DEPRESCRIBING BENZODIAZEPINES IN OLDER ADULTS

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I would like to thank you for participating in our research.

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-Ryan Anne Pishock & Dr. Kristin Sagedy

Benzodiazepines have been prevalent since first marketed in the 1960's

Benzodiazepines are the second most common medication class linked to overdose mortality

Despite endorsement of GDR's, they continue to be prescribed

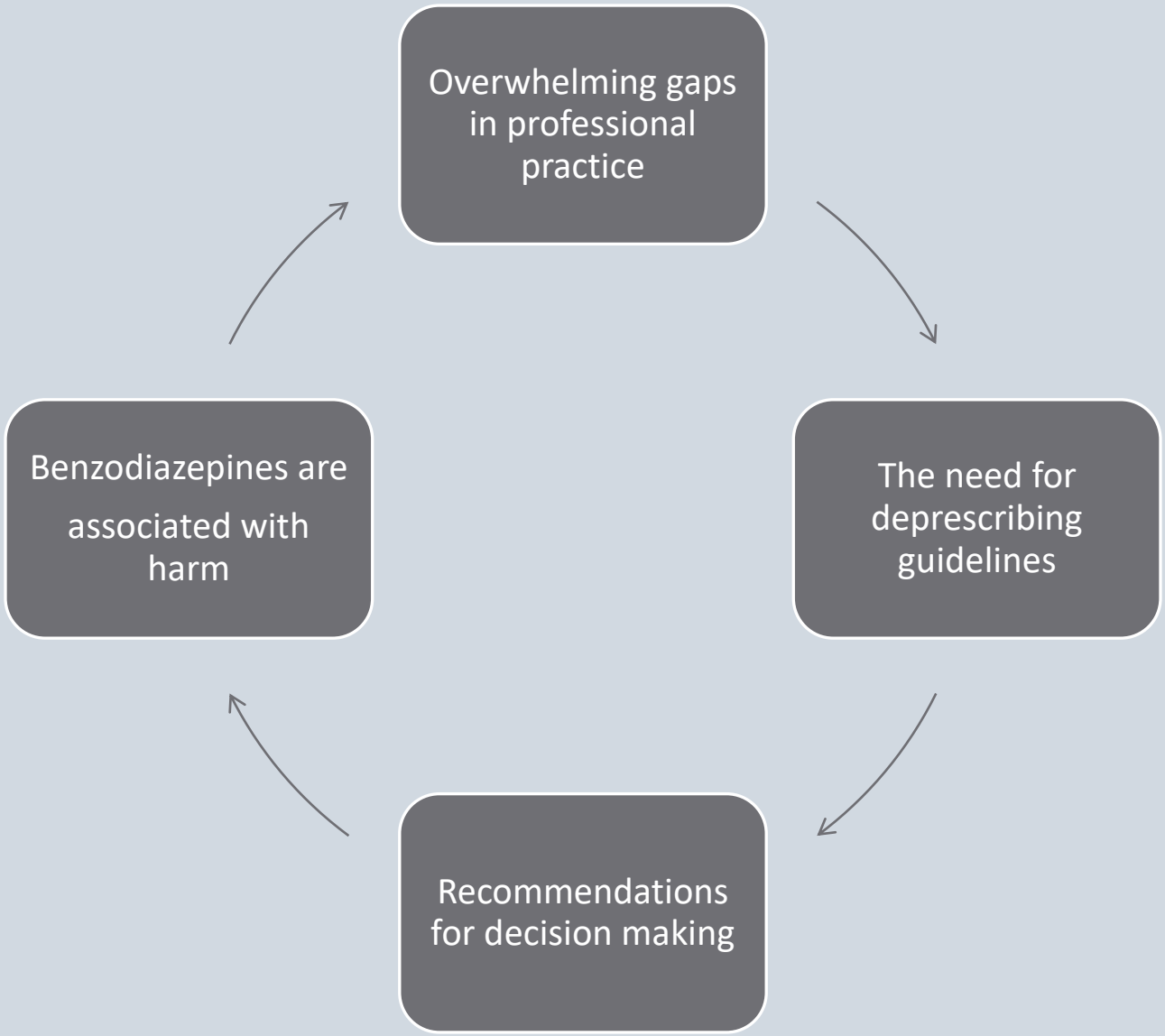
Older adults are more vulnerable to outside stressors, polypharmacy and increased sensitivity to medication side effects

Benzodiazepines can cause falls and cognitive impairments

Guidelines advocate for avoidance in older adults, however with little or viable alternatives

Various geriatric organizations, support complete avoidance of benzodiazepines in older adults

Deprescribing tools are not widely utilized and those existing validate the inappropriate medications often prescribed to older adults


Overwhelming gaps in professional practice
The need for deprescribing guidelines
Recommendations for decision making
Benzodiazepines are associated with harm

What patient attitudes should a clinician expect?

https://deprescribing.org/wp-content/uploads/2018/08/benzodiazepine-deprescribing-information-pamphlet.pdf

How do I engage patients in deprescribing benzodiazepines?

-Risks of ongoing benzodiazepine use (falls, memory impairment)

-Potential benefits of benzodiazepine discontinuation (reduced fall risk, improvement in thinking/memory)

-Therapeutic effect of benzodiazepines is frequently absent after 4 weeks of use, however amnestic effects often persist

-Mild, short-term, adverse drug withdrawal effects can be expected during tapering

How should tapering be approached?

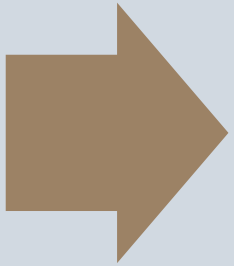
-Very gradual dose reductions to lowest available doses, followed by intermittent drug-free days have been used successfully in clinical trials

-Consider using a slower rate with those more likely to have a higher risk of relapse

-Taper over a several month period

-Monitoring for adverse drug withdrawal effects

What withdrawal symptoms can be expected and how should they be dealt with?



-Withdrawal symptoms are mild and short term and tend to appear and peak more quickly (1-2 days) and be more severe with abruptly stopping short-acting benzodiazepines compared with after tapering long-acting benzodiazepines (4-10 days)

-A gradual taper of short-acting agents may reduce their severity

-Common withdrawal symptoms reported in the literature include irritability, sweating, gastrointestinal symptoms and anxiety

-Patients should be reassured these symptoms are typically mild and short term and that discomfort is usually temporary

-Severe withdrawal symptoms do not appear to occur with tapering but have been reported in patients stopping very high doses without tapering or those with underlying seizure disorders

What non-drug approaches can be used to help with insomnia?

-Cognitive-Behavioral Therapy (CBT) for treatment of insomnia has been widely studied and demonstrates long-term improvements in sleep outcomes

-When used as part of a deprescribing intervention, CBT combined with tapering improved post-intervention benzodiazepine cessation rates compared with tapering alone

-Virtual and self-help options are also available

What monitoring needs to be done, how often, and by whom?

-Tapering will reduce, but may not eliminate withdrawal symptoms

-At each step in the taper, monitor for severity and frequency of adverse drug withdrawal symptoms, potential benefits, mood, and sleep quality

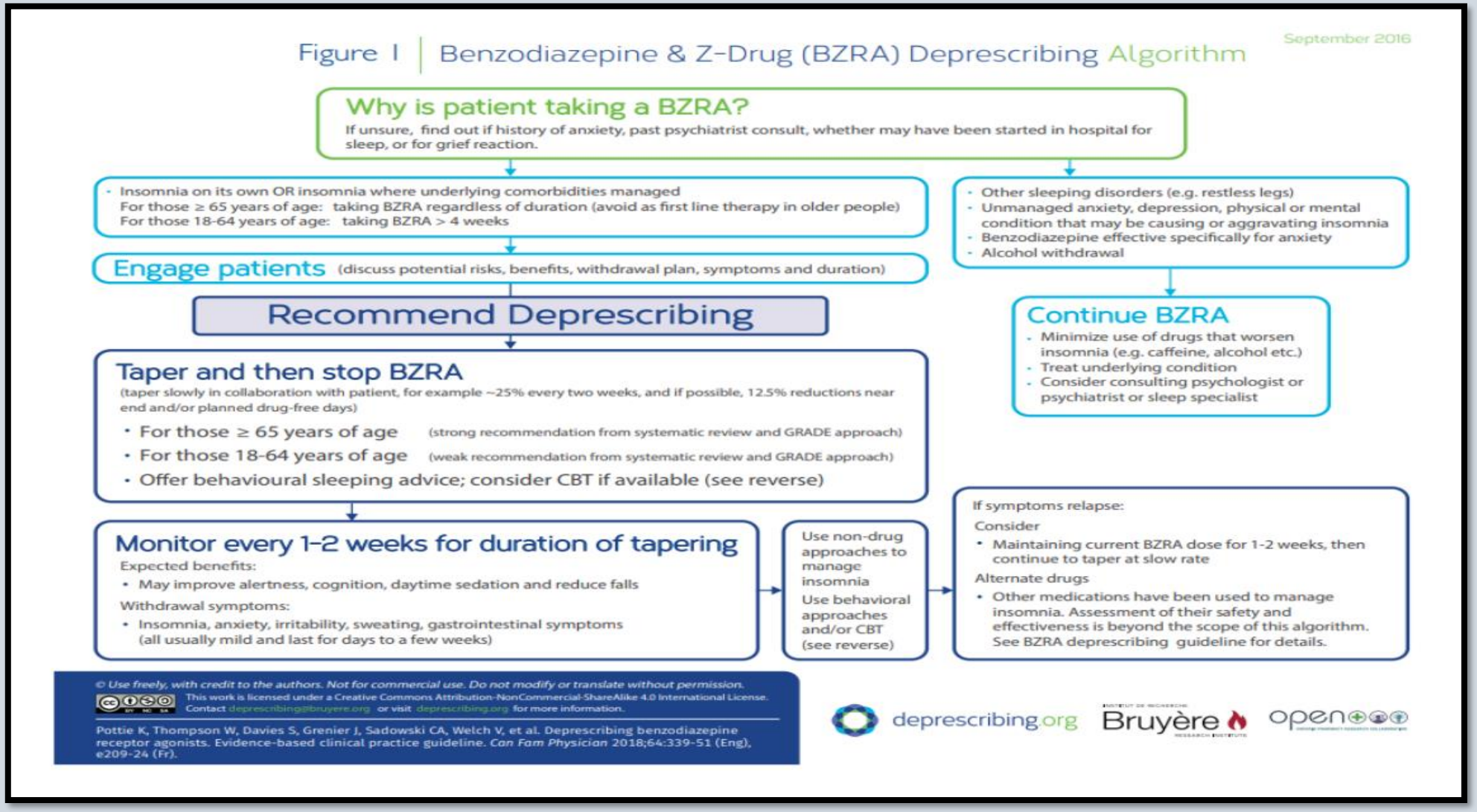
-Consider maintaining the current benzodiazepine dose for 1 to 2 weeks before attempting the next dose reduction, then continue to taper at a slower rate

What if insomnia returns or persists?

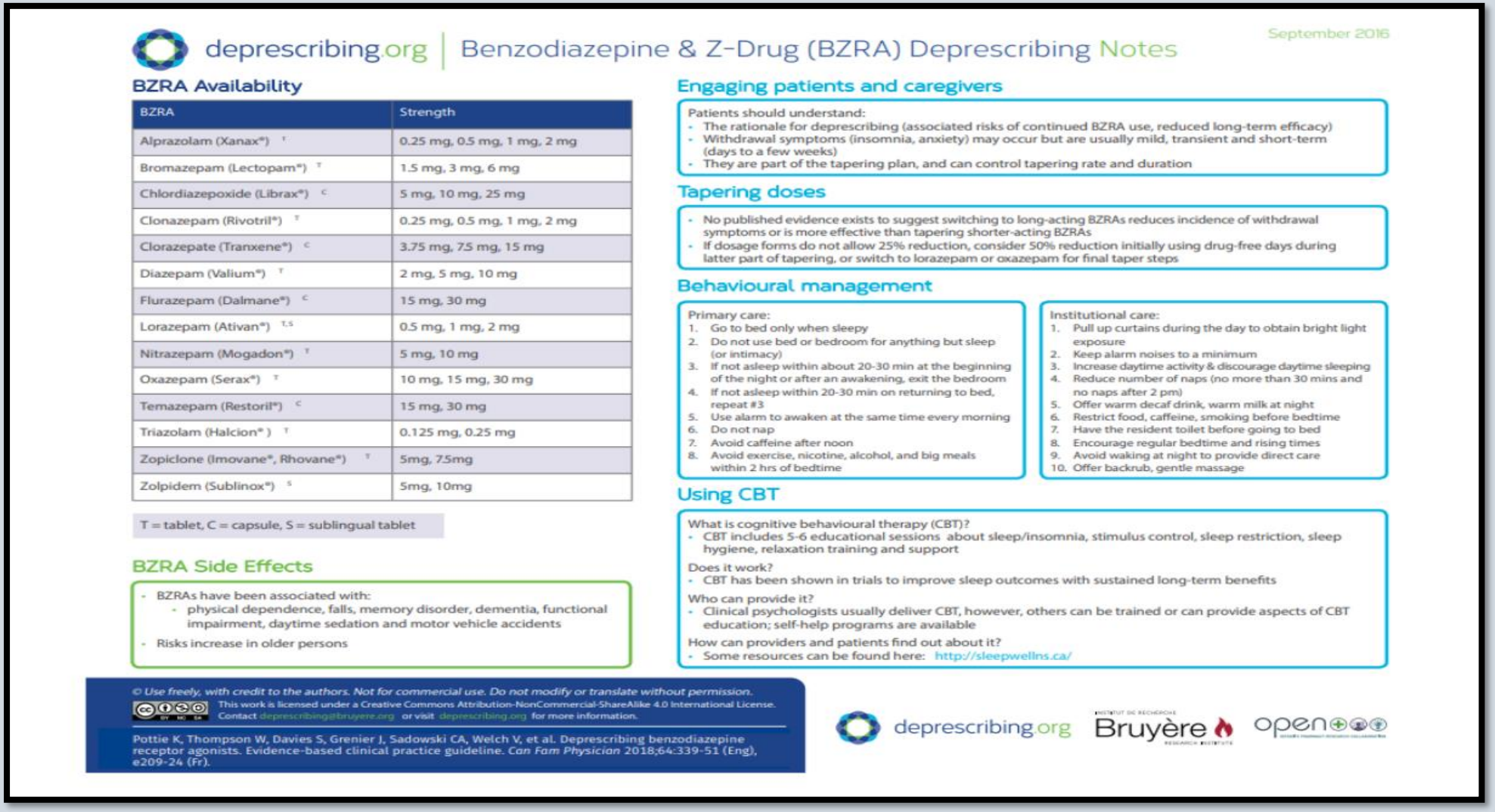
-There are no medications for primary or chronic insomnia in the elderly that are proven to be safe and effective

-CBT is strongly recommended for chronic insomnia

Prescriber Algorithm



Prescriber Algorithm



deprescribing.org | Benzodiazepine & Z-Drug (BZRA) Deprescribing Notes

September 2016

BZRA Availability

BZRA	Strength
Alprazolam (Xanax®) T	0.25 mg, 0.5 mg, 1 mg, 2 mg
Bromazepam (Lectopam®) T	1.5 mg, 3 mg, 6 mg
Chlordiazepoxide (Librax®) C	5 mg, 10 mg, 25 mg
Clonazepam (Rivotril®) T	0.25 mg, 0.5 mg, 1 mg, 2 mg
Clorazepate (Tranxene®) C	3.75 mg, 7.5 mg, 15 mg
Diazepam (Valium®) T	2 mg, 5 mg, 10 mg
Flurazepam (Dalmane®) C	15 mg, 30 mg
Lorazepam (Ativan®) T,S	0.5 mg, 1 mg, 2 mg
Nitrazepam (Mogadon®) T	5 mg, 10 mg
Oxazepam (Serax®) T	10 mg, 15 mg, 30 mg
Temazepam (Restoril®) C	15 mg, 30 mg
Triazolam (Halcion®) T	0.125 mg, 0.25 mg
Zopiclone (Imovane®, Rhovane®) T	5mg, 7.5mg
Zolpidem (Sublinox®) S	5mg, 10mg

T = tablet, C = capsule, S = sublingual tablet

BZRA Side Effects

- BZRAs have been associated with:
  - physical dependence, falls, memory disorder, dementia, functional impairment, daytime sedation and motor vehicle accidents
- Risks increase in older persons

Engaging patients and caregivers

Patients should understand:
- The rationale for deprescribing (associated risks of continued BZRA use, reduced long-term efficacy)
- Withdrawal symptoms (insomnia, anxiety) may occur but are usually mild, transient and short-term (days to a few weeks)
- They are part of the tapering plan, and can control tapering rate and duration

Tapering doses

- No published evidence exists to suggest switching to long-acting BZRAs reduces incidence of withdrawal symptoms or is more effective than tapering shorter-acting BZRAs
- If dosage forms do not allow 25% reduction, consider 50% reduction initially using drug-free days during latter part of tapering, or switch to lorazepam or oxazepam for final taper steps

Behavioural management

Primary care:
1. Go to bed only when sleepy
2. Do not use bed or bedroom for anything but sleep (or intimacy)
3. If not asleep within about 20-30 min at the beginning of the night or after an awakening, exit the bedroom
4. If not asleep within 20-30 min on returning to bed, repeat #3
5. Use alarm to awaken at the same time every morning
6. Do not nap
7. Avoid caffeine after noon
8. Avoid exercise, nicotine, alcohol, and big meals within 2 hrs of bedtime

Institutional care:
1. Pull up curtains during the day to obtain bright light exposure
2. Keep alarm noises to a minimum
3. Increase daytime activity & discourage daytime sleeping
4. Reduce number of naps (no more than 30 mins and no naps after 2 pm)
5. Offer warm decaf drink, warm milk at night
6. Restrict food, caffeine, smoking before bedtime
7. Have the resident toilet before going to bed
8. Encourage regular bedtime and rising times
9. Avoid waking at night to provide direct care
10. Offer backrub, gentle massage

Using CBT

What is cognitive behavioural therapy (CBT)?
- CBT includes 5-6 educational sessions about sleep/insomnia, stimulus control, sleep restriction, sleep hygiene, relaxation training and support

Does it work?
- CBT has been shown in trials to improve sleep outcomes with sustained long-term benefits

Who can provide it?
- Clinical psychologists usually deliver CBT, however, others can be trained or can provide aspects of CBT education; self-help programs are available

How can providers and patients find out about it?
- Some resources can be found here: http://sleepwellns.ca/

Pottie K, Thompson W, Davies S, Grenier J, Sadowski CA, Welch V, et al. Deprescribing benzodiazepine receptor agonists. Evidence-based clinical practice guideline. *Can Fam Physician* 2018;64:339-51 (Eng), e209-24 (Fr).

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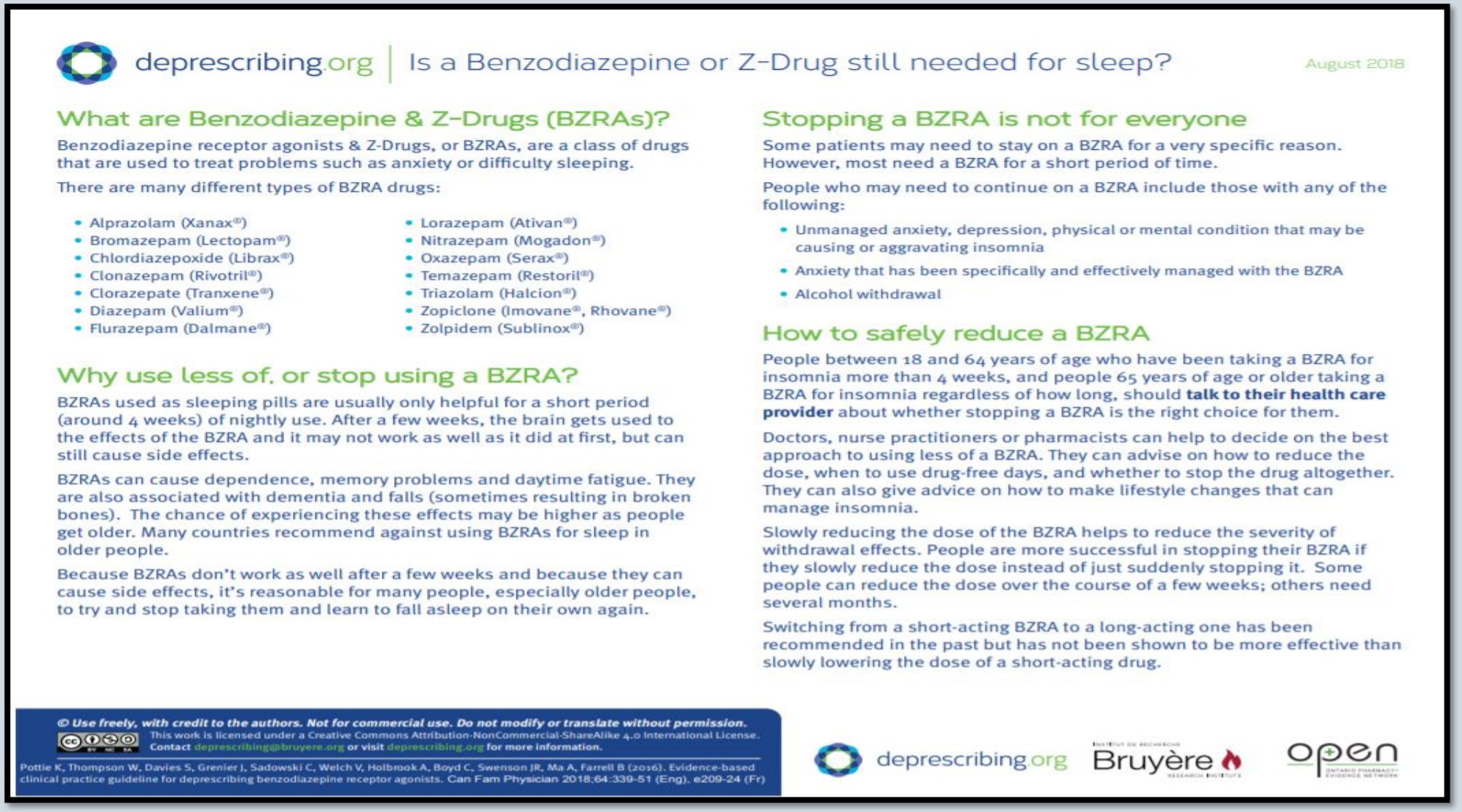
Patient Pamphlet



deprescribing.org | Is a Benzodiazepine or Z-Drug still needed for sleep?

August 2018

What are Benzodiazepine & Z-Drugs (BZRAs)?

Benzodiazepine receptor agonists & Z-Drugs, or BZRAs, are a class of drugs that are used to treat problems such as anxiety or difficulty sleeping.

There are many different types of BZRA drugs:

- Alprazolam (Xanax®)
- Bromazepam (Lectopam®)
- Chlordiazepoxide (Librax®)
- Clonazepam (Rivotril®)
- Clorazepate (Tranxene®)
- Diazepam (Valium®)
- Flurazepam (Dalmane®)
- Lorazepam (Ativan®)
- Nitrazepam (Mogadon®)
- Oxazepam (Serax®)
- Temazepam (Restoril®)
- Triazolam (Halcion®)
- Zopiclone (Imovane®, Rhovane®)
- Zolpidem (Sublinox®)

Why use less of, or stop using a BZRA?

BZRAs used as sleeping pills are usually only helpful for a short period (around 4 weeks) of nightly use. After a few weeks, the brain gets used to the effects of the BZRA and it may not work as well as it did at first, but can still cause side effects.

BZRAs can cause dependence, memory problems and daytime fatigue. They are also associated with dementia and falls (sometimes resulting in broken bones). The chance of experiencing these effects may be higher as people get older. Many countries recommend against using BZRAs for sleep in older people.

Because BZRAs don't work as well after a few weeks and because they can cause side effects, it's reasonable for many people, especially older people, to try and stop taking them and learn to fall asleep on their own again.

Stopping a BZRA is not for everyone

Some patients may need to stay on a BZRA for a very specific reason. However, most need a BZRA for a short period of time.

People who may need to continue on a BZRA include those with any of the following:

- Unmanaged anxiety, depression, physical or mental condition that may be causing or aggravating insomnia
- Anxiety that has been specifically and effectively managed with the BZRA
- Alcohol withdrawal

How to safely reduce a BZRA

People between 18 and 64 years of age who have been taking a BZRA for insomnia more than 4 weeks, and people 65 years of age or older taking a BZRA for insomnia regardless of how long, should **talk to their health care provider** about whether stopping a BZRA is the right choice for them.

Doctors, nurse practitioners or pharmacists can help to decide on the best approach to using less of a BZRA. They can advise on how to reduce the dose, when to use drug-free days, and whether to stop the drug altogether. They can also give advice on how to make lifestyle changes that can manage insomnia.

Slowly reducing the dose of the BZRA helps to reduce the severity of withdrawal effects. People are more successful in stopping their BZRA if they slowly reduce the dose instead of just suddenly stopping it. Some people can reduce the dose over the course of a few weeks; others need several months.

Switching from a short-acting BZRA to a long-acting one has been recommended in the past but has not been shown to be more effective than slowly lowering the dose of a short-acting drug.

Pottie K, Thompson W, Davies S, Grenier J, Sadowski C, Welch V, Holbrook A, Boyd C, Swenson JR, Ma A, Farrell B (2016). Evidence-based clinical practice guideline for deprescribing benzodiazepine receptor agonists. Can Fam Physician 2018;64:339-51 (Eng), e209-24 (Fr)

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What to expect after reducing a BZRA

Some people may have difficulty sleeping when a dose is first reduced, but many will not. Difficulty sleeping tends to be worst in the first few days after reducing or stopping, and usually resolves in a few weeks.

Some people have other symptoms of withdrawal (e.g. anxiety, irritability, and sweating); these symptoms tend to be most severe in the first few days and get better within a few weeks. If anything odd happens, people should talk to a health care provider for advice.

Reducing or stopping a BZRA may improve alertness and thinking ability, and reduce daytime sedation and fall risk.

Other ways to manage insomnia

For a person who lives in the community:

- Go to bed only when sleepy
- Do not use bed or bedroom for anything but sleep (or intimacy)
- If not asleep within 20-30 min on going/returning to bed, exit the bedroom
- Use alarm to awaken at the same time every morning
- Do not nap
- Avoid caffeine after noon
- Avoid exercise, nicotine, alcohol, and big meals 2 hours before bedtime

For a patient who lives in long-term care or hospital:

- Pull up curtains during the day for light exposure
- Keep alarm noises to a minimum
- Increase daytime activity
- Reduce number of naps (no more than 30 minutes and no naps after 2pm)
- Have warm decaf drink, warm milk at night
- Restrict food, caffeine, smoking before bedtime
- Use toilet before going to bed
- Have regular bedtime and rising times
- Avoid waking at night for direct care
- Try backrub, gentle massage

What to do if insomnia continues

Talk to a health care provider about treating underlying conditions that are affecting sleep. Avoid using other medication to treat insomnia. Most sedatives contribute to sedation and increase risk of falls. Ask about "cognitive behavioural therapy" – an educational approach that has been shown to help patients stop BZRA. Check out this resource for more information: http://sleepwellns.ca/. You can also discuss other options for managing your insomnia if it gets worse when you use a lower dose or stop your BZRA.

Personalized BZRA dose reduction strategy:

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This pamphlet accompanies a deprescribing guideline and algorithm that can be used by doctors, nurse practitioners, or pharmacists to guide deprescribing.

Visit
deprescribing.org
for more information.

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