Benzodiazepine Prescribing Guidelines Work Session

Benzodiazepine Prescribing Guideline Worksession

Facilitated by:
Ben Crocker, Psychiatrist, MMC
James Berry, Physician, EMMC
Gillian Bartlett, Professor, McGill University

Benzos are over-prescribed- and the reasons behind many prescriptions are not evidence based or based on previously published guidelines.

These guidelines have since received feedback from various groups and have been revised and presented at various state level meetings and events.

Goals of the document:

- The primary goal should be to stop people who should not even be put on the drug.
- That section should then be followed with a section describing when benzos might be useful.

Availability of recommendations to physicians:

- Very often this essential information regarding guidelines for benzo use is not available to family physicians where benzos are most regularly prescribed.

What about long term prescription of benzos?

- All of the studies regarding benzodiazepine use are for effects pertaining to short term use (2-6 weeks), however they are not always prescribed that way. Is there enough evidence out there to come up with prescribing guidelines?
- Benzos were designed to be used while patients are waiting for other treatments (e.g. SSRIs, counseling) to be put into place and become effective.
- Research shows that the benefits of benzos are short term. When used for longer term, no studies have shown benefits to a control group.
- The interest in studying benzos is waning, and losing interest for other types of drugs.

Current issues:

- The guidelines were sent to the Maine Psychiatric Association and received LOTS of responses regarding long term benzo prescriptions. These were not well received. Many had a clear lack of understanding of what the guidelines are and their purpose and role in prescription recommendations.
- If the guidelines are not used by the psychiatry profession, there is a concern that patients will shop for their drugs from various psychiatrists if they cannot get them from their primary care.
- Polypharmacy involves more than one physician prescribing the same drug, this has become a huge problem. How should this be dealt with? Patients need a 'medical home'- all prescribing should come from and be monitored and controlled through the same physician.
- These are evidence based guidelines and not an evidence linked guidelines. An evidence linked guideline would demonstrate various links of support. The guideline then receives feedback and is revised- it might be nice to do this, but more help is needed.

"The goal should not be to make people happy, but to make them get better."

What do we do with the guidelines?

- The rate of benzo use is about half that of comparable Medicare use.
- The best use of the guidelines are to serve as a standard for benzo use.
- The guidelines should be set up on summary sheet, including a quick read of just a few steps, do's and don'ts- including how to get patients off of benzos.
- The contraindications should be placed at the front of this document. Section C (med conditions aggravated by benzos) should be put up front.

All of the guidelines should be the same for doctors across all specialties. The hard part will be involving physicians in acute emergency specialties.

Tapering Benzos:

- We need to find out from physicians how easy it is to follow the tapering schedule recommendation. How easily can this recommendation be put into a dosage and prescribed?
- It is often easier to get patients to the point of using a lower dose of benzos, rather than to have them discontinue the medication completely.
- Following tapering schedule recommendations may be easier if patients were referred to a pharmacy that offered liquid compounding.
- Would the section regarding the tapering schedule be better addressed in an appendix to the recommendations? It may be too complicated to address in a single paragraph.
- From a pharmacy perspective, tapering is not hard if explicit directions received from physicians. The schedule can be VERY specific or even a more open ended tapering schedule. It is often hard for patients and doctors to communicate as to what is required and what is working effectively for tapering?
- Successful tapering often requires more than one prescription to complete the process. Physicians should be encouraged to write out the tapering process very clearly so everyone in the office is aware of it and using the same method. It may help to type out a specific list of tapering instructions for the patient.
- Have the dosages for tapering been examined? Often the dosage available is the maximum dosage recommended. This makes it hard for the patients to break it and taper and is recommended. Would having lower doses available in a pill form make tapering easier?

Concerns regarding initial benzo prescription:

- If a doctor feels a patient may have difficulty stopping short term benzo treatment, what is the plan for long term care?
- Before doctors write the prescription, they should consider where this patient will be in 6 months. Will they be following up with the patient again? Is the reason benzos are being considered an acute or chronic problem?
- When considering a benzo prescription, physicians should also consider if there is a history of substance abuse or other health problems.
- The section of the recommendations related to this needs to be expanded.
- Emergency Rooms need to give more informed consent about the side effects and interactions of benzos. If the doctors do not have time to do this with the patient, then other treatment alternatives should be considered.

Psychiatry:

- These guidelines were initiated by a psychiatrist, so that profession has been involved in the development of these guidelines.

Intended audience:

- The guidelines were initially written for general practitioners and psychiatrists.

Finalization and publication of guidelines:

- We are closer to signing now after having these guidelines defined. Patient education especially needs to be a part of these guidelines.
- Having a published set of guidelines will help patients understand the consistency of the recommendations they should be receiving across more than one physician.
- To date, the word 'draft' has been on every copy of these guidelines, nothing has been finalized, and it is always in evolution. Where do we go from here? These guidelines are only as valuable as they are accepted and engaged by the prescribing physicians, the patients and the public.
- We are getting closer to taking the term 'draft' off these guidelines because they are practical vs. other guidelines that are unrealistic. We are encouraged by the fact this is taking lots of time, it is an important matter not to be taken lightly.

Physician alerts:

- The alerts that have been going out are hard on physicians. They only say what they are doing wrong in terms of benzo prescribing without offering an alternative. This document should also include alternatives and safety profiles of alternatives.

Benzo alternatives:

- To what extent is it appropriate to offer fast acting medications vs. trying to struggle to try to find other fast acting interventions that will relieve the same symptoms? Most of the alternatives I am using are not specified for anxiety (such as Trazadone).
- Are we going to wait for someone to bring forth a brand named product to treat what benzos treat, or will we try some clinical trials with other generics to prove they work?
- (Jeff Barkin) Those trials are not going to happen.
- This puts the doctor in an odd situation because there is no evidence.

Benzo prescription and acute patient crisis:

- There is also concern over the prescription of benzos to help patients dealing with short term grief. If these patients in severe need are not given benzos, what could happen to them?
- There is pressure to prescribe benzos when patients are in crisis and at risk for suicide. There are medication alternatives available despite the lack of evidence. Lots of people and money are involved; I wouldn't say that people wouldn't be willing to study these alternatives necessarily. People need more specific alternatives, and we need more evidence for these alternatives. Often the lack of evidence is described as the reason not to prescribe the alternatives.

- If anyone has opinions or anecdotes on this issue please email or contact the group at: www. mainebenzo.org

- A final copy of The Benzodiazepine Prescribing Guidelines is needed, not a draft.