## Talking with your patient about deprescribing benzodiazepines

## Why Your Patient Could Benefit from Deprescribing

- Feel better: Patients who have depended on a benzodiazepine for several months or years
  will feel better mentally, emotionally and physically after the drug is eventually
  discontinued.<sup>1</sup>
- Trauma recovery support: The risk of benzodiazepines in the treatment of posttraumatic stress disorder (PTSD) outweighs potential short-term benefits and can worsen severity of symptoms, lead to aggression, depression and substance use, or even cause PTSD in patients with recent trauma.<sup>2</sup>
- **Tolerance:** With rare exceptions for severe panic disorders and social phobias, benzodiazepines can lose effectiveness with long-term use (i.e., greater than 3 months). Tolerance often leads to physical and psychological dependence.<sup>3,4</sup>
- **Long-term harm**: Several adverse effects of long-term use should be considered, such as falls, bone fractures, motor vehicle accidents, poor memory and cognition, and risk of overdose or death when combined with an opioid.<sup>5-8</sup>

## How to Successfully Deprescribe a Benzodiazepine

- **Start the conversation**: Begin with simple, open conversations about benzodiazepines. 9 Ultimately, it is a positive provider-patient partnership that will help the patient successfully discontinue benzodiazepines. 10-12 Seek help for patients who misuse or abuse benzodiazepines, or who have alcohol or opioid co-dependencies before deprescribing.
- It's a process: It is likely to take several visits before a patient is ready to deprescribe. One visit may be used to broach the idea that benzodiazepines are not great long-term treatments. The next visit a deeper dive into why. Provide them an <u>educational brochure</u> about benzodiazepines. Steady progress toward a shared goal with the patient is ultimately best for everybody involved. This stepwise approach can really help get your patient onboard. 10-13
- Everyone is fully committed: Both provider and patient should recognize that coming off a benzodiazepine is a challenge. If a patient is forced or persuaded to deprescribe against their will, it often leads to failure. If both provider and patient are sufficiently motivated, there is a very high probability of success.
- **Empower your patient:** Benzodiazepine deprescribing is a less frightening experience when the patient has some measure of control over the process. A sufficiently gradual and individualized taper makes the process better.

- Set expectations: An educated patient who confidently understands the cause and nature
  of withdrawal symptoms will find the deprescribing process much easier. A gradual taper
  will reduce withdrawal symptoms but may not eliminate them. Previous bad experiences
  with deprescribing are usually because the drug was tapered too quickly, and the patient
  did not know what to expect.<sup>1</sup>
- **Go slowly:** A sufficiently slow taper of the benzodiazepine permits the neuroadaptive responses induced by the drug to regain control of their natural central functions. This healing process of the mind can take a long time, similar to slow physical healing of other parts of the body.<sup>1</sup>
- It's not a competition: The rate of taper is not critical. Each person's experience with deprescribing is unique, and differs in type, quality, severity, time-course, and duration.<sup>1</sup>
- **Help make it simple:** Some patients will benefit from using a pharmacy who can bubble pack. Pill boxes and smartphone medication reminder apps can also be helpful. Because bubble packs and pill boxes are not child-resistant, lock boxes are also available. Many patients may not have the means to access these tools and may need your help.

## References:

- 1. Ashton CH. Benzodiazepines: how they work and how to withdraw (aka The Ashton Manual). Available online at https://benzo.org.uk/manual/index.htm. Accessed 11 February 2022.
- 2. Guina J, Rossetter S, DeRhodes B, Nahhas R, and Welton RS. Benzodiazepines for PTSD: A Systemic Review and Meta-Analysis. *J Psych Pract*. 2015; 21:281-303.
- 3. Schweizer E, Rickels K, Weiss S, and Zavodnick S. Maintenance drug treatment of panic disorder I: results of a prospective, placebo-controlled comparison of alprazolam and imipramine. *Arch Gen Psychiatry*. 1993;50:51-60.
- 4. Otto MW, Pollack MH, Gould RA, Worthington JJ, McArdle ET, et al. A comparison of the efficacy of clonazepam and cognitive-behavioral group therapy for the treatment of social phobia. *J Anxiety Dis*. 2000;14:345-358.
- 5. Ray WA, Griffin MR, Schaffner W, Baugh DK, Melton LJ. Psychotropic drug use and the risk of hip fracture. *N Engl J Med*. 1987;31:363-69.
- 6. Dassanayake T, Michie P, Carter G, and Jones A. Effects of benzodiazepines, antidepressants and opioids on driving: a systematic review and meta-analysis of epidemiological and experimental evidence. *Drug Saf.* 2011; 34:125-56.
- 7. Crowe SF and Stranks EK. The residual medium and long-term cognitive effects of benzodiazepine use: an updated meta-analysis: *Arch Clin Neuropsych*. 2018;33:901-11.
- 8. Bachhuber MA, Hennessy S, Cunningham CO and Starrels J. Increasing Benzodiazepine Prescriptions and Overdose Mortality in the United States, 1996-2013. *Am J Public Health*. 2016;106:686-88.
- 9. Oude Vos Haar RC, Couvee JE, Van Balkom AJ, Mulder PG, and Zltman FG. Strategies for discontinuing long-term benzodiazepine use: meta-analysis. *Brit J Psych*. 2006;189:213-220.
- 10. Discontinuation strategies for patients with long-term benzodiazepine use: a review of clinical evidence and guideline. Rapid Response Report: Summary with Critical Appraisal. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 29 July 2015.
- 11. Ray M, Anderson R, Harrod C. Deprescribing benzodiazepines: clinical evidence and management strategies. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2019.
- 12. Prescribing drugs of dependence in general practice, Part B Benzodiazepines. Melbourne: The Royal Australian College of General Practitioners, 2015.
- 13. Lingford-Hughes AR, Welch S, Peters L, and Nutt DJ, et al. BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *J Psychopharmacol*. 2012;26:899-952.