Safe & Effective Use of Benzodiazepines in Clinical Practice:
The role of guidelines or standards
Learning Objectives

• Articulate the value of practice guidelines and the limitations of data regarding unsafe benzodiazepine use

• Identify key change processes and milestones for quality improvement projects focused on benzodiazepine prescribing
Issues in General

Benzodiazepines

• One of the most commonly prescribed classes of psychotropic medications

• In 2008, roughly 1 in 20 adults filled a BDZ Rx
  – Long Term use (120 day supply within 1 year)
    • Characteristic of 0.4% population ages 18-35
    • 2.7% populations ages 65-80
  – Vast majority of Rx written by non-psychiatrists

Olfson et al, 2015
Paulozzi et al, 2014
Dell’Osso et al, 2015
Issues in General

• BDZs - widely prescribed in almost all psychiatric conditions, as well as in many other medical disorders.
• Often prescription practices do not align with current evidence.
• Scientific literature provides conflicting recommendations regarding the continued role of BDZs in ongoing treatment, with varying interpretations of the benefits and risks associated with their prescription.
• Paucity of guidelines focusing specifically on BDZs
  – usually confined to disorder-specific treatment guidelines that very rarely provide specifics on dosage, selection of appropriate BDZ or specific length of treatment.
• All guidelines contend
  – prescribers should employ BDZs as primarily a short-term, stabilizing intervention
  – require significant monitoring of a range of possible adverse side-effects, including the potential for tolerance, dependency, rebound symptoms and withdrawal.

Dell’Osso et al, 2015
Issues in Supervising Practice

• Use of controlled substances (benzodiazepines and stimulants) not driven by diagnostic work and/or consideration of alternative treatments
  – Knowledge
  – Attitudes
  – Skills

• Lack of careful monitoring of dose, refills, medication response, use of (and engagement with) alternative treatments
  – Time
  – Team

• Lack of identification of and intervention skills for
  – Primary and comorbid Substance Use disorders
  – Pain Disorders
Issues: Deleterious Effects

- Cognitive
- Psychomotor
- Disinhibitory
- Tolerance, Dependence and Withdrawal
- Abuse and Overdose
- Street Value
Strategies

• Consensus Statements
• Guidelines
• Protocols
• Audits
Guidelines by Disorders

- Anxiety Disorders
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Social Anxiety Disorder
- Insomnia
- Post Traumatic Stress Disorder
- Obsessive Compulsive Disorder
- Affective Disorders
- Schizophrenia and other Psychotic Disorders
- Borderline Personality Disorder
- Alcohol Withdrawal
Guideline Sample
The Jewish Board, NY, NY

- Part of Psychiatry Manual, Guidelines for Use of Benzodiazepines within agency practice
- Created based upon consensus work at another Agency
- Created with internal feedback from:
  - Psychiatrists
  - Nurse Practitioners
  - CQI Staff
  - Directors
- In place since June 2015
- Initial feedback and utility…
Generally agreed upon indications in psychiatry

1. anxiety: acute and chronic (especially PD, GAD, SAD)
2. acute insomnia
3. acute agitation particularly in mania and psychosis
4. alcohol withdrawal
5. akathisia
6. catatonia
7. co-prescription during initiation phase of antidepressant in PD and GAD
8. tremor
Disputed indications in psychiatry

1. acute stress disorder
2. posttraumatic stress disorder
3. chronic insomnia
Guidelines Sample

The Jewish Board, NY, NY

Relative Contraindications
1. patients 65 years and older
2. current substance use disorder
3. history of substance use disorder
4. borderline Personality Disorder
5. co-prescription of opiate pain medications (especially methadone and suboxone)
6. clients with recent suicidal ideation and/or poor impulse control

Absolute Contraindications
1. active use of alcohol with unreliable reports about use and increasing requests for meds
Articulated Concerns

1. physiological dependence
2. heightened anxiety symptoms
3. falls (populations at risk include those 65 years and older, patients with diabetes, coprescription of antihypertensive medication and other medications that also can cause orthostasis)
4. driving impairments
5. memory interference
6. misuse and diversion
7. teratogenic effects
8. immediate post-partum effects on neonate
Guidelines Sample - The Jewish Board, NY, NY

Documentation standards when prescribing benzodiazepines

1. Documentation of a clear rational for indications, balance of indications and contraindications

2. Indications for short term use of benzodiazepines should be documented, including a timeframe for review. Follow up is necessary and includes any indications of dependence or need for a discontinuation taper.

3. Indications for long term use of benzodiazepines should be documented, including use of (or consideration of) alternative interventions. Stability of dosing should be noted along with any indications of dependence or need for a discontinuation taper.
Guidelines Sample
The Jewish Board, NY, NY

Documentation standards when prescribing benzodiazepines

4. Prn dosing should be used judiciously. Prn use and response should be carefully tracked and standing dosing reconsidered based upon use.

5. Risks of use, including use of information obtained from i-STOP review.

6. Recommendations for combined psychopharm treatment with psychosocial interventions to manage anxiety, distress tolerance, insomnia and drug seeking behavior. These include Motivational Interviewing, Cognitive Behavioral Strategies and Mindfulness techniques.
Guidelines Sample - The Jewish Board, NY, NY

Documentation standards when prescribing benzodiazepines

7. Use of code A (2-3 month supply)
8. Response to lost controlled substance prescriptions
9. Refill requests which occur before dosing runs out.
Sample: Protocol for Prescription of Benzodiazepines
Joe Parks, MD, Director of MO HealthNet

1. For new patients reporting prior prescription treatment with benzodiazepines and requesting continuation
   a. obtain medical records from previous prescriber
   b. call all pharmacies where they have been filling benzodiazepines and verify and document pattern of refills for previous 12 months for all benzodiazepines - date of fill, medications, dosage, number dispensed, prescribing physician
   c. inquire with pharmacy if they are flagged as inappropriately drug seeking
   d. inquire with patient if they had been receiving benzodiazepines from more than one prescriber and/or telling him that more than one pharmacy in prior 12 months
   e. if patient has been using more than one prescriber and pharmacy in the previous six months or more than two pharmacies in prescribers in the previous 12 months obtain urine drug screen
   f. if they are a Medicaid patient check cyber access for benzodiazepines prescribing history, diagnoses of substance abuse/dependence
   g. obtain history of prior alcohol use/abuse, illegal drug use/abuse, prescription drug use/abuse
Sample: Protocol for Prescription of Benzodiazepines
Joe Parks, MD

2. For current FHC requesting new start for benzodiazepines
   a. inquire with patient if they had been receiving benzodiazepines from any non-FHC prescribers
   b. call all pharmacies where they have been filling any medication and verify no benzodiazepines from other prescribers. Inquire with each pharmacy if they are flagged as inappropriately drug seeking
   c. if patient has been using more than one prescriber and pharmacy in the previous six months or more than two pharmacies in prescribers in the previous 12 months obtain urine drug screen
   d. if they are a Medicaid patient check cyber access for benzodiazepines prescribing history, diagnoses of substance abuse/dependence
   e. obtain history of prior alcohol use/abuse, illegal drug use/abuse, prescription drug use/abuse
Sample: Protocol for Prescription of Benzodiazepines
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3. Safest and most effective utilization of benzodiazepines - benzodiazepines are most effective and safe when used for limited time and or on an intermittent PRM basis. When used as a standing daily dose indefinitely they will become ineffective for a substantial portion of patients.

   a. time-limited for acute situational anxiety such as death of a loved one. Instruct the patient only to use the benzodiazepine as an intermittent PRM and not as a standing daily dose. Instruct the patient that the medication will not be continued indefinitely and set a time in the future by which you expect the medication to be discontinued of no more than three months

   b. ongoing intermittent PRM usage. Intermittent PRM usage avoids development of tolerance and reinforces self-management of anxiety and worry. It is important to instruct patients that the medication is more effective if used intermittently and tends to become ineffective if taken as an ongoing daily dose. Example of this type of usage is Klonopin 0.5mg #10/month
4. I will not prescribe benzodiazepines for patients who have refused a trial of the usual recommended medications prior to taking benzodiazepines. I use the following medications prior to resorting to the benzodiazepines:
   a. high-dose SSRIs –
      a. Prozac 40 to 60 mg
      b. Celexa 40 to 60 mg - check EKG at 40 mg per QT prolongation and again at 60 mg continue therapy is QT interval is normal
   b. low dose propranolol (20-40mg BID) for blocking autonomic symptoms of anxiety such as sweating, palpitations, tremulous
   c. buspirone with the target dose of 60 mg a day
   d. hydroxyzine up to 100 mg TID
   e. reduction/elimination of caffeine
   f. increase of physical activity – “feeling anxious as a reminder that it's time to take a walk”
5. Refer to Dr. Parks when information above has been obtained and non-benzodiazepine options have been exhausted.
CQI Project

• 50 Psychiatric Practitioners, 4-6 month project
• Goals:
  – Identify what is wrong. Action Item:
    • Review of Diagnosis, including SU
  – Articulate why and how
  – Identify change needed
  – How will change occur, how will we know,
  – How maintain change
  – How monitor
  – How manage challenges
Contact Information

Paula Panzer, MD
Chief Clinical & Medical Officer
The Jewish Board
NY, NY
ppanzer@jbfcs.org