Benzodiazepine Detoxification and Reduction of Long term Use

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Model of general drug misuse and dependence.
Tactical interventional options

Social dimension

- Increasing breaking of social limits→ education and occupational impairment → life revolves around subculture and procuring supply → loss of other interests

Behavioural dimension

- Impulse to use (peer pressure) → recreational use → escalation of use → compulsion to use (psychological dependence) → cessation → relapse (85%) → eventual permanent cessation

Physical dimension

- Tolerance (depending on drugs)→ physical dependence → withdrawal problems (depending on drugs) → relapse → physical harm → morbidity up, mortality up

Legal dimension

- Primary (Misuse of Drugs Act, 1971)
- Secondary - criminality → thieving, prostitution

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The Current Extent of Long term Use:
Patients Newly Prescribed
Anxiolytic Medicines
1996-2005

A **longitudinal** study in a large primary care population in the UK

Preliminary Results: Donoghue and Lader

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Population

- 100 Practices across UK
- 520 GPs
- Proportion of patients in each UK region matches national picture
- Currently 778,872 patients
- = 1.2936% of estimated UK population

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New Prescriptions

- In 2005, 4,404 patients = 340,444 nationwide
- 1996-2005
- Number of patients decreased by 1.6%
- Number of prescriptions decreased by 7%
- Average doses decreased by 25%
- Average length of treatment decreased by 15%

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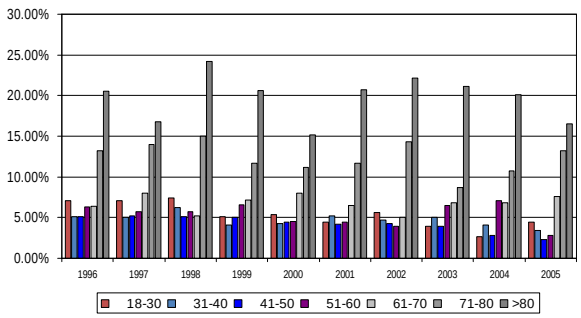
% of patients receiving >3 months treatment by age



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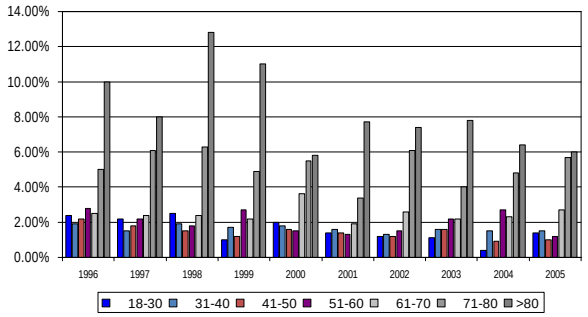
% of patients receiving >1 year's treatment by age



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Withdrawal features with BZDs

1. They have notorious reputation with the public
2. Little or no dose escalation yet physical dependence
3. Characteristic withdrawal syndrome ("sedative/alcohol") - often bizarre symptoms - claims for prolonged syndrome
4. Can be hazardous - fits, psychosis
5. Poor outcome, especially in the elderly

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Withdrawal symptoms

- Frequent: anxiety, insomnia, tremor, irritability, restlessness, dizziness, sweating, nightmares, abdominal pain, muscle stiffness and spasms, mild hypertension
- Serious (uncommon): seizures, confusion, delirium
- Perceptual: tinnitus, hyperacusis, photophobia, depersonalisation and derealisation

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Prevention of iatrogenic therapeutic dose dependence

- Avoid prescribing BZDs in someone with personality disorder, depression or a history of substance or alcohol misuse
- Also avoid in the elderly
- Prescribe for <4 weeks for anxiety and <2 weeks for insomnia
- Document any unavoidable extension
- Use lowest effective dose
- Advise patient of risk of cognitive-psychomotor impairment alcohol interaction, and of dependence
- Consider alternatives – counselling, CBT etc
- Consider other drugs – SSRI, buspirone, pregabalin

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Two groups of patients to manage

- Those taking BZDs for a chronic syndrome but remaining at therapeutic doses (with or without co-morbidity such as depression)
- Those who misuse BZDs by abusing their prescriptions or buying illicitly: usually but not necessarily associated with other misuse, e.g., of opioids

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Strategies for withdrawal from normal dose dependence

- Treat co-morbid medical and psychiatric conditions, especially MDD
- Never stop abruptly unless vital to do so
- Progressively withdraw over several weeks
- Switch to a longer half-life BZD or adjunctive medication

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Management of BZD dependence in non-abusing patients – non-specific

- Only make a diagnosis of dependence if clear evidence of withdrawal syndrome
- In first instance use advisory letters or counselling
- Provide education as to rationale for withdrawal
- Instruct in other therapies such as relaxation (physiotherapist) or counselling
- Consider referral to a patient self-help or group therapy organisation
- Or start CBT if available

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Management of BZD dependence in non-abusing patients – discontinuation

- Ensure that gradations can be small and practicable e.g., liquid preparation
- Some advocate switching to long acting preparation
- Gradually reduce, say 10% every 7 days
- Slow down rate if symptoms become too severe
- Slow down towards end of taper
- Keep in regular contact with patient
- Mobilise family and carers
- Allow very slow taper only if absolutely necessary

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Use of group therapy

Two main approaches:

1. Set up a group at one point in time for a cohort of patients withdrawing simultaneously
2. Conduct an ongoing group so that those who have successfully withdrawn can support those starting the process

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Prevention of BZD misuse

- Assess other substance misuse problems
- Assess alcohol misuse problems
- BZDs are not appropriate in the management of opioid maintenance
- BZDs are used in alcohol withdrawal procedures to prevent seizures – an anticonvulsant is generally preferable
- The ideal is to avoid prescribing BZDs completely

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Management of BZD dependence in abusing patients – non-specific

- Confirm and estimate the size of the problem
- A urine screen (with the patient' consent) may provide useful information
- Educate the patient as to the dangers, particularly of potentiation of drugs
- Treat insomnia with relaxation therapy or CBT
- Signed contracts are fashionable – they carry dubious legal weight
- Educate the patient about what to expect with BZD withdrawal and how to cope with any symptoms
- Regular follow-up

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Management of BZD dependence in abusing patients – specific

- Ensure that gradations can be small and practicable e.g., liquid preparation
- Some advocate switching to long acting preparation
- Gradually reduce, say 10% every 7 days
- Start fairly briskly but then slow down rate if symptoms become too severe
- Slow down towards end of taper
- Allow very slow taper only if absolutely necessary

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Co-morbid alcohol abuse

- Therapeutic dilemma – is BZD use substituting for and sparing the abuse of alcohol?
- Is it the lesser of two evils?
- Should alcohol reduction and eventual abstinence be the immediate goal?

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Reducing supply

- No evidence for effectiveness – cost "on the street" of many addictive drugs is historically low
- BZDs are usually diverted from warehouses or wholesalers

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Reducing demand

- Mainly an educational exercise – not much evidence for effectiveness unless intense personalised treatment, initially within prison system

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Withdrawal problems

- A medical problem
- Generally accepted that treatment starts with detoxification
- Addicts often ambivalent about discontinuation
- Too often no further treatment – inadequacy of resources
- Dependence with BZDs – very common with constant high dose use

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Reducing harm

- Slogan - "Harm minimisation"
- HIV and injecting - changed regulatory and medical attitudes but not enough
- One exercise in reformulating temazepam was a dismal failure
- Overdose – reflects street provenance

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Overview

- Clearly distinguish normal dose iatrogenic use versus high dose non-medical use
- Separate groups into different treatment categories
- Use different facilities
- Try and avoid unnecessary, high dose or prolonged prescription
- Tailor treatment to individual requirements
- Treat co-morbidity early and vigorously
- Mobilize all resources
- Instruct in alternative non-drug techniques for coping with problems and symptoms

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