one dependent on date of birth. The birth date method is easy to understand and apply, especially for non-researchers. It is unobtrusive in comparison with other methods of randomization and so the doctor is less likely to be distracted from important non-verbal cues in the consultation. Furthermore, to our knowledge there is no inherent bias to the use of birth dates.[14]

It has been said that lowering benzodiazepine dosage may do more harm than good, in that the patient suffers more distress because of the reduced dose, yet does not have the benefit of coming off the medication.[15] The supporters of this view have usually considered stopping benzodiazepines as the only successful outcome. The present research contradicts this view. Intervention patients who reported reduction in their benzodiazepine intake showed a modest psychiatric improvement over the trial period as judged by the general health questionnaire. Although this group included nine subjects who reported stopping taking benzodiazepines there was no improvement in the psychiatric status of these stoppers. However, among the 11 patients who reported decreasing but not stopping benzodiazepines, there was improvement. Lowering benzodiazepine dosage is therefore valuable in its own right and should be encouraged, even if the patient is unable to cease intake completely.

Among night-time users, individuals receiving minimal intervention were significantly more likely than controls to reduce their medication, both according to self-report and prescribing records. Among daytime users, however, there was no difference between intervention patients and controls. It seems therefore that daytime users require more than minimal intervention to help them withdraw from benzodiazepines. This finding also lends further weight to the argument for a separate classification of daytime and night-time users.

A number of factors were found to be associated with a successful outcome in the trial. Being on an antidepressant at the end of the study was strongly predictive of a recorded reduction in benzodiazepine prescribing. One explanation could be drug substitution, that is, patients were being transferred from one psychotropic to another, the antidepressant being used as a hypnotic or anxiolytic instead of the benzodiazepine. Another possibility is that depression, which is common among these patients,[16] is being successfully treated, thereby reducing the need for other psychotropic drugs. The area is clearly complex, as illustrated by the finding that patients excluded by their general practitioner from the research, on the grounds that it might be harmful to them, were much more likely than study patients to be on an antidepressant at the end of the trial. Nevertheless, it would seem a rational policy to identify depression in chronic users and it may be that treating this with an antidepressant will assist withdrawal of benzodiazepines.

Taking a low baseline dose of benzodiazepines and a short acting preparation were both associated with a greater chance of reduction as reported by patients. The first of these findings has been noted before,[6] but is still surprising as one would expect that being on a higher initial dose would give more scope for reduction. Shorter acting preparations are generally thought to carry a greater risk of withdrawal symptoms and consequently it is often recommended that they be substituted by a long acting drug such as diazepam when withdrawal is being considered.[15] The results of this study suggest that it may be better to leave patients on their short acting preparations when a dose reduction is being attempted. The link between more physical illness and successfully stopping benzodiazepines is also an unexpected finding. One explanation is that these individuals only require their medication to overcome the psychological distress associated with physical illness and having recovered from, or adapted to the latter, they no longer have any real need for tablets.

No particular characteristic of doctors or their practices was identified as being important in helping chronic users to withdraw. However, 81% of patients who reported reducing their benzodiazepine consumption identified their doctor's support as being helpful during withdrawal. The self-help booklet also received a positive response from both patients and doctors.

Some chronic users can successfully reduce their intake of benzodiazepines with a simple and practical intervention delivered by their general practitioner. The intervention does not cause psychological distress or increased consultation and this applies whether individuals are successful in reducing their intake or not.

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Corrigendum — formulary for self-care

In the editorial by Herxheimer and Britten (Formulary for self-care, *Br J Gen Pract* 1994; **44**: 339-340) a line of text was omitted. The sentence running between pages 339 and 340 should have read: Forty eight per cent of the general practitioners, who in 1993 received a copy of the *OTC Directory*,[2] an illustrated catalogue of branded over the counter products, said they referred to it at least weekly, mainly to recommend an over the counter product or to identify what a patient was taking.[1]