DRUG & ALCOHOL FINDINGS *Analysis*

This entry is our analysis of a document considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original document was not published by Findings; click Title to order a copy. The summary conveys the findings and views expressed in the document. Below is a commentary from Drug and Alcohol Findings.

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Canadian guidelines on benzodiazepine receptor agonist use disorder among older adults.

Canadian Coalition for Seniors' Mental Health
Canadian Coalition for Seniors' Mental Health, 2019

What have Canadian experts judged to be the best clinical practice around the prevention, assessment, and treatment of benzodiazepine use disorders in older people?

SUMMARY The Canadian Coalition for Seniors' Mental Health received a grant from Health Canada to create a set of four guidelines on the prevention, assessment and management of substance use disorders among older people. This analysis outlines recommendations for benzodiazepines and benzodiazepine-like drugs. The guidelines for alcohol, cannabis, and opioids have also been added to the Effectiveness Bank.

The umbrella term for benzodiazepines and benzodiazepine-like drugs is 'benzodiazepine receptor agonists', which have similar benefits, side effects and risks. For brevity, this analysis will use the term benzodiazepines to refer to both.

These drugs have sedative effects, and have been approved for sedation, the treatment of anxiety and panic disorders, seizures, alcohol withdrawal, short-term treatment of insomnia, and the involuntary, continuous contraction of muscles. They are also prescribed for reasons not specifically approved for ('off label' use), for example, to treat anxious depression or the behavioural and psychological symptoms of dementia.

Older people have increased sensitivity to benzodiazepines and decreased ability to process some longer-acting benzodiazepines (eg, diazepam). All benzodiazepines increase the risk of cognitive impairment, delirium, falls, fractures, hospitalisations, and motor vehicle crashes.

A guide to the guidelines

The goal of the featured document was to provide practical guidance for clinicians on either preventing the development of benzodiazepine use disorders or optimally assessing and treating older people who have developed benzodiazepine use disorders. 'Benzodiazepine use disorder' refers to a problematic pattern of benzodiazepine use leading to clinically significant impairment or distress. According to DSM-5 criteria, benzodiazepine use disorder is indicated by the presence of at least two pre-defined symptoms or adverse effects within a 12-month period (unfold the supplementary text). Mild benzodiazepine use disorder is indicated by the presence of 2–3 symptoms, moderate benzodiazepine use disorder by 4–5 symptoms, and severe benzodiazepine use disorder by six or more symptoms. DSM-5 criteria may under-identify substance use problems among older people due to some screening questions potentially becoming less relevant to this cohort (eg, impact of substance use on occupation and social obligations).

Close supplementary text

1. The benzodiazepine is taken in larger amounts or over a longer period of time than intended.
2. Persistent desire or unsuccessful efforts to cut down or control benzodiazepine use.
3. A great deal of time is spent in activities to obtain benzodiazepines, use them, or recover from their effects.
4. Craving, or a strong desire or urge to use a benzodiazepine.
5. Recurrent benzodiazepine use resulting in a failure to fulfil major role obligations at work, school, or home.
6. Continued use of the benzodiazepine despite persistent or recurrent social or interpersonal problems caused or exacerbated by their effects.
7. Important social, occupational, or recreational activities are given up or reduced because of benzodiazepine use.
8. Recurrent benzodiazepine use in situations in which it is physically hazardous.
9. Continued use of the benzodiazepine despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by drug use.
10. Either a need for markedly increased amounts of the benzodiazepine to achieve desired effect or a markedly diminished effect with continued use of the same amount of the benzodiazepine.
11. Symptoms of withdrawal are evident OR the benzodiazepine (or a closely related substance such as alcohol) is taken to relieve or avoid withdrawal symptoms.

Close supplementary text

The quality of evidence for each recommendation in the guideline was graded high, moderate, or low, where:
• **high** meant further research was unlikely to change confidence in the effect of the proposed course of action;
• **moderate** meant further research was likely to have an important impact on confidence and may change the estimated effect of the proposed course of action;
• **low** meant further research was very likely to have an important impact on confidence and is likely to change the estimated effect of the proposed course of action.

The strength of each recommendation was also graded:
• **strong** recommendations indicated high confidence that desirable consequences outweigh undesirable consequences;
• **weak** recommendations indicated that there is either a close balance between benefits and downsides (including adverse effects and burden of treatment), uncertainty regarding the magnitude of benefits and downsides, uncertainty or great variability in patients' values and preferences, or that the cost or burden of the proposed intervention may not be justified.

A separate category was created for recommendations which were not primarily based on evidence, but were agreed to represent **best clinical practice**.

Prevention

Strategies to prevent benzodiazepine use disorders include avoiding the initial prescription of benzodiazepines, particularly if this would place the older person at high risk for harm, and following good prescribing practices where they are used. Older patients need to be well informed and prescribers well trained, and both need to be supported by a healthcare system where non-pharmacological alternatives are readily available.

Recommendation 1. Long-term use of benzodiazepines (more than four weeks) in older people should be avoided in most cases because of the risk of harm posed by the drugs, and the minimal effects in the treatment of insomnia and anxiety disorders and the behavioural and psychological symptoms of dementia.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 2. Appropriate first-line non-pharmacological options for the treatment of insomnia and anxiety disorders include cognitive-behavioural therapy.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 3. A benzodiazepine should only be considered in the management of insomnia or anxiety after the patient has not seen a benefit from non-pharmacological interventions or safer pharmacological alternatives, or for short-term use until more appropriate treatment becomes effective.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 4. An assessment of risk for benzodiazepine use disorder and other potential adverse effects from these drugs should be done prior to prescribing a benzodiazepine.
Consensus that this represents best clinical practice

Recommendation 5. If a benzodiazepine is being considered, the older adult should be informed of both the limited benefits and risks associated with use, as well as alternatives they could take, prior to deciding on a management plan.
Consensus that this represents best clinical practice

Recommendation 6. Initiating treatment with a benzodiazepine should be a shared decision between the prescriber and the older person. There should be agreement and understanding on how the benzodiazepine is to be used (including planned duration of no more than 2–4 weeks) and how use is to be monitored.
Consensus that this represents best clinical practice

Recommendation 7. Older adults who are receiving a benzodiazepine should be:
• educated and provided the opportunity to discuss the ongoing risks of taking benzodiazepines;
Quality of evidence: moderate
Strength of recommendation: strong
• encouraged to only take the benzodiazepine for a short period of time (2–4 weeks or less) at the lowest dose possible to achieve the desired effect;
Quality of evidence: moderate
Strength of recommendation: strong
• monitored during the course of their prescription for evidence of treatment response and effectiveness, current and potential adverse effects, concordance with the treatment plan, and/or the development of a benzodiazepine use disorder;
Consensus that this represents best clinical practice
• supported in stopping the drug, which may require a gradual reduction until it is discontinued.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 8. Health care providers should consider policies to decrease the inappropriate use of benzodiazepines in their practice settings, including medication reviews, prescribing feedback, audits and alerts, multidisciplinary case conferences, and brief educational sessions. Regulators, health authorities, and professional organisations should consult with clinical leaders and older people about how to minimise the inappropriate use of benzodiazepines.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 9. Health care institutions, including acute care hospitals and long-term care facilities, should implement protocols that minimise new prescriptions for benzodiazepines because of the potential for harm and the risk of this leading to long-term use following discharge to the community or other transitions in care.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 10. Health care practitioners, older people, and their families should advocate for adequate access and funding of effective non-pharmacological alternatives for the management of insomnia, anxiety disorders and behavioural and psychological symptoms of dementia.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 11. Clinicians should be aware that benzodiazepines are prescribed more frequently to women and consider the potential role of implicit bias (the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner) in prescribing practices.
Quality of evidence: low
Strength of recommendation: weak

Assessment

Clinicians may underestimate the likelihood of substance use problems among older people, so it is important that they take a comprehensive history of current and past use of drugs, including benzodiazepines.

Recommendation 12. All older people should be asked about their current and past substance use during health examinations, admissions to facilities or services, pre- and post-operative assessments, when considering the prescription of a benzodiazepine, and at transitions in care.
Consensus that this represents best clinical practice

Recommendation 13. Healthcare practitioners should be aware of and vigilant to the symptoms and signs of substance use disorders. Particular attention should be paid to this possibility when assessing common conditions encountered in older adults, such as falls and cognitive impairment.
Consensus that this represents best clinical practice

Recommendation 14. Where a benzodiazepine use disorder is suspected, assessment should include indication (ie, the condition for which the medication is being prescribed), dose, duration, features indicative of benzodiazepine use disorder, readiness to change, and presence of overlapping medical and mental health

problems, including any other past or current substance use or misuse.
Consensus that this represents best clinical practice

Recommendation 15.
• The use of multiple substances is common and should be inquired about for all older people with a benzodiazepine use disorder.
Quality of evidence: moderate
Strength of recommendation: strong
• Health care practitioners should avoid prescribing benzodiazepines concurrently with opioids whenever possible.
Quality of evidence: moderate
Strength of recommendation: strong
• Patients should be advised to avoid taking benzodiazepines with alcohol.
Quality of evidence: low
Strength of recommendation: weak

Management

Even without evidence of a benzodiazepine use disorder, clinicians should opt to deprescribe benzodiazepines in older patients because of the risk of side effects. Deprescribing is the process of ceasing to prescribe a drug, and typically involves creating a plan with the patient to gradually reduce the dose before stopping it altogether.

Recommendation 16. A person-centred, stepped-care approach to enable the gradual withdrawal and discontinuation of benzodiazepines should be used. Clinicians and patients should share in: planning and applying a gradual dose reduction scheme supported by appropriate education of the patient; identifying and optimising alternatives to manage the underlying health issue(s) that initiated or perpetuated the use of benzodiazepines; developing strategies to minimise acute withdrawal and managing previous symptoms that re-emerge as needed; and establishing a schedule of visits for reviewing progress.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 17. Clinicians should avoid the abrupt discontinuation of a benzodiazepine after it has been used for more than four weeks in people with benzodiazepine use disorder due to the risk of withdrawal symptoms, people becoming more reliant on the drugs to avoid symptoms of withdrawal, the re-emergence of previous symptoms, and/or higher likelihood of relapse with resumption of benzodiazepine use.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 18. Management of acute benzodiazepine withdrawal symptoms should be monitored carefully and can be guided by a validated tool, and managed with minimal use of an appropriate benzodiazepine when symptoms of withdrawal develop.
Quality of evidence: low
Strength of recommendation: weak

Recommendation 19. Treatment regimens involving multiple benzodiazepines should be simplified and converted to a single benzodiazepine. The consumption of multiple benzodiazepines can result in exaggerated pharmacological effects, unintended overdosing, and other potential adverse reactions.
Consensus that this represents best clinical practice

Recommendation 20. Clinicians should avoid routinely switching patients from benzodiazepines with a 'short half-life' (they work quickly, but take longer to leave the body) to those with a 'long half-life' (they take longer to work, but take less time to leave the body). However, it may have a role in certain situations, for example when alprazolam is the problem substance [see Public Health England blog on alprazolam].
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 21. Consider the use of psychological interventions such as cognitive-behavioural therapy during efforts to withdraw patients from benzodiazepines as they can improve the older person's experiences and increase the likelihood of stopping benzodiazepine use.
Quality of evidence: high
Strength of recommendation: strong

Recommendation 22. Prescribing a substitute drug to alleviate benzodiazepine withdrawal symptoms is not routinely recommended.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 23. Consider referring to a specialty addiction or mental health service for older people with a benzodiazepine use disorder whose drug use is escalating in spite of medical supervision, who have failed prior efforts to reduce or stop benzodiazepine use, are at high risk for relapse or harm, and/or suffer from significant mental health problems.
Consensus that this represents best clinical practice

The ethical challenges of deprescribing benzodiazepines

If an older person believes they are deriving a benefit from benzodiazepines, they may disagree with a clinician who suggests their prescription be stopped. The perceived benefit may be related to how much they were impacted by the original target symptoms, as well as the degree to which these symptoms improved with the benzodiazepine.

The clinician must consider the possibility of harm from continued use, including the development of a substance use disorder. Although avoiding or discontinuing the long-term use of a benzodiazepine is the recommended course of action for most older people, it is not necessarily the right course of action for every individual.

After considering all perspectives, if the clinician believes that the harms of continuing benzodiazepine therapy significantly outweigh the benefits, deprescribing should be actively encouraged and adopted. Prescribers who are uncomfortable continuing to prescribe a benzodiazepine to an older person do not have a duty to do so, as it is ethically indefensible to provide treatment against sound medical judgement. However, discontinuing a benzodiazepine that has been used over a long period should never be done abruptly.

The authors' conclusions

Concern about the risks of benzodiazepines for older adults has grown in recent years. The developers of the featured guidelines hope to inspire prescribers, health care team members, and older people and their families to support alternatives to these medications. To this end:

- Older adults should be involved in a shared decision-making process about the prescribing and deprescribing of benzodiazepines.
- Older people should be able to access non-pharmacological therapies such as cognitive-behavioural therapy and cognitive-behavioural therapy for insomnia (known as CBTi), in order to prevent the inappropriate use of benzodiazepines and to aid those who are experiencing symptoms of a substance use disorder.
- Hospitals, other health care facilities, community-based agencies, and their quality improvement teams should routinely explore the impact of care transitions on prescribing patterns.

FINDINGS COMMENTARY Insightful comparison adding value to the commentary on alcohol from the Canadian Coalition for Seniors' Mental Health, the featured guideline on benzodiazepines contained considerably more recommendations based on *expert consensus*, rather than *evidence* that they constitute the best clinical practice. This highlighted the lack of evidence in certain areas, and the importance of guidance such as this for exposing gaps in knowledge and raising awareness of benzodiazepine use disorders among older people.

For their 2007–2008 "Inquiry into physical dependence and addiction to prescription and over-the-counter medication", the All-Party Parliamentary Drugs Misuse Group received evidence from across the healthcare, pharmaceutical and drug treatment sectors as well as from support groups and people with experience of substance use problems and substance dependence. More than half of the evidence related to concerns about benzodiazepines and other classes of tranquillisers. On the topic of benzodiazepines, the report set out two problems: the first related to people prescribed benzodiazepines; and the second referred to people (mis)using the drugs outside of a medical context, often with other illicit drugs. The scale of benzodiazepine dependence was thought to be very high, affecting an estimated 1.5 million people in the UK.

According to a 2017 study, which extrapolated the findings of a sample of patients in GP surgeries to the entire patient population in England, more than a quarter of a million people (296,929) may have been taking prescription benzodiazepines for longer than the recommended time (more than four weeks). Of these, as many as 119,165 patients could be willing to accept support for withdrawal. Using national prescribing data in Scotland to examine the problem for adults over the age of 65 in 2011, a study found that benzodiazepines and benzodiazepine-like drugs were commonly prescribed for older people, with care home residents approximately three times more likely to be prescribed them than non-care home residents (free version available at time of publication). A report on patients receiving specialist treatment for substance use problems in England during the financial year 2016/17 (other than those treated in prisons), revealed that 7% had a known problem with benzodiazepines, and the rate was slightly higher at 11% when looking at patients with opioid use problems.

Whether prescribed by clinicians or accessed by people on the illicit market, their sedative effect means that benzodiazepines can be particularly dangerous when consumed along with opioids – increasing the risk of a fatal overdose (1 2). Therefore, while the focus of the featured guideline was on addressing the inappropriate prescribing of benzodiazepines and substance use disorders stemming from the misuse of benzodiazepines, the broader significance is that this work adds another string to the bow of overdose prevention.

Last published in 2017, there is no more important document for UK clinicians involved in treating problem substance use than the so-called 'orange guidelines', which includes a section on how to treat older people. From page 119 the guidelines discuss the pharmacological management of dependence on benzodiazepines.

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