Benzodiazepine Use and Dependence

Disclaimer

Contents

Background

About benzodiazepine use and dependence

Benzodiazepines have traditionally been used in the treatment of anxiety, depression, muscle tension and insomnia. There are well-recognised harms from long-term use of benzodiazepines. These include dependency, cognitive decline, and falls.

Alternatives to benzodiazepines (including cognitive behavioral therapy, self-help advice and other medications) should be considered with the relative benefits and risks noted for both acute and longer-term treatment.

Assessment

History:

- Ask what the reason is for benzodiazepine use, e.g. to manage symptoms of anxiety, insomnia, pain, or withdrawal from methamphetamine (ice).
- Obtain a history of ***benzodiazepine use.*** Patients may not disclose the full extent of their use initially. Be non-judgmental and encourage honesty.

Benzodiazepine use

- ➢ *Names of benzodiazepines used*
- ➢ *Average dose taken, frequency of use (e.g. 3 times daily, daily, every second day), duration of use, periods of abstinence*
- ➢ *Whether prescribed or non-prescribed*
- ➢ *Reasons for starting*
- ➢ *Past history of seizures, confusion, or delirium*
- ➢ *Other problems related to use, such as work performance, relationship issues, poor memory*
- ➢ *Current goals relating to use*
- ➢ *Past attempts at withdrawal*

- Use SafeScript to view recent usage patterns and identify if other prescription medications are being misused.
- Look for signs of ***intoxication.***

Signs of benzodiazepine intoxication

- ➢ *Poor short-term memory*
- ➢ *Confusion*
- ➢ *Delirium*
- ➢ *Paradoxical agitation*
- ➢ *Sedation*
- ➢ *Slurred speech*
- ➢ *Ataxia*

Confirm dependency, risk categorisation

Signs of dependency

Patients may:

- *feel they cannot cope without taking benzodiazepines.*
- *experience anxiety, insomnia, or become unwell after reducing their benzodiazepines.*
- *feel the medication has less effect over time.*
- *take extra doses during a stressful time.*
- *have increased their dose.*
- *make sure they always have access to benzodiazepines.*
- *find benzodiazepines are interfering with their lives in some way, or taking priority over other activities e.g., time off work, family or relationship problems, difficulty coping, difficulty remembering things.*

- Low risk – not dependent, intermittent user
- Moderate risk – benzodiazepine-dependent long-term user as prescribed e.g., elderly patient using benzodiazepine daily at night
- High risk – benzodiazepine-dependent with ≥ 3 ***complexity factors*** e.g., substance misuse and poly drug use.

Complexity factors

Complexity factor	*Definition*
Poor mental health	• *Kessler Psychological Distress Score (K10) ≥ 30, or* • *presence of serious mental health diagnoses e.g., bipolar disorder, schizophrenia, borderline personality disorder*
Lack of meaningful activity	*Unemployed and not studying or performing home duties*
Housing insecurity	*Homeless or at risk of eviction*
Pregnancy	*Pregnant*
Serious criminal justice involvement	*E.g. on a court order or on parole*
Multiple previous AOD treatment episodes	*> 5 AOD treatment episodes (lifetime)*
Children potentially unsafe	*Clinician concern about parenting capacity*
Significant or serious physical health issue	*Serious physical illness (e.g. liver, cardiovascular, respiratory, neurological disease) that significantly impacts on wellbeing and functioning*

Consider consequences of dependency

Consequences of dependency

- *Diminished capacity to drive or operate machinery*
- *Parenting and relationship issues*
- *Anti-social behaviour*
- *Confusion*

- *Diminished concentration*
- *Associated use of other psychoactive substances*
- *Memory impairment*
- *Falls, cognitive impairment, and delirium in the elderly even at low, long-term doses*[1]

- Withdrawal symptoms may occur after as little as 6 weeks use.
- Higher doses, longer use, and using > 1 benzodiazepine are associated with more prolonged and severe withdrawal symptoms.

Routinely screen for use of other drugs:

- A helpful question may be: "Do you regularly use other substances such as illicit drugs or medicines not as prescribed?"
- If more detailed assessment is required, consider using the eASSIST-lite questionnaire.

Management

Practice Point

Benzodiazepine withdrawal can be complex and lengthy

- *Unlike other drug reductions, the withdrawal symptoms can be worse towards the end of the withdrawal process, meaning that a slower withdrawal process may be required.*
- *It can take up to a year for people to be drug free and in very severe cases up to 2 years.*

Manage based on risk:

Low risk – not dependent, intermittent user

1. *Discuss risk of dependence and importance of short-term use only.*
2. *Provide **alternatives to benzodiazepine***

Alternatives to Benzodiazepines

- *Discuss sleep hygiene and behavioural interventions.*
- *Consider prescribing Mirtazapine 15 mg at night for depression and insomnia.*
- *Consider prescribing Melatonin 2 mg at night in older patients and sleep onset insomnia.*
- *Consider beta blockers (propranolol 20 mg) for physical symptoms such as tremors (which may occur during withdrawal) and for patients requesting medications for performance anxiety e.g., for a presentation or job interview.*
- *See Anxiety in Adults and Depression in Adults for more management tips.*

Moderate risk – benzodiazepine-dependent long-term user as prescribed e.g., elderly patient using benzodiazepine daily at night.

Long term treatment of insomnia or anxiety with low dose benzodiazepines, even at once daily dosing, should be reviewed (there is lack of evidence for long-term efficacy[2]). Consider a reduction plan for this group of patients (e.g., in the elderly).

1. Avoid sudden cessation (cold turkey) as it can be dangerous and is usually extremely painful and distressing.
2. Stabilise the patient's benzodiazepine intake before starting reduction.
3. If the patient is on a short or medium-acting benzodiazepine, convert to diazepam using the DASSA – Benzodiazepine Equivalents table via a gradual, staged process at a rate of one equivalent dose per day.

   Note: If the patient is only taking one benzodiazepine dose at night, do not convert to diazepam as this may increase risk of falls, particularly in the elderly.

4. Begin ***reduction*** at a reduction rate of 10 to 15% every 2 weeks but individualise depending on symptoms. Often the last reduction is the hardest, due to psychological as well as chemical dependence.

   Benzodiazepine reduction

   Benzodiazepine withdrawal can be complex and lengthy.

   - ➢ *Unlike other drug reductions, the withdrawal symptoms can be worse towards the end of the withdrawal process, meaning that a slower withdrawal process may be required.*
   - ➢ *It can take up to a year for people to be drug free and in very severe cases up to 2 years.*

5. Consider the role of other agents and cognitive behaviour therapy for the management of insomnia and anxiety:

   - ***Alternatives to benzodiazepine***
   - ***Analgesics for withdrawal symptoms***

     If the patient is experiencing acute physical pain secondary to benzodiazepine withdrawal:

     - ➢ *use analgesics (with the exception of opioids) according to the recommended dose instructions.*
     - ➢ *encourage alternative pain relief methods, e.g. rest, hot or cold packs, massage, relaxation, and meditation.*

6. Offer to refer all patients for additional supports. If patient has co-morbid mental health condition and is opposed to seeing a drug and alcohol service, consider referral to adult psychological therapies.

7. For benzodiazepine-specific help, refer to Reconnexion (self-referral accepted).

High risk – benzodiazepine-dependent with ≥ 3 complexity factors e.g., substance misuse and poly drug use

1. Consider whether the patient is suitable for general practice benzodiazepine withdrawal (e.g., supportive home environment, engaged, co-operative).

2. Avoid sudden cessation (cold turkey) in known patients as it can be dangerous and is usually extremely painful and distressing.
    - If high-dose benzodiazepine users, sudden cessation may induce a withdrawal seizure.
    - If new patient, consider whether they are drug seeking and manage accordingly.

3. Stabilise the patient's benzodiazepine intake before starting reduction.

4. If the patient is on a short or medium-acting benzodiazepine, convert to diazepam using the DASSA – Benzodiazepine Equivalents table via a gradual, staged process at a rate of one equivalent dose per day. If the patient is taking more than the equivalent of 50 to 80 mg of diazepam daily, reduce the daily dose before converting to diazepam.

5. Begin reduction at a reduction rate of 10 to 15% every 1 to 2 weeks but individualise depending on symptoms (see ***example***). Often the last reduction is the hardest, due to psychological as well as chemical dependence.

Example - Benzodiazepine reduction schedule

A reduction rate of between 10 to 15% of the total daily dose every 1 to 2 weeks is recommended but this should be individualised.

	Morning	***Lunch***	***Evening***	***Total Daily***	***10% Reduction of Total Daily Dose***
Previous dose	*5mg Diazepam*	*5mg Diazepam*	*5mg Diazepam*	*15mg*	*13.5mg (adjust to 12.5mg for practicality)*
Reduction 1	*2.5mg Diazepam*	*5mg Diazepam*	*5mg Diazepam*	*12.5mg*	*11.25mg (adjust to 10mg for practicality)*
Reduction 2 (about 1 to 2 weeks after reduction 1)	*2.5mg Diazepam*	*5mg Diazepam*	*2.5mg Diazepam*	*10mg*	*9mg*

Once the lowest practical dosage is reached e.g., quarter of a tablet three times a day, reduce the dosage to twice daily, then daily dosing until the patient is taking the lowest practical daily dose. The patient can then stop taking diazepam.

6. Consider the role of other agents and cognitive behaviour therapy for the management of insomnia and anxiety during and after withdrawal:
    - Alternatives to benzodiazepines

- Analgesics for withdrawal symptoms

7. Offer to refer all patients for additional supports. If patient has co-morbid mental health condition and is opposed to seeing a drug and alcohol service, consider referral to adult psychological therapies.

8. For benzodiazepine-specific help, refer to Reconnexion (self-referral accepted).

9. Consider seeking advice:
    - If patient is pregnant, contact the Women's Alcohol and Drug Service.
    - If requiring advice regarding management of patients, phone Drug and Alcohol Clinical Advisory Service (DACAS) on **1800-812-804.**
    - If requiring help to reduce patient's doses, contact Reconnexion Anxiety and Benzodiazepine information and counselling service on **1300-273-266.**

Referral

- Offer to refer all patients for management, counselling, and support to either of:
    - Low risk alcohol and drug treatment assessment
    - Moderate to high risk alcohol and drug treatment assessment.
- If patient has co-morbid mental health condition and is opposed to seeing a drug and alcohol service, consider referral to adult psychological therapies.
- Consider seeking advice:
    - If the patient is pregnant, contact the Women's Alcohol and Drug Service.
    - If requiring advice regarding management of patients, phone Drug and Alcohol Clinical Advisory Service (DACAS) on **1800-812-804.**
    - If requiring help to reduce patient's doses, contact Reconnexion Anxiety and Benzodiazepine information and counselling service **1300-273-266** or **(03) 9809-8200.**

Information

For health professionals

Further information

- Australian Medicines Handbook – Benzodiazepine Length of Action Table
- NPS MedicineWise – Sleeping Pills and Older People: The Risks
- Psychotropic Therapeutic Guidelines – Benzodiazepines, Zolpidem, and Zopiclone: Problem Use (subscription required)
- Reconnexion – Health Professionals

For patients

- Reconnexion:
    - Relaxation Techniques

- Hints for Good Sleep
- How to Manage a Panic Attack Cards (available from Reconnexion as wallet size laminated cards)
- What is a Panic Attack and What Helps
- Activities That can Help With Your Depression
- Activities to Help in Withdrawal from Benzodiazepines
- Step by Step Guide to Reducing From Benzodiazepines and Recovery From Withdrawal

- The following resource are available for a small fee for order from the Reconnexion website The Better Sleep Booklet

Sources

References

1. Hill KD, Wee R. Psychotropic drug-induced falls in older people: a review of interventions aimed at reducing the problem. Drugs Aging. 2012 Jan 01;29(1):15-30.
2. Guina J, Merrill B. Benzodiazepines I: Upping the Care on Downers: The Evidence of Risks, Benefits and Alternatives. J Clin Med. 2018 Jan 30;7(2).

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