SOMETHING FOR THE PAIN

EPISODE 29: Surveying Substance Use Disorder: Benzodiazepines

(30 mins)

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[cue guitar music]

[Sam Steffen]

This is *Something for the Pain*, a podcast produced by Project ECHO Idaho, made for Idaho's healthcare professionals working to prevent, treat, and facilitate recovery from opioid and substance use disorders throughout the Gem State. I'm your host, Sam Steffen.

theme song

Today we're continuing our theme of 'Surveying Substance Use Disorders' and are going to be talking about Benzodiazepines. This episode features a presentation by Nari Hsiu, Psychiatrist and Addiction Medicine Specialist at the Boise VA Medical Center titled "Tapering Off Benzodiazepines: The How and Why." While Dr. Hsiu is employed by the Boise VA Medical Center, she would like listeners to know that her opinions are expressly her own and do not represent those of the Boise VA Medical Center. This lecture was recorded on Nov. 11, 2021 as a part of ECHO Idaho's Opioids, Pain and Substance Use Disorders series. Here to introduce today's presenter is former ECHO Idaho director, Lachelle Smith.

[Lachelle Smith]

Welcome to ECHO Idaho Opioids, Pain and Substance Use Disorders, my name is Lachelle Smith, will facilitate the conversation today. So today our talk is brought to us by Dr. Nari Hsiu, a psychiatrist and addiction medicine fellow, on "Tapering Off Benzos: the How and Why," so we will give the floor to Dr. Hsiu.

[Nari Hsiu]

Alright, thank you. So I am Nari Hsiu, I'm a psychiatrist and addiction medicine fellow at UW here in Boise. And today we are talking about tapering off of benzodiazepines, focusing on the how and the why.

So learning objectives: so we're going to review the scope of the problem; identify the risks of benzodiazepine use; review some of the indications for tapering folks off of benzodiazepines; discuss ways to begin the conversation of benzodiazepine taper, which I think is pretty relevant, clinically, for a lot of us, and the most challenging aspect in a lot of ways, for benzo tapers; and then discuss kind of the pharmacological techniques for tapering people off of benzodiazepines.

So here's a little bit of a timeline for benzodiazepine prescribing. So in 1960 Chlordiazepoxide, also known as Librium entered the market, and benzodiazepines kind of as a class became commonly referred to as a minor tranquilizer. They were considered at the time kind of compared to other medications being used to have less serious side-effects, less toxicity, less potential for abuse and less

potential for physical dependence and even suicide risk. So they were kind of deemed safe at that time. As we kind of continued to prescribe them into the 1970s, we saw that these were really heavily prescribed; they were considered the most prescribed medication in the world by the time we hit the 70s. And then in 1975, the FDA said, "Woah, woah, woah, woah, woah—hey, wait a minute! We're starting to notice some prevalence of abuse with this medication, misuse, and some serious side effects going with the medication…" and kind of the pattern of prescribing that was happening. And then by 2016, the FDA placed black-box warnings on benzodiazepines that they are not prescribed to patients also using opioids due to the very high risk of overdose death, respiratory depression and other serious interactions. So really over the course of like 40-50 years, we see kind of these medications hit the market, really be effective, and then people start putting the breaks on them because we've been kind of overprescribing and maybe getting people into some stickier situations that we had intended to in the 60s.

So here are some of the trends and some of the language that we use for benzodiazepines. Long-term use is defined as more than 2-4 weeks, but people often are prescribed these medications for months or years even, or even decades. Prescription use from 1996 to 2013 has increased from 4.1% to 5.6%. You see that ambulatory visits for benzodiazepine prescribing have increased from 27.6 million in 2003 to 62.6 million in 2015. We're also seeing this increased rate of overdose deaths from 1996 to 2010, where there's the 0.58 per 100,000 adults, which is now 3.07 in 100,000 adults. So we're definitely seeing higher overdose deaths associated with benzodiazepine use. And then in 2017, 11,500 of those overdose deaths involved benzodiazepines and 85% of those also included an opioid. So this talk is not going to focus on opioid de-prescribing; certainly that is an area of concern. But when we look at benzodiazepines, we certainly see that we're putting folks at increased risk of overdose potential and death, especially with concurrent opioid use.

So one of my areas of focus is in addiction medicine so I want to kind of address how benzodiazepines can be correlated with addictive behaviors. You know 58-100% of people prescribed chronic benzodiazepines become physically dependent, so that's one reason to be very cautious because of that kind of physiological change that happens. And then 5-10% of those folks will develop a substance use disorder, so they'll meet DSM-5 criteria; and then 50% of patients with a substance use disorder history will develop a benzodiazepine use disorder. So this gets a little bit risky when we're talking about using this medication for people who are even naïve to stimulants or anxiolytics and people who have a history of substance use. Benzodiazepines are themselves not often the primary substance that's being abused; oftentimes alcohol is involved. Opioids, like we had said before, and stimulants, can be comorbid, so we always want to screen for any other use disorder, especially with those other high-risk ones. And then physical dependence can develop within weeks of starting. Now, certainly this depends on the patient, kind of how much they're taking, how long they've been taking it for, but if someone is taking a benzodiazepine chronically, daily, for a significant length of time, they really can develop that addictive and physical dependent aspect to the medication.

This is from The National Institute of Drug Abuse, kind of detailing how we have slowly kind of increased the number of deaths involving benzodiazepines since 2001 and then taking us up to 2014. There is more evidence, like we talked about, with having a high rates of benzodiazepine overdose deaths in 2017 so this scale is slowly kind of just climbing, unfortunately, so we have to get this onto our radar of just like, "Okay, something is not working…" in terms of how we're prescribing and how these medications are being used concurrently with other very dangerous medications and/or alcohol.

So let's address some of the risks of benzodiazepines. I'm sure folks know quite a few of them. This is stuff from VA Academic Detailing and really this is stuff I caution my patients about, you know. The big ones: when you're using a benzodiazepine just having that sensation of feeling very tired, very drowsy, sedated, having trouble with thinking, cognitive processing, it get slow, you get forgetful, and then certainly we see a lot of mood change related to benzodiazepine use, so kind of worsening of anxiety, worsening of depression, irritability, anger outbursts—those are all fairly well associated. And then we know now—there's a lot more evidence coming out—that benzodiazepines exacerbate PTSD symptoms, so those really classical symptoms of nightmares, and hypervigilance, hyperarousal, inability to process those past events—benzodiazepines actually become a barrier to treatment. And so we always caution our folks who have a diagnosis of PTSD that, if they're on a benzodiazepine, this is making their PTSD symptoms worse and preventing them from recovering adequately. And then certainly there's the aspect of becoming physically dependent and having withdrawal symptoms, COPD and sleep apnea, risk for pneumonia, car accidents, unsteady walking, increased risk of falls…I always tell my patients who are older than 65 that their risk for falls is a lot higher with benzodiazepine and you know it's just one of those things that we just kind of caution folks about for keeping them off the medication or at least reducing or tapering off the medication. And then certainly overdose risk, like we've talked about. And then risk for birth defects or infants needing emergency care because of withdrawal symptoms.

So you know when we're talking about benzodiazepine, we're really working with patients to kind of establish a risk versus benefits analysis. You know this is obviously kind of primed to say obviously the risks outweigh the benefits and while certainly there areas where the benefits can really kind of more or less outweigh the risks, those can be few and far between, and it's for a very kind of select population in mind for folks who would be appropriate for kind of long term use of benzodiazepines. We often talk about the benefits of benzodiazepines being that like short term acute relief from symptoms. And benzodiazepines are really effective, otherwise they wouldn't really be around and kind of prescribed so often in our patient populations, but certainly long-term use, we see all these other features that get us really worried as clinicians. And so we're kind of being really mindful of educating and kind of providing that perspective for our patients.

So, I'm going to state this again because I think it's really important to hear, but overdose deaths have a high prevalence of opioids and benzodiazepine prescribing with 30% of all overdose deaths in 2010 involving a benzodiazepine and then 77% of benzodiazepine overdose deaths involving opioids. So they go hand-in-hand.

So why would anyone use a benzodiazepine if there's, you know, so many risks involved? This came out of the National Institute of Drug Abuse that 46% of folks do use a benzodiazepine to relax or relieve tension; a fair amount of them, 22% use it to help with sleep; and then a fair portion of them also use it to help with emotions, which is a very broad category in my mind, so I think this is referring more to anxiety, depression, panic disorders, panic states; to get high; and then there's a small portion of people that do it to experiment and small slices of people who do it to increase or decrease the effects of other drugs. So we often see people who are maybe on stimulants, that are you know having insomnia or feeling too anxious on the stimulant and to counteract that they take a benzodiazepine so they kind of level-off.

This is from an article by Robert DuPont called "Just Say No to Benzodiazepine Prescribing in Substance Use Individuals," where I kind of pulled some quotes that I thought were relevant. So…

"…benzodiazepine use for individuals in recovery is playing Russian roulette. Some survive the gamble at least for awhile, and many do not."

And I think this really kind of infers the idea that folks with substance use disorders are at high risk for getting themselves into a spiral of using another medication—either a benzodiazepine or something else—to kind of become physiologically dependent on and then addicted to. And then I like this piece, too:

"…anxiety is not a benzodiazepine-deficient disease."

You know, humans are not kind of born without benzodiazepines in their system and like need it like a vitamin or a supplement. And in some ways it may feel like we are a benzodiazepine-deficient society, but physiologically we're not born benzodiazepine-deficient because it's not a normal supplement that we need to have in our diets necessarily to kind of treat anxiety. And I think this kind of points out that there are other ways that we should be identifying to treat anxiety, insomnia, and other disorders that may be kind of masked by a benzodiazepine.

So why would we taper anyone off of a benzo? Well, because it's high-risk for overdose; high-risk for misuse; high-risk for abuse-potential. And it's not recommended for people who have comorbid diseases and we generally want to be cautious in the elderly, we want to be cautious in people who are on concurrent chronic opioids and the risks really generally outweigh the benefits for long-term use. We're seeing that more and more and the evidence is bearing that out. It's an important reminder that long-term taper may be appropriate in all patients on long-term therapy and just to be really mindful that once people have been on a benzodiazepine for decades, it's kind of expected because of the physiological changes involved that it's going to take a long time to get them off the medication.

So in my line of work, I have hard conversations with people a lot of the time. One of the ways I think we can be successful doing this is by kind of doing all the things like meeting people where they are, building rapport, kind of setting expectations, and then really getting to the root cause for what people are concerned about in terms of getting off of a benzodiazepine. And that can apply to any medication that you're concerned about for people taking or kind of thinking like, this is dangerous and probably we should be decreasing this medication and getting you off of it.

So building rapport, for some people, is easier said than done. But it's really important to kind of have that relationship with your patient, to kind of have that trust instilled into the room before you kind of start saying, you know, "I'm going to take this medication away from you because I think it's not indicated…" So having that trust set up.

And then setting expectations early-on with patients; so when you're first meeting with someone and they are already being prescribed a benzodiazepine, letting them know, like, "Hi, I don't prescribe Xanax," for example, you know, "I am more than happy to help you to stop taking this medication or figure out other ways to manage your anxiety or whatever symptom it is that we're treating…" and then kind of putting the plug in, too, like, you know—we—me, you, the team of us—we're going put together a plan to get you off of this medication that's safe and also treating the underlying condition.

And certainly you want to provide education about anxiety disorders because these are the most common reasons that people are prescribed benzodiazepines and you want to provide information about benzodiazepine use in terms of treating anxiety disorders and how in the short-term you get relief

from the anxiety when you get a benzodiazepine in your system, but unfortunately as the anxiety gets worse and you use the benzodiazepine more you become reliant on it and then your risk for all the other things that we talked about increases and the system of avoidance gets perpetuated and we end up getting into a bigger problem that we're trying to get out of.

Certainly I talk to my folks who are over 65 about kind of the loss of autonomy that's put at risk, so if you fall when you're elderly, that sets you up for a plethora of medical problems and if we're putting you at increased risk for falling, we're also putting you at increased risk for losing your autonomy at an earlier age than maybe you had planned. And so kind of setting that frame in people's mind, like, you know, this is a medication that's actually going to kind of worsen the aging process in some ways for you, like it's just going to make it harder for you to deal with some of the changes going on for the changes with your cognition, changes with your memory, risk for falls and really puts you at risk for being more dependent on others sooner than you had planned.

What I like to tell people when we're discussing getting them off of benzodiazepines is focusing more on the behavior than on the guilt aspect of, you know, "you're just using these to get out of a situation…" So I usually say things along the lines of, you know: "What your benzodiazepine use is telling me is that your anxiety is not getting better and we're not treating it right and we need to find an alternative way to manage your anxiety," if that's the situation, "…in order to reduce your risk for falls, cognitive impairment and dependence on this medication." So this is like kind of my general spiel, and the reason I use this is because it really puts the onus on the team, you know, you want to be collaborative, you want to understand where they're coming from and really identify what's going on that could be helpful to get them off the medication and identify other ways to treat their anxiety. This is all easier said than done.

So this is from VA Academic Detailing it's kind of a step-by-step outline for ways to approach the conversation. I like this because it's kind of a nice little script that you can use. So kind of expressing concern, providing that education on the potential risks, and assessing where they are in terms of readiness to begin the tapering process and then kind of negotiating that plan.

So once you have agreed with the patient on tapering off a benzodiazepine, you want to agree on the timing and discuss some of the symptoms that you anticipate patients having when they're on the taper and really letting them know that those symptoms are temporary. They're going to last for a few days, maybe up to a week depending on how long they've been on it, how long your taper-protocol is, but just to really set that expectation so that way they're not thinking you know, "I have to go back to using my medication right away because now I'm just feeling much, much worse off medication and this is not working for me." Generally you want to have a slow taper to decrease those withdrawal symptoms. And, if they start having distressing symptoms, you can adjust the taper, you know, you can collaborate with the patient, it doesn't have to be completely formulaic, following one outline that would work for someone else, it should be individually tailored. So some of the things you want to let your patients know about is that some of the withdrawal symptoms in the first 1-4 days are really going to be that rebound anxiety and insomnia, those are going to be the most prevalent. So just kind of setting expectations, you know, I often tell people to start tapering on the weekends, so you're not going to work having the rebound anxiety and insomnia because you can at least rest on the weekends. And then for the following 10-14 days, kind of let them know about some of the more full-blown withdrawal symptoms where they have really severe sleep disturbance, irritability, panic attacks, tremor and

worsening of anxiety and insomnia. And that might be an indication that you have to slow the taper down. And then more than 14 days or two weeks later, you might actually see an unmasking or a return of the baseline anxiety symptoms and this can actually be really important diagnostically because then you can treat them with a medication that's more appropriate for long-term use. Always provide reassurance that their symptoms will resolve because this is kind of going to be a little bit uncomfortable for the beginning, and then you know hopefully will taper off and then get better as you go through the taper. Certainly you want to consider a higher level of care if you're not able to manage them as an outpatient, so you could consider psychiatric hospitalization if it's someone with concurrent alcohol use or other psychiatric disorders that you're worried about them decompensating. You know, you kind of want to have that discussion with the patient and that's really on an individual basis. And then a nice principle to go by is to use a benzodiazepine with a long half-life to prevent some of those rebound anxiety symptoms, the insomnia and those discontinuation symptoms.

So benzodiazepine tapering can be uncomfortable and unfortunately there's very limited evidence for adjunctive agents. Like I said earlier, if they're having those symptoms you can just slow down on the taper; you know, gradual taper is preferred because you don't want them to think that they need to go back onto the benzodiazepine because that's the opposite direction of where you're trying to go. There are some medications that have been helpful in kind of managing the symptoms, so Carbamazepine may be helpful—there's limited evidence—but this is a medication you do have to be very careful with genetic testing for certain populations so you have to get it HLAB1502 testing for so you don't precipitate Stevens-Johnson Syndrome

[Sam Steffen]

For listeners who may not be familiar with this disease, Stevens-Johnson Syndrome is a rare, serious disorder of the skin and mucous membranes, usually caused by a reaction to medication that begins with flu-like symptoms, followed by a painful rash that spreads and blisters.

[Nari Hsiu]

Gabapentin, pregabalin can be helpful kind of as conjunctive medications for the anxiety and the insomnia; melatonin for insomnia, for sleep; trazadone, also, for the insomnia; and then hydroxyzine kind of as a PRN medication to help with the anxiety, so you know—it's very patient dependent.

Certainly we want to kind of maximize some of the non-pharmacological options for addressing the symptoms related to benzo withdrawal; so if folks are experiencing insomnia, nightmares, sleep disturbances, always review sleep hygiene. It seems really basic but you want to kind of go back to the basics with this. So, avoiding stimulants before bedtime, avoiding TV, blue light, phones, you know, reserving the bed for sleep and sex, getting out of the bed after 30 minutes if you're still awake, making sure that people are kind of calming down into the evening instead of ramping themselves up. You want to make sure, too, that when you are tapering that you're scheduling most of the benzos at night during the period so that way you get kind of more bang for your buck. Certainly if you need to and people need to have coverage in the daytime, you can do that, but it's kind of nice to increase the dose or have higher doses at nighttime than in the morning so that you're really maximizing the effects of the impact.

And then certainly with anxiety symptoms and panic attacks, having some psychological techniques, getting folks involved in individual or group behavior therapy or cognitive behavioral therapy can be

really helpful. Having people do physical activity, aerobics, walking, swimming, yoga, meditation, acupuncture, those are all great techniques to getting people to kind of learn how to address the anxiety in a different way.

So going back to kind of that 14 day period off of benzodiazepine, so when you're tapering and you start to unmask some symptoms of anxiety and some symptoms of insomnia. Certainly for anxiety if you're feeling like this person meets criteria for something like a panic disorder or generalized anxiety you want to start looking at medications like SSRIs, SNRIs, buspirone is great for generalized anxiety disorder, hydroxyzine, pregabalin, and then also kind of doing a two-hit punch—medications and therapy. Getting people involved with cognitive behavioral therapy or exposure therapy to really kind of treat that underlying anxiety disorder because these are going to be more of the long-term solutions rather than kind of that short burst of treatment that the benzodiazepine offers.

And then for insomnia, you want to make sure that you're not missing kind of a sleep disorder. So if somebody has primary insomnia, which is fairly atypical, you can use CBT-I, there's CBTI-coach, which is an app that came out from the VA, that just has like journaling and a lot of psycho education about insomnia, and then you can get folks involved in brief behavioral therapy. And then certainly there's medications that can help with that, too. So doxepin, which is a TCA, and then non-benzodiazepine medications like zolpidem as options.

So when you are tapering, this is kind of the nitty-gritty portion of it, there's a couple different ways that you can approach it. So there's short tapers, over the course of 4-6 weeks, or there's long tapers over the course of several months to years, really depending on the patient. So if you're going to do a shorter taper, you just want to kind of decrease the dose by 50% over the first month and then kind of hold for a little bit at 50% of that dose for awhile and then start to kind of start to chip away every two weeks by 25%. You want to make sure though when you're doing these tapers that you're always using the original dose amount as your starting point and you're not using the dose that they're going from after that and calculating from there because then that gets really messy. Longer tapers, there's a lot of practice variation, you can do 10-25% dose reduction over the course of like 2-4 weeks. I prefer this, you know typically I'll convert people over to clonazepam because it's longer acting and there's less withdrawal symptoms or discontinuation symptoms. And we'll just do like a very very slow taper so it's comfortable, so people aren't feeling like they need to have another medication. So we're kind of, hopefully, we're not dropping the ball on them.

Some kind of general tips—you can begin the taper with a benzodiazepine that is being prescribed. If they're not able to tolerate the taper with a short-acting benzodiazepine like Xanax, you can certainly switch to a longer-acting option. This here is nice, using diazepam for younger adults and then lorazepam for adults age 65 and over. A slower or longer taper schedule is recommended in most cases, so really kind of emphasizing that. And the rate of benzo taper should ultimately be determined by the patient's symptoms, so really checking in with patients, making sure that they have a way to access you and kind of know what to go back to if they're not feeling like that medication or that dose adjustment is working out for them. An alternative way that I like to do for tapering people off their medications is reduce the actual total number of tablets that a person will have for a month, so if they get 30 tablets of .5 of Klonopin in a 30 day period, you can just decrease it to like 20 tablets and say, "Okay, you've got these 20 tablets, you know, over the course of the next month what you can do is just on the days that you feel like you want to do this, you can take the medication. But you're not going to get a refill until 30

days after and even then we're going to start decreasing it from there." I like this method because it really puts the onus on the patient to decide when they're going to take the medication, for them to be responsible for when they're going to take it, and then known, you know, that they only have x amount of the medication remaining. So it's kind of for a specific patient that you feel like has that kind of buy-in and really wants to manage their medications on their own and that you have a good rapport with, but I think it can be really helpful to kind of build that kind of collaborative like "I'm providing this medication for you but you're the patient and you're in charge of your body, and I'm letting you be autonomous."

So some key points: if you don't start a benzodiazepine you don't have to taper a benzodiazepine. Make sure that if you are starting a benzodiazepine that you have an exit plan. You know, always educate your patients that you're going to do short-term benzodiazepine treatment, you know, 4-6 weeks and then we're going to stop after that. If we need to we can taper and it will be a very short taper. And then just kind of have that clearly defined and discussed with the patient. You know, really important to know that abrupt discontinuation of benzodiazepines can be dangerous and extremely uncomfortable. Gradual taper is preferred over augmenting withdrawal symptoms with other medications because then you're kind of running the risk polypharmacy, and then really essential to set clear and consistent boundaries, expectations and instructions regarding benzodiazepine tapers.

[Lachelle Smith]

What questions do folks have about benzo tapering generally or anywhere else you want to take it?

[Neil Ragan]

I'm curious as to whether…

[Sam Steffen]

Speaking here is Dr. Neil Ragan, family medicine physician at Health West in Pocatello and regular participant at ECHO Idaho.

[Neil Ragan]

any of the providers in today's crowd have had the experience where somebody has come back to them and said, "Doctor, I am so grateful that you took me off my benzo." I'm still waiting for that patient, personally, and—does that ever happen?

[Jessica Bringman]

I did, just recently.

[Sam Steffen]

Speaking here is Jessica Bringman, nurse practitioner in Idaho and an ECHO Idaho participant.

[Jessica Bringman]

I had a sixty-some year-old female that presented and she had been on clonazepam for several years and she was also on three anti-depressants and I talked to her about the risks of long-term benzodiazepine use and she was like, "take me off of these, now!" And so we started a slow taper, I didn't make it fast, and she ended up tapering herself faster than I had originally wanted to taper her

and she's been off of it…she's had no requests to go back on it, and she's had some significant anxiety-provoking things that have gone on since she's been off of it, but she's still happy that she is not on it. And she told me, she said, "I did not understand how much of a fog I was in!" So she's thankful that she's not taking it anymore.

[Julie Wood]

I also have, but it's been very, very few.

[Sam Steffen]

This is Julie Wood speaking here, an Idaho physician and Medical Director at Optum Idaho—also an ECHO Idaho participant.

[Julie Wood]

I would say that my experience was very similar—in that you just build that rapport, you work with them, you let them know you're there and that you're going to do this slowly. And I again have had a couple of people that say they actually feel better, they don't feel as tired, they don't feel as foggy, but I've also on the flip-side had many people file formal grievances because of my practices, so it's hit or miss.

[Neil Ragan]

For me, getting the buy-in is the hard part. I always feel like I'm dragging this patient to a place that they don't want to go and they're resisting all the way, and these are not contentious relationships, I mean, I feel like I have good relationships with these patients, but I always feel like I'm the one that's pushing them and they're resisting…and of course, every other medication that you throw at them they've tried and it doesn't work and so-on and so-forth, and they come back with, "Well, this is the only thing that allows me to function, you know, I'm able to work, I'm able to do the things that I need to do to get through life…why are you taking this away from me when nothing else works?" And so I struggle with that piece of it.

[Lachelle Smith]

Jake, what would you say to that?

[Jake Harris]

I think that's the more common thing to happen.

[Sam Steffen]

Speaking here is Jacob Harris, Psychiatrist at the VA Medical Center in Boise and a panelist for ECHO Idaho's Opioids, Pain and Substance Use Disorders series.

[Jake Harris]

Several years ago the VA did an outreach where they sent people letters who were on benzodiazepines who were either on opioids in conjunction with that or were over 65, and I was like, "Oh, that's a great idea…none of my patients are going to respond because if they're still on a benzo, I've already had this

discussion." Lo and behold, like a week after the mail-out goes out I see a patient and he's like, "I can't believe that you didn't tell me about all these things with this benzo, I want to get off of this." And so it was a good reminder that I probably didn't have the discussion overtly enough and often enough with this person and had kind of given up and said, "Here's your benzo, in this case you don't have anything else going on, we'll just keep it going…" and then he was able to taper off and actually did pretty well. But I think the vast majority of people are more in the category of even if they agree to it, they will get to the point where they say "Yeah, I still wish I could be on that benzodiazepine, it tends to work better." And I think that speaks to the power of a benzodiazepine—it is an incredibly effective medication and once someone has had that as the medication, other things to target anxiety don't work as well. And I think that's the biggest risk in starting it, cause it's not going to happen to every single person that they become addicted, that they start having behavioral issues related to it, but what will happen is that it's a lot harder for anyone who's been on a benzo to go to anything else to target their anxiety. I think that is also one of the very common things that we see, is that someone will come in and say, "This is the only thing that works and here's how terribly I'm doing in my life." So both at the same time, I got to be on this and my life is terrible. So they're either saying I need more or they're saying I need to do something more, and I really like to point that out to them, that, "Yes, you're on this medication and yes, it's working, and I'm not going to argue that this medication doesn't work for you, but what I am going to point out is that you're not in a great place and I think we can get you to a better place in the long-term that will either include less benzodiazepine or maybe not any benzodiazepine at all and it will take time and it will take effort and it will be a little bit rocky, but we can get you to a better place than you're currently at…" And that's usually where I get the most buy-in from people, where they can kind of recognize, "Oh, yeah, I'm not like where I want to be, anyway, so it's not like I'm going from perfect to going off the med and being horrible, I'm going from already-in-distress-all-the-time and maybe I can get better."

[Julie Wood]

I think sometimes kind of coming at it as a harm reduction approach, too, is…okay, maybe we can't get you off completely but if we can decrease how much you're using, and look at the potential benefits around that, that can sometimes be helpful for patients as well—or I've found that in the past.

[Jake Harris]

And I completely agree on that. I've had patients that have panic disorder that when they came to me they were on high dose of alprazolam and that's it and the one I'm thinking of is still on alprazolam, we've gotten him down to about 50% of what he was on, but we've started an SSRI an slowly titrated it, so over time I still have this patient on a dose of Xanax or alprazolam that I'd like to get lower, but he's on a significantly lower dose than he was several years ago, and he's doing better.

There's a question in the chat that I think we could address—

[Sam Steffen]

ECHO Idaho sessions typically feature multiple participants joining live via Zoom. One of the benefits of attending live is that participants can easily ask questions in Zoom's chat feature to receive answers from ECHO panelists and presenters, just like Dr. Harris is addressing here.

[Jake Harris]

"How strong is the recommendation to taper a non-benzo receptor agonist, meds like zolpidem?"

So the hypnotics, the z-drugs—that include zolpidem and zaleplon —they hit a different area of the brain, they're not as generalized as the Gaba-agonists like the benzodiazepines, and the biggest issue with them is that they've never really been tested long-term and so people do become pretty tolerant to them quite quickly. And I think that's the biggest thing that we know, is that the tolerance to it. We also know that hypnotics are associated with amnestic events so if someone takes it and then they don't go to sleep then they do things and they don't lay down that memory of it happening, and that's one of the risks. And then you know the risks in PTSD, the risks in trauma, the risks combined with opioids—they're there, but they're not as strong as with the regular benzodiazepines. I kind of lump them together with an asterisk. If we're really addressing insomnia, I will try to get something else that's going to be more helpful than those medications and I will try to use them only short term, but mostly because they just lose their efficacy over the long-term.

[Lachelle Smith]

When are you reaching for benzos, or are you? Short-course, long-course, break your anxiety?

[Jake Harris]

There are definitely times where benzos can be appropriate. Psychotic patients, absolutely. Short-term—someone died in the family and someone's not sleeping, that's a great time for a hypnotic like zolpidem to be used. A stressor in life that comes up that causes somebody to be really panicky but is expected to be short-term, that's when it's good to use a benzo. When it's not great to use a benzo is when they come in and they say, "My sleep has been terrible for 20 years and my anxiety has been terrible for 20 years." You're not going to start a benzo and get them off of a benzo. It's going to work so well that they're going to be like, "this works!" and then you'll run out of options down the road. So those are the patients that I would be more cautious in. So when you start an SSRI you start low and go slow in anxiety because you can have a temporary increase in anxiety and restlessness and those are the cases where you can use a benzodiazepine for a short-term period. If you do that I strongly recommend that the patient knows that it is a short-term prescription only to target anxiety right now while we get this medication going and within 2-6 weeks we are going to stop this medication and not continue it. That is the discussion that I have with patients when I start it in those cases.

[Lachelle Smith]

Thank you. Nari, do you have anything you want to add?

[Nari Hsiu]

No, I totally agree with that. Dr. Harris nailed it.

Music

[Sam Steffen]

That again was Nari Hsiu, DO, Psychiatrist and Addiction Medicine Specialist, VA Medical Center, Boise presenting "Tapering Off Benzodiazepines: The How and Why" That lecture was recorded live on Nov. 11, 2021 as a part of ECHO Idaho's Opioids, Pain and Substance Use Disorders series.

If you'd like to watch the Zoom recording of that presentation, that video is currently available on the ECHO Idaho YouTube channel, which you can access through our website. The PowerPoint slide deck as well as information about how to contact some of the organizations and services mentioned in that talk, are available in our podcast show notes, on our podcast webpage: www.uidaho.edu/echo-podcast

Banjo music

If you're interested in joining our free, live ECHO sessions to receive Continuing Education credit, learn best practices, ask a question or grow your community—please visit our website at www.uidaho.edu/ECHO where you can register to attend, sign-up to receive announcements, donate, and find out more information about our programs.

[Fade out banjo music]

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[cue guitar strum and guitar theme w/ lyrics in background]

We here at ECHO also want to hear your feedback. We welcome your questions, comments and suggestions and invite you to email us at echoidaho@uidaho.edu. And don't forget to subscribe to Something for the Pain using your podcast app. And if you have a moment, write us a review!

[bring up theme song lyrics and chorus until first "echo Idaho", then drop volume and continue playing]

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The contributing voices on today's episode were those of: [Nari Hsiu, Lachelle Smith, Neil Ragan, Julie Wood, Jessica Bringman, and Jake Harris].

We'd also like to thank all of our listeners, without whom none of this would be possible. Without you, we'd just be talking to ourselves.

[Continue to theme chorus, fade]