnia) remain sources of debate in medical circles. Physicians must consider multiple factors when prescribing benzodiazepines. Good clinical judgment and an evidence-based approach remain key to safe and appropriate prescribing. The Standard tries to strike the best balance between the benefits benzodiazepines and Z-drugs provide for many patients with the risk posed to some patients.

Risks of Benzodiazepines in Manitoba

CPSM participates in the Adult Inquest Review Committee of the Chief Medical Examiner to review all deaths involving prescription medications. These reviews indicate deaths from other drugs are climbing rapidly while opioid deaths have levelled off. Alprazolam and Gabapentin, as well as diphenhydramine, have become significant drugs of abuse in Manitoba.

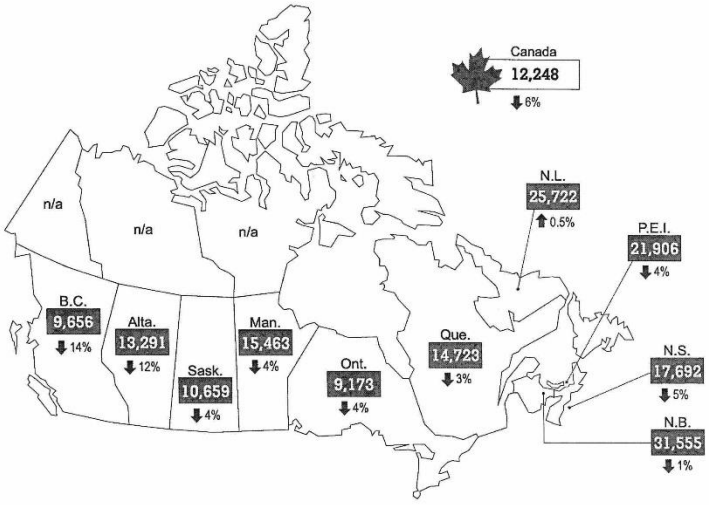
- Alprazolam is the benzodiazepine that contributed to the largest number of overdose deaths last year.
- Most opioid deaths can be attributed to one or more opioids combined with other drugs, often benzodiazepines and/or Z-Drugs.
- The two drug classes that were the top contributors to opioid overdoses were benzodiazepines and antidepressants from 2014-2017.
- Alprazolam, Zopiclone, and/or SSRIs contributed in total to 11, 9, and 8 drug overdose deaths respectively from 2016-2018.

The lessons learned from this provincial death data should transform physician prescribing practices. The Standard is to urge physicians to **be mindful of polypharmacy - the overall risk may outweigh the benefit from individual medications. Opioids, benzodiazepines, antidepressants, Z-Drugs, antipsychotics, and gabapentin all interact with each other often contributing to these deaths.**

Outside of Atlantic Canada, Manitoba has the highest rate of prescribing benzodiazepines and related drugs, at 50% higher than neighbouring Ontario and Saskatchewan. In 2017 there were 15,463 defined daily doses per 1000 population for these drugs.

Pan-Canadian Trends in the Prescribing of Opioids and Benzodiazepines, 2012 to 2017

Figure 5 Defined daily doses per 1,000 population, Canada,* for benzodiazepines and benzodiazepine-related drugs, 2017



British Columbia and Alberta had the largest decreases in the rate of prescribed benzodiazepines and benzodiazepine-related drugs.

Notes
* Data was not available for the territories.
↓ ↑ Percentage change in prescribing from 2016 to 2017.
n/a: Not available.
Source
Prepared using data from CompuScript, IQVIA.

A study in Manitoba in 2016 concluded that a limited segment of the population that received benzodiazepine prescriptions was classified as sustained users, and a smaller proportion of that group escalated to doses higher than those recommended by product monographs and clinical guidelines. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500380

Risks of Benzodiazepines in General

Benzodiazepines and Z-Drugs carry significant risk such as:

- Sedation, confusion, drowsiness and postural instability contributing to the risk of falls and subsequent fractures;
- Impairment of psychomotor skills, judgment, and coordination increasing the risk of motor vehicle accidents;
- Negative effects on cognition and memory, delirium, drug-related pseudo dementia and a possible link to cognitive decline and Alzheimer's disease;
- Dependency and abuse potential;
- Risky interaction with medications or herbals;
- Sleep automatism (in the case of Z-Drugs), including food binging, and even driving while asleep or in a sleep-like state.

The Standard recognizes that:

- Initiating benzodiazepines and/or Z-Drugs in hospital substantially increases the risk of long-term use and dependency.
- Cognitive behavioural therapy, brief behavioural interventions and tapering protocols have a proven benefit in sedative-hypnotic discontinuation and are also beneficial in improving sleep.
- The number needed to treat with a benzodiazepine and/or Z-Drugs to get improved sleep is 13, whereas the number needed to harm is only 6. [BMJ: doi: 10.1136/bmj.38623.768588.47(published 11 November 2005)

Risks of Benzodiazepines in the Elderly

Benzodiazepines and/or Z-Drugs have been identified as problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

Benzodiazepines and Z-Drugs carry significant risks beyond those for the general patient population:

- Sedation, confusion, drowsiness and postural instability contributing to the risk of falls and subsequent fractures;
- Further impairment of psychomotor skills, judgment, and coordination increasing the risk of motor vehicle accidents;

- Negative effects on cognition and memory, delirium, drug-related pseudo dementia and a possible link to cognitive decline and Alzheimer's disease.

Driving or Operating Heavy Machinery and Benzodiazepines and Z-Drugs

MPI, in its Drug Impaired Driving educational sessions for physicians and other health professionals, highlights the potential perils associated with driving among individuals who are prescribed benzodiazepines and Z-drugs. This is reflected in the CMA Guide for determining medical fitness to operate motor vehicles, which also highlights the peril associated in combination with alcohol.

MPI's advice to prescribers is for any patient provided with a new prescription or an increase in dosage that they should temporarily stop driving until they can be reassessed by the prescriber (please note that this would generally not call for a notification of MPI in accordance with the mandatory reporting requirement). The prescriber can determine whether it is reasonable to resume driving when the clinical reassessment is conducted. Should some degree of functional impairment be suspected at the time of reassessment, the prescriber should, at that point, report to MPI with an appropriate recommendation, which could be that the patient's driver license be suspended or that a functional driving assessment be conducted.
The same applies with necessary modifications to patients who operate heavy machinery. Such patients should also be provided with a note indicating they should not operate such equipment for either a limited time period or until reassessment.

Application of Standard

This Standard applies to Benzodiazepines and what are known as the Z-Drugs (Zopiclone, Zolpidem, Zaleplon, and Eszopiclone) because of the similarity of these drugs in prescribing for similar medical conditions, risks, addictions (abuse and diversion), and use.

BENZODIAZEPINE RECEPTOR AGONIST EQUIVALENCY ESTIMATES
(Diazepam 10 mg as reference)

	Ashton	Kalvik et al.	Shader & Greenblatt	Alessi-Severini et al.
Diazepam	**10 mg**	**10 mg**	**10 mg**	**10 mg**
Alprazolam (Xanax®)	0.5 mg	1 mg	1 mg	1 mg
Bromazepam (Lectopam®)	5 mg	6-12 mg	NA	10 mg
Chlordiazepoxide (Librium®)	25 mg	20-50 mg	50 mg	20 mg
Clobazam	20 mg	NA	NA	20 mg
Clonazepam (Rivotril®)	0.5 mg	1-2 mg	0.5 mg	0.5 mg
Potassium Clorazepate	15 mg	15 mg	15 mg	NA
Flurazepam (Dalmane®)	30 mg	30 mg	30 mg	30 mg
Lorazepam (Ativan®)	1 mg	1-2 mg	2 mg	2 mg
Oxazepam (Serax®)	20 mg	30 mg	30 mg	20 mg
Nitrazepam (Mogadon®)	10 mg	10-20 mg	10 mg	10 mg
Temazepam (Restoril®)	20 mg	20-30 mg	30 mg	30 mg
Triazolam (Halcion®)	0.5 mg	0.5 mg	0.25 mg	0.25 mg
Zaleplon	20 mg	NA	NA	20 mg
Zolpidem	20 mg	NA	10 mg	NA
Zopiclone	15 mg	NA	NA	7.5 mg

Ashton H. benzo.org.uk : Benzodiazepine Equivalence Table. http://www.benzo.org.uk/bzequiv.htm. Published 2007. Kalvik A., Isaac P., Janecek E. Benzodiazepines: Treatment of anxiety, insomnia and alcohol withdrawal. Pharmacy connection Sept/ Oct 1995 20-32. Shader RI, Greenblatt DJ. *J Clin Psychopharmacol*. 1997;17(4):331. Alessi-Severini S, Bolton JM, Enns MW. Sustained Use of Benzodiazepines and Escalation to High Doses in a Canadian Population. *Psychiatric Serv*. 2016;67(9):1012-1018.

Tapering

Gradual dose reduction is the central tenet in discontinuing benzodiazepine and Z-Drugs and supervision is the preferred tapering strategy. Patient preference is not a valid reason to defer tapering.

Various taper plans, suggestions, and schedules are included in the resources above.

Working with the Pharmacist

With a high level of knowledge of dosage forms, equivalencies, tapering tools, and the potential for compounding intermediate dosage forms when necessary, as well as the most frequent contact with shared patients, pharmacists can and should often play an active role in planning and providing feedback during and after benzodiazepine and Z-drug tapers. Some pharmacists can assist in preparing tapering schedules.

Furthermore, collaborating and communicating with the pharmacist especially when tapering is in progress is beneficial because the pharmacy maintains ongoing documentation on patient interactions and any issues/concerns they may have noted over time. Providing the pharmacy with a patient care plan for tapering will keep all healthcare providers informed, especially if the

patient contacts the pharmacist if they are experiencing any withdrawal symptoms or are requesting early refills. Randomized controlled trials have shown sedative-hypnotics deprescribing rates of 43% when pharmacists and physicians worked in collaboration.[1]

Consider a tripartite agreement with the patient-pharmacist-physician. Having a patient use only one pharmacy for their prescriptions helps the pharmacist know and assess the patient and enables the physician to inform the pharmacist in advance of special requests.

Suggested Resources

Managing Benzodiazepine Use in Older Adults by the Centre for Effective Practice in Ontario is an **excellent clinical tool** which can be adapted for other ages.

Deprescribing Benzodiazepine Receptor Agonists: Evidence Based Clinical Practice Guideline issued by the College of Family Physicians of Canada is a helpful resource.

Prescribing Drugs of Dependence in General Practice Part B, by the Royal Australian College of General Practitioners includes a framework for accountable prescribing of benzodiazepines in a practical guide that physicians can use to minimise harm and maximise benefits to patients. There are terrific **resources** included such as examples of responses to patient requests for benzodiazepines, communications with patients, practice policies and forms, patient agreements, drug and alcohol assessment tool, and a GP Guide to Insomnia.

Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults has useful guidance on either preventing the development of Benzodiazepine use disorder or optimally assessing and treating older patients who have developed such a disorder. The tapering guidance is helpful and can be applicable for other ages.

Patient Pamphlet: Insomnia and Anxiety in Older People: – Sleeping pills are usually not the best solution.

Toolkit: Less Sedatives for Your Older Relatives – A toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in hospitals.

Toolkit: Drowsy Without Feeling Lousy – A toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in primary care.

www.mysleepwell.ca has an online hub of cognitive behaviour therapy for insomnia.

Ementalhealth.ca has information for both patients and physicians.

Balancing the Risks and Benefits of Benzodiazepines – Jama Network

[1] Martin P, Tamblyn R, Benedetti A, Ahmed S, Tannenbaum C. Effect of a Pharmacist-Led Educational Intervention on Inappropriate Medication Prescriptions in Older Adults: The D-PRESCRIBE Randomized Clinical Trial. JAMA 2018:320:1889-98

Frequently Asked Questions

Prescribing Benzodiazepines & Z-Drugs Medical Purposes

The Frequently Asked Questions (FAQs) are provided to support registrants in implementing this Standard of Practice. The FAQs do not define this Standard of Practice, nor should it be interpreted as legal advice. It is not compulsory, unlike a Standard of Practice. The FAQs may be edited or updated for clarity, new developments, or new resources at any time.

The College of Physicians & Surgeons of Manitoba (CPSM) has received calls from healthcare providers and patients about the new Standard for prescribing benzodiazepines and z-drugs. In this document we hope to address some of the common questions received.

What is the Standard of Practice about?

This Standard of Practice sets out the requirements related to prescribing benzodiazepines and z-drugs. The Standard exists to ensure quality care and to ensure *patient* and *public* safety. While your doctor applies clinical judgment and discretion to your individual care, your doctor is also expected to follow this Standard to ensure all patient care is safe and ethical. The Standard of Practice for Prescribing Benzodiazepines & Z-Drugs came into effect on November 1, 2020.

Why does CPSM get to make decisions that affect my medications?

To protect the public

CPSM's job is to protect the public and ensure quality in the practice of medicine. The Standard of Practice for Prescribing Benzodiazepines & Z-Drugs is evidence-informed and promotes safe and ethical care of all patients. The Standard outlines the expectations that doctors must follow to balance individual care and public safety.

Standards are created by a group of experts in the relevant field of practice, often including doctors, nurses, pharmacists, lawyers, and members of the public. Feedback is also sought from the public prior to finalization.

To promote current and quality medical care

As medicine evolves, new information is discovered. After decades of prescribing benzodiazepines and z-drugs, we know more about the risks of these medications today,

especially when it comes to long-term use and higher doses. As the evidence of the risks compared to benefits of these drugs evolves, doctors must adapt their prescribing to align with current medical knowledge. These drugs are helpful for many patients, but they also pose risks for some patients and the public. The Standard tries to strike the best balance possible between the benefits and the risks.

What are benzodiazepines and z-drugs? What are their effects?

Benzodiazepines are sedative medications often prescribed to treat anxiety and sleep disorders. Commonly prescribed benzodiazepines include, but are not limited to, alprazolam (Xanax®), lorazepam (Ativan®), temazepam (Restoril®), clonazepam (Rivotril®), and diazepam (Valium®). Z-drugs, like zopiclone or zolpidem, are chemically similar to benzodiazepines and have similar effects and risks associated with their use. These sedatives essentially slow-down the activity of the brain and this slows bodily functions like heart rate and breathing, which can make you feel more calm or sleepy.

While these medications may be effective to decrease anxiety or improve sleep at first, regular use leads to tolerance and physiological dependence. With regular, longer-term use, the brain and body become accustomed to the effect. For some people, escalating doses are needed for relief of symptoms. Similarly, cutting back or missing doses can create rebound symptoms (including anxiety), often reinforcing the perceived need for the medication. Long-term use, and/or higher-dose use, increases the likelihood of side-effects and risk of harm.

Why are benzodiazepines and z-drugs considered so harmful?

For the same reason benzodiazepines and z-drugs make you feel calm or sleepy (by slowing some brain and body functions), they have associated side-effects and risks of harm. See the list of side-effects and risks below. These harmful effects are worsened by long-term and/or high-dose use. Some patients can develop addiction to these medications and experience serious repercussions. Misuse, overuse, or combining these medications with other sedatives increases the risk of overdose and death. In Manitoba, benzodiazepines and z-drugs have become significant drugs of abuse and are known to be sought after by substance users. The likelihood of diversion (sharing, selling, stealing) of these medications is very high and this has had a profound impact on public safety. Benzodiazepines and z-drugs are responsible for an increasing number of deaths in Manitoba, regardless of whether these drugs are prescribed alone or with painkiller medications like opioids or other prescription drugs.

What are the side-effects and risks of benzodiazepines and z-drugs?

Common side-effects and risks of benzodiazepines and z-drugs include:

- Sedation, confusion, drowsiness, and instability when standing/moving that can add to risk of falls and subsequent fractures.
- Impairment of psychomotor skills, judgment, and coordination that can increase the risk of motor vehicle accidents.
- Negative effects on cognition and memory, delirium, drug-related pseudo-dementia and a possible link to cognitive decline and Alzheimer's disease.
- Tolerance and physiological dependence, leading to withdrawal with abrupt cessation, or large dose changes.
- Sedative-Hypnotic Use Disorder (addiction).
- Risky interaction with medications or herbals.
- Risk of sleep automatism (in the case of z-drugs), similar to sleepwalking, when a person acts out scenarios when sleeping or dreaming.

Benzodiazepines and z-drugs are also particularly problematic in older adults. The risk of motor vehicle accidents, falls, and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or z-drugs.

Does my doctor have to taper my medication?

The Standard provides evidence for doctors to consider and discuss with patients *before* starting benzodiazepines and z-drugs, as well as guidelines to manage patients *already* taking these medications. Good clinical judgment and an evidence-informed approach are key to safe and appropriate prescribing. Your doctor should discuss the reason for taking these medications, their potential side-effects and risks, and reasonable expectations for their effect. This is part of the clinical judgment applied to continuing or changing medications. **Given the overwhelming evidence of the harm these medications can cause (see above), the Standard recommends your doctor attempt slow dose reductions, also known as step-downs or tapering**. This is particularly important if the harm outweighs the benefit of taking the medication, especially if benzodiazepines and z-drugs have been prescribed for a long time and/or at a high dose.

Do I have to get my dose down to zero?

The Standard asks your doctor to partner with you to attempt tapering. It asks that your doctor help you make informed decisions about your care by evaluating the risks of continuing the medication compared to the benefits. With slow and steady dose reductions (tapering), over weeks to months, over even years, you may eventually take your dose down to zero. However, all taper attempts are worthwhile, and even small dose reductions can improve cognitive function (things like memory, concentration, range of affect) and improve safety. It is not

mandatory to taper off your medication completely; with incremental step-downs your doctor may find the lowest dose that allows you wellness, function, and minimizes side-effects/risks.

Why am I being tapered off benzodiazepines and z-drugs if they work for me?

The Standard **does not** recommend your doctor stop prescribing or "cut off" these medications. It recommends that your doctor take a closer look at why they are prescribing them. The Standard promotes a discussion about the benefit versus harm benzodiazepines and z-drugs carry for you and how to improve safety around use. In the past two decades, clinical guidelines have recommended against long-term use of benzodiazepines and z-drugs. Their effectiveness to treat conditions like anxiety and insomnia is debated by doctors. They may work well for some patients, but it is important to be aware of the risk they carry to both individuals and the public. While they can have important therapeutic uses, the supply of these medications needs to be clinically safe and appropriate.

Can my doctor cut off my medications?

CPSM and the Standard encourage communication and collaboration between you and your doctor. However, based on clinical judgment and safety, a doctor may need to proceed with a taper when a patient may not agree. A doctor may also limit the amount dispensed to a patient at a time if safety concerns arise (e.g. medications may need to be dispensed weekly or daily from the pharmacy in some situations). There are times when safety, either individual, public, or both, takes precedence over the therapeutic relationship between doctor and patient. If a doctor learns that the medications they prescribe are being misused, abused, or diverted, rapid tapers or sudden cessation of prescribing may be necessary to manage risk of overdose or death, and for public safety.

What can I expect if my dose is reduced?

Because benzodiazepines and z-drugs are drugs of physiological dependence, which means the brain and body become used to them, changes in the dose can create rebound or withdrawal symptoms. **This is normal for anybody who takes these medications over time**.

With dose reductions, you may *temporarily* experience more worry or anxiety, mild sleep disturbances, heightened emotions, shakiness, sweating, twinging or restless limbs, or digestive upset. This does not mean your anxiety or insomnia will become uncontrollable; with small changes, these symptoms will settle and pass with time. Ideally, dose step-downs should be small, with enough time in between each change for you (your brain and body) to adjust to the decrease. These symptoms will settle with time; many people start to feel "normal" or back to baseline within two to four weeks of a change. Your doctor may wait until you feel closer to baseline function, or more like yourself again, before making the next change. **This is a highly individualized process**

and should be discussed regularly with your doctor. Rapid tapers or changing medications yourself is not recommended.

What is a reasonable timeframe to taper?

There is no one-size-fits-all approach to tapers. The process is individualized and considers starting dose, length of use, and concurrent medical conditions, as well as your life circumstances. Slow and steady step-downs tend to be more successful, as this allows your brain and body time to adjust to changes. If tapers progress too quickly, they can feel overwhelming and unmanageable. However, remember that even small changes can create discomfort, and it is important to know that this is a normal experience for many and that it will pass. You may need to draw on extra support during these changes. With the guidance of your doctor, you may also need to take **tapering breaks** and remain on a stable dose for a while, before taking the next steps in a taper. Psychological work done during such tapering breaks can increase your success with future taper attempts. Conversely, for safety reasons, your doctor may initiate a taper or the next step-down before you feel ready.

Why change my medication if it took years to find this balance?

Given the risks described (see page 2-3), being stable on a dose of a medication for years is not a reason to forgo reexamination. As bodies and lives change over time, medications should also be reevaluated over time. Particularly since **the risks associated with benzodiazepines and z-drugs increase with age**. However, if taper attempts are unsuccessful over time and there is a documented benefit of continuing a stable dose of medication that outweighs the harm, doctors and patients may choose to continue the benzodiazepines and z-drugs.

I've never abused my pills - why can't I have more than a month at a time?

While it may not feel like the risks, harms, or concerns apply to you, CPSM and doctors must set parameters to promote public safety. That means *drawing a line* between safe and unsafe amounts of medication that can be available at one time. This line must balance the needs and lifestyles of both well and unwell community members. CPSM has made similar prescribing rules for benzodiazepines and z-drugs, as with opioid pain medications, because of the known risks of these medications. The Standard makes firm recommendations, or rules, for prescribing and dispensing intervals to limit the supply of these drugs in the community and promote safety. These recommendations are also to ensure that doctors are taking a frequent and active role in managing the use of these medications.

What are the new rules? Are there any exceptions?

Specifically, the prescribing and dispensing rules in the Standard are that:

- Benzodiazepines and z-drugs prescriptions can only be written for a **maximum of three months at a time**; and
- **Only a one-month supply** can be dispensed at a time. Exceptions to this rule apply only if use is 1) infrequent (as in, taking a single dose for travel or having a CT scan), 2) you live in a remote community, or 3) for travel if you have been on a stable long-term prescription. For these exceptions of remote living and travel, your doctor may allow a dispensing interval of up to three months only. This limit also applies if you leave the country for longer than three months at a time; still only a maximum of three months' supply of benzodiazepines and z-drugs may be prescribed and dispensed at one time.

This means that simply fewer pills are available in a home and within the community at a given time. For example, even if you have never misused or lost your medications and always got 90-days at a time, what would happen if someone stole all your medication? What if someone who has never tried them before, such as a minor, gets access, takes them, and overdoses? These are the types of risks doctors and CPSM must balance with the needs of patients who take their medications as prescribed. One-month of medication has been determined to be an amount of pills that balances community risk with patient need. When safety concerns arise, doctors can choose to further limit dispensing intervals to ensure patient and public safety (e.g. medications may need to be dispensed weekly or daily in some situations). It is a good idea to lock up medications in your home.

Are there resources to help me?

The symptoms or reasons you started these medications may still exist and can feel distressing. Evidence shows that other non-medication treatments, such as Cognitive Behavioural Therapy (CBT) for anxiety or CBT for insomnia, sleep hygiene techniques, mindfulness, and healthy exercise, are all effective ways to manage mental health issues, often with longer-term benefits than benzodiazepines and z-drugs. You can discuss optimizing non-medication and other medication-based treatments with your doctor. Ask for a referral to counselling or specialized services. If your distress becomes overwhelming, call or present to local crisis services. There are also peer-lead support groups that have helped many people recover from mental health issues, such as the Anxiety Disorders Association of Manitoba, the Mood Disorders Association of Manitoba, 12-Step programs, and other self-help groups that can offer more support.