Opioid Agonist Therapy 101:
An Introduction to Clinical Practice Workshop

BENZODIAZEPINES AND OPIOID AGONIST TREATMENT: A PRACTICAL APPROACH TO CARE

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Faculty/Presenter Disclosure

- **Faculty:** Marina Reinecke
- **Relationships with commercial interests:** None

Learning Objectives

At the end of this activity, the participant will be able to:

- Discuss important risks and side-effects associated with benzodiazepine use.
- Discuss the benefits of discontinuing benzodiazepines in patients on OAT.
- Differentiate when it is appropriate to take over an existing benzodiazepine prescription and when not.
- Propose a practical approach to initial dosing and dispensing of benzodiazepines along with OAT.
- Select patients who are good candidates for prescribed tapers and, implement successful tapering strategies through collaboration with patients and their supports.


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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 members 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 members 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

The evidence: Opioids and benzodiazepines

Benzodiazepines increase opioid toxicity and risk of overdose.

- The **serum concentration of opioids is lower in mixed overdoses** than in pure overdoses, suggesting that other drugs significantly lower the lethal opioid dose (Cone 2004).

- Most **opioid overdoses involve multiple drugs in addition to opioids.** Overall, the top two other substances contributing to deaths between 2014 and 2017 were **benzodiazepines** and antidepressants.

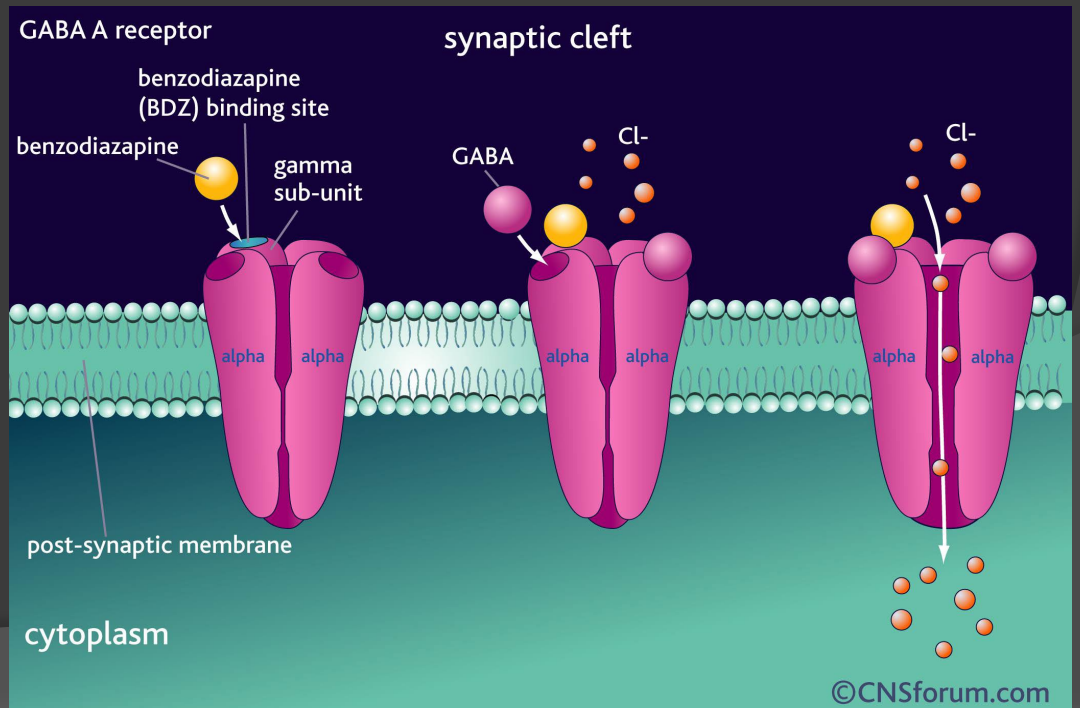
Government of Manitoba, Manitoba Health, Seniors and Active Living, Epidemiology and Surveillance. (2018). Surveillance of Opioid Misuse and Overdose in Manitoba: October 1 – December 31, 2017.

Short term and long-term harms

- Daytime sedation
- Falls, fractures
- Cognitive and functional impairment
- Memory disorders (episodic memory impairment)
- Motor vehicle accidents
- Physical dependence, sedative hypnotic use disorder
- Risks of diversion
- **Respiratory depression/death (especially in combination with alcohol, opioids or other sedating medications)**

Benzodiazepine withdrawal symptoms

- Common: GI symptoms, irritability, insomnia, anxiety, sweating
- Less common, more severe: tremors, dysphoria, psychosis, delirium tremens, seizures



Initial Assessment

- **Take the time to take a good history** - it determines next steps
- Name them!
- Prescribed or other sources?
- Do you take them and if so, **how many days out of the week?**
- How many tabs; how often?
- Original indication?
- Have they been a problem?

Inherited Prescriptions

- Set the stage!
- Strong recommendation: Take over prescribing if prescription needs to continue!!
- Communicate with original prescriber
- Respectful education – usually well received
- Dispense with methadone or buprenorphine/naloxone

Choosing a starting dose

- Long acting agents preferred in OUD population!
- Diazepam useful tablet sizes
- Benzodiazepines are often used to treat intermittent withdrawal!
- Once stable dose of OAT, needs ALWAYS decreases
- NEVER more than diazepam 10mgs BID; max 15mgs BID
- OD dosing an option once tolerant to sedation with diazepam

Can’t control use… ?

- Consider in-patient start!!
- CARMA clinic handout
- Prescriber referral required

Monitoring…

- Limit carries to 5 carries per week until tapered off

- Periodic comprehensive UDS's
- Clinical presentation
- Collateral history
- Pill counts
- If street supplementation – stop prescribing!

- Consider motor vehicle branch notification if heavy or binge use and driving

De-prescribing benzodiazepines

- Is the planned and supervised process of dose reduction or stopping of benzodiazepines because they are either causing harm or no longer providing benefit

Goal: ↓harm,
↓medication burden,
←→/↑quality of life

De-prescribing benzodiazepines

- Consider reason for taking benzodiazepine and manage
- Do not initiate taper until stable dose of OAT; usually after 3-6 months
- More urgent in the elderly
- More urgent if polypharmacy

Engage | Plan Taper | Monitor

- Discuss adverse effects of benzo's and the benefits associated with decreasing or stopping use
- Discuss goals and preferences
- Discuss the process – Decrease in small increments to minimize withdrawal effects
- Discuss adverse effects – usually mild and short term (days to weeks). May include: GI symptoms, irritability, insomnia, anxiety, sweating

Engage → Plan Taper → Monitor

Benzodiazepine	Equivalent to 5 mg diazepam (mg) *
Alprazolam (Xanax®)**	0.5
Bromazepam (Lectopam®)	3–6
Chlordiazepoxide (Librium®)	10–25
Clonazepam (Rivotril®)	0.5–1
Clorazepate (Tranxene®)	7.5
Flurazepam (Dalmane®)	15
Lorazepam (Ativan®)	0.5–1
Nitrazepam (Mogadon®)	5–10
Oxazepam (Serax®)	15
Temazepam (Restoril®)	10–15
Triazolam (Halcion®)**	0.25

http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b06.html

Drug	Available doses
Alprazolam	0.25mg, 0.5mg, 1mg, 2mg scored tabs
Temazepam	15, 30 mg caps
Diazepam	2mg, 5mg, 10mg scored tabs
Lorazepam	0.5mg, 1mg, 2mg tabs (0.5 mg tab not scored) 0.5mg, 1mg, 2mg SL tab
Oxazepam	10mg, 15mg, 30mg scored tabs
Triazolam	0.125mg, 0.25mg scored tabs
Flurazepam	15mg, 30mg cap
Nitrazepam	5mg, 10mg scored tab
Clonazepam	0.25mg, 0.5mg, 1mg, 2mg scored tabs

Engage | Plan Taper | Monitor

- Taper benzodiazepine 10-25% q2-3 weeks
- Usually bigger dose reductions to start and then smaller as get around 25% of original dose
- Can use planned drug free days near end

UNIVERSITY OF NEWCASTLE

Neurology, Neurobiology & Psychiatry

Professor Heather Ashton

ASHTON MANUAL

INDEX PAGE

BENZODIAZEPINES: HOW THEY WORK AND HOW TO WITHDRAW

(aka The Ashton Manual)

- PROTOCOL FOR THE TREATMENT OF BENZODIAZEPINE WITHDRAWAL
- Medical research information from a benzodiazepine withdrawal clinic

Professor C Heather Ashton DM, FRCP

Revised August 2002

Engage → Plan Taper → Monitor

- See your patient regularly to assess for withdrawal symptoms and benefits
- Adjust taper according to patient response/situation
- Remember, any dose reduction is a positive step!

References

- Deprescribing.org *Benzodiazepine and Z-drug (BZRA) Deprescribing Notes*, Feb 2019
- http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b06.html
- Paquin et al. *Risk versus risk: a review of benzodiazepine reduction in older adults.* Expert Opin Drug Saf 2014;13(7):919-34.
- Pottie K et al. *Deprescribing benzodiazepine receptor agonists. Evidence-based clinical practice guideline*