*Opioid Agonist Therapy 101:*
*An Introduction to Clinical Practice Workshop*

# BENZODIAZEPINES AND OPIOID AGONIST TREATMENT: A PRACTICAL APPROACH TO CARE

Marina Reinecke MBChB, CCFP (AM), ISAM

# Disclosure of Commercial Support

- **This program has received financial support from *The College of Physicians and Surgeons of Manitoba* in the form of *funding for payment of presenters and organizers.***
- **This program has received in-kind support from *The College of Physicians and Surgeons of Manitoba* in the form of *logistical support.***

- **<u>Potential for conflict(s) of interest</u>:**
  - None identified

# 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 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.


...when denial is the best alternative.
Sweet, refreshing...
VALIUM
www.somethingawful.com

# 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.

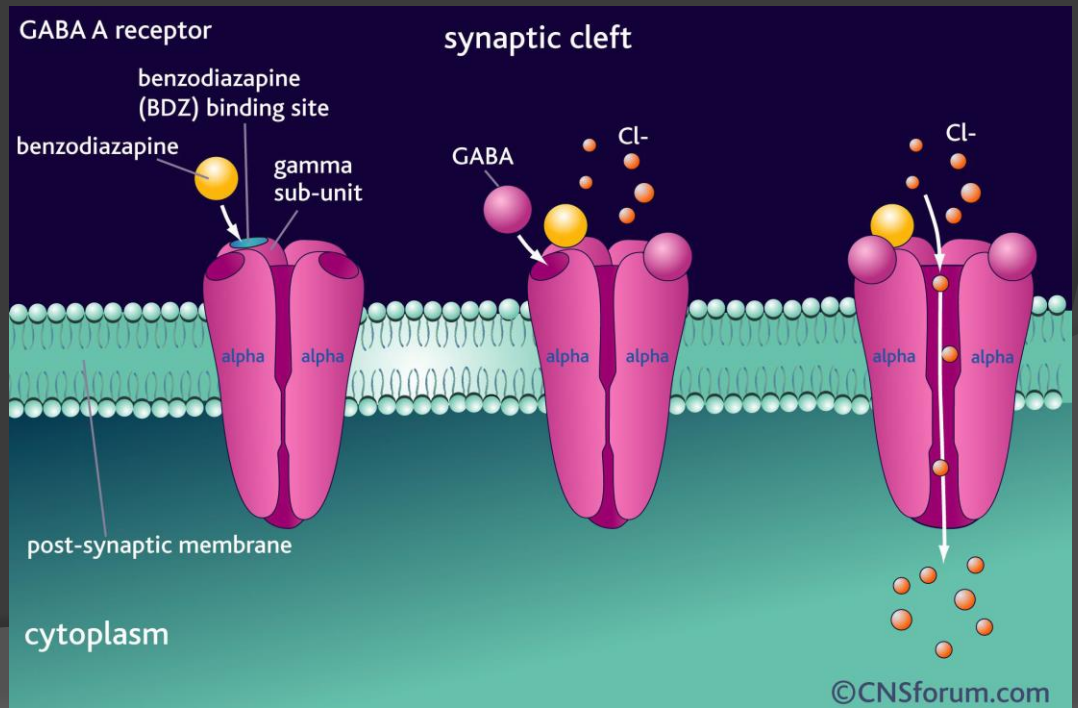
Government of Manitoba, Manitoba Health, Seniors and Active Living, Epidemiology and Surveillance. (2018). Surveillance of Opioid Misuse and Overdose in Manitoba: October 1 – December 31, 2017.

# 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
- Limit carries to 5 carries per week until tapered off
- Attempted taper once dose and life ‘stable’

# Choosing a starting dose

- Long acting preferred!
- 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

# Can’t control use… ?

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

# Monitoring…

- 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 initial and current reason for taking benzodiazepine
- May have to delay taper to manage underlying conditions
- Stable dose of OAT; usually after 3-6 months

Engage | Plan Taper | Monitor

- Discuss goals and preferences
- They are part of the planning process!
- Discuss adverse effects and benefits associated with long term benzodiazepine use
  - Adverse effects: memory, cognitive impairment, accidents and falls
  - Benefits: improved thinking, better memory, less daytime drowsiness, decreased risk of falling

Engage | Plan Taper | Monitor

- 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

- Convertion to a long acting benzodiazepine preferred in OUD population (diazepam or clonazepam)
- Consider available doses of different benzos
- The patient should be involved in planning taper

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)<br>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*