Community Behavioral Health

Clinical Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications

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INTRODUCTION

Prescriptions for benzodiazepine medications (primarily for anxiety or insomnia) filled in the United States increased by 320% between 1996 and 2013. Over this same interval, overdose deaths associated with these medications increased over 500%.[1] A portion of this increase in mortality is likely attributable to the higher dose per prescription observed, as well as the marked increase of opioid prescribing over this same period. The role of benzodiazepines in opioid overdose deaths nationwide increased from 18% of opioid overdose deaths in 2004 to 31% in 2011.[2] In Philadelphia, the issue is even more significant, with a 2016 report finding that approximately 90% of all opioid overdose deaths also involved benzodiazepines.[3] Reporting from the Philadelphia Department of Public Health in 2017 states that use of the dangerous combination of opioids and benzodiazepines remains common, with approximately one third of people currently using prescription opioids also using a benzodiazepine.[4]

In response to these concerns, these guidelines aim to reduce unsafe prescribing of benzodiazepines. This is best accomplished by limiting the initiation of benzodiazepines when more effective or safer options are readily available, given the high liability for these medications to complicate recovery from substance use disorders or lead to iatrogenic benzodiazepine dependence. Tapering and discontinuing these medications once dependence has formed is challenging for several reasons, including potential for a dangerous withdrawal syndrome. Safe tapering and discontinuation may require transfer to a higher level of care, increased contact with the prescribing physician or care team, and other individualized interventions. Please refer to CBH Clinical Guidelines for Tapering Benzodiazepines for additional information.[5]

These guidelines should be understood to apply to benzodiazepine receptor agonists (e.g. zolpidem), in the case of sleep, as well as to barbiturates and other less-commonly prescribed, controlled sedative-hypnotics, where even greater risks may exist.

The full text of each guideline statement occurs in bold at the start of each section.

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[1] Bachhuber et al., Increasing Benzodiazepine Prescriptions and Overdose Mortality in the United States, 1996–2013. Am J Public Health. Published online ahead of print February 18, 2016: e1–e3. doi:10.2105/AJPH.2016.303061

[2] Jones CM, McAninch JK. Emergency department visits and overdose deaths from combined use of opioids and benzodiazepines. Am J Prev Med. 2015;49(4): 493–501.

[3] Philadelphia Department of Public Health. Overdose deaths involving opioids in Philadelphia. CHART 2016;1(1):1-8.

[4] Philadelphia Department of Public Health. Prescription Opioid and Benzodiazepine Use in Philadelphia. CHART 2018; 2(9):2-6.

[5] "Clinical Guidelines for Tapering Benzodiazepines." CBH Provider Manual, Section 7.2. February 2019.

GUIDELINE 1: REGARDING MONOTHERAPY

Guideline 1: Benzodiazepines should not be initiated as monotherapy for the treatment of anxiety disorders.

While there is evidence that benzodiazepines can be used safely and effectively for the treatment of anxiety, evidence-based guidelines recommend their reservation as second-line agents.[6, 7] Other pharmacologic treatments, primarily Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) and Selective Serotonin Reuptake Inhibitors (SSRIs) have the benefit of a much stronger base of clinical trial evidence to support as first-line use and have significant safety advantages. Nonpharmacologic treatments may also be considered as first-line treatments for multiple anxiety disorders; those focusing on cognitive-behavioral and exposure-based models have the strongest supporting evidence.

Exception

Treatment should be individualized when possible to help support individuals' recovery goals. When there is documented intolerance or poor response to first-line treatments for anxiety disorders (see the table on the following page below), then benzodiazepine monotherapy may be appropriate.

[6] Katzman MA, Bleau P, Blier P, Chokka P, Kjernisted K, Van Ameringen M; Canadian Anxiety Guidelines Initiative Group on behalf of the Anxiety Disorders Association of Canada/Association Canadienne des troubles anxieux and McGill University, Antony MM, Bouchard S, Brunet A, Flament M, Grigoriadis S, Mendlowitz S, O'Connor K, Rabheru K, Richter PM, Robichaud M, Walker JR. Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders.BMC Psychiatry. 2014;14 Suppl 1:S1. doi: 10.1186/1471-244X-14-S1-S1. Epub 2014 Jul 2.

[7] Borwin Bandelow , Leo Sher, Robertas Bunevicius , Eric Hollander, Siegfried Kasper, Joseph Zohar, Hans-Jürgen Möller. WFSBP Task Force On Mental Disorders In Primary Care and WFSBP Task Force on Anxiety Disorders , OCD and PTSD. Guidelines for the pharmacological treatment of anxiety disorders, OCD, and PTSD in primary care. Int J Psychiaty Clin Practice. 2012 Jun; 16 (2):77-84.

First-line Pharmacologic Therapy for Anxiety Disorders					
	Panic Disorder	Generalized Anxiety Disorder	Social Anxiety Disorder	Obsessive Compulsive Disorder	Post-traumatic Stress Disorder
Selective Serotonin Reuptake Inhibitors (SSRI)					
Citalopram	X				
Escitalopram	X	X	X	X	
Fluoxetine	X			X	X
Fluvoxamine	X		X	X	
Paroxetine	X	X	X	X	X
Sertraline	X	X	X	X	X
Serotonin-Norepinephrine Reuptake Inhibitors (SNRI)					
Venlafaxine	X	X	X		X
Duloxetine		X			
Adapted from Bandelow et al., 2012. First-line here refers to medications supported fully by clinical trial evidence and that gave a good risk/benefit ratio. Discussion of methods for grading of evidence and risk/benefit discussed more fully in Bandelow et al., 2008.					

GUIDELINE 2: REGARDING INSOMNIA TREATMENT

Guideline 2: Benzodiazepines should not be used for the treatment of insomnia without appropriate evaluation and should not be used chronically.

Prior to the initiation of benzodiazepines or benzodiazepine receptor agonist medications, a thorough evaluation for underlying causes of secondary insomnia should be performed and documented.[8] This evaluation should screen for sleep-related breathing disorders (e.g. obstructive sleep apnea), sleep-related movement disorders (e.g. restless legs syndrome), adverse medication or caffeine effects, behavioral causes (e.g. poor sleep hygiene), and psychiatric syndromes known to cause insomnia. Individuals should also be screened for other contraindications discussed in these guidelines. When benzodiazepines are used for the treatment of insomnia, an initial treatment period of 2–4 weeks is recommended, as many individuals will remain asymptomatic after tapering at this point.

Exception

Some individuals may experience chronic insomnia that recurs with attempts to taper, beyond expectable and short-term rebound insomnia. In such cases, longer-term treatment may be

[8] Schutte-Rodin et al., Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults. J Clin Sleep Med 2008;4(5):487-504.

acceptable, provided there is appropriately documented rationale. Referral for sleep medicine evaluation or behavioral sleep therapy should also be considered.

GUIDELINE 3: REGARDING PRESCRIBING TO THOSE WITH SUBSTANCE USE DISORDERS

Guideline 3: Benzodiazepines should not be prescribed to individuals with substance use disorders.

Benzodiazepines have a significant liability for misuse; in order to avoid complicating the recovery of individuals with substance use disorders, a thorough screening for past and current substance use disorder must be documented prior to the prescribing of benzodiazepines.[9] For the purposes of such an evaluation, individual self-report cannot be the only source of information: a treatment history from CBH Member Services, collateral information from other providers, or urine drug screening are acceptable methods of objective assessment. Individuals with current or past substance use disorders should rarely, if ever, be prescribed benzodiazepines.

Exception

There may be cases where therapy with benzodiazepines is medically necessary despite substance use. Thorough documentation of medical decision making and the steps taken to protect the individual from harm is required. A plan to assess for abuse or diversion of medications in an ongoing fashion must also be documented.[10] Urine drug screening is typically the simplest method. Evidence of persistent or repeated substance use, medication diversion, or other aberrant medication-related behavior should be addressed via behavioral contract specifying tapering, referral to an alternate level of care, or administrative discharge. **Such an exception will not apply when the individual is actively using illicit opioids.**

GUIDELINE 4: REGARDING PRESCRIBING TO THOSE WITH OPIOID PRESCRIPTIONS

Guideline 4: Benzodiazepines should not be prescribed to individuals enrolled in Medication-Assisted Therapy (MAT) for opioid use disorders or to individuals who are prescribed chronic opioid medications for pain.

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[9] APA (American Psychiatric Association) (2009). Practice guidelines for the treatment of individuals with Panic Disorder. Arlington, VA: American Psychiatric Association.

[10] CMS Drug Diversion in the Medicaid Program: State Strategies for reducing Prescription Drug Diversion in Medicaid. 2012. <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/downloads/drugdiversion.pdf>

Given the danger (discussed above) represented by the combination of benzodiazepines and opioids, such a combination is contraindicated.[11]

Exceptions

Initiation of benzodiazepines for individuals receiving MAT or opioids must be accompanied by documentation that such prescribing adheres to all other parts of these guidelines, documented rationale establishing medical necessity, and ongoing collaboration between both prescribing providers.

In some cases, individuals will be encountered who have been maintained on chronic opioids and chronic benzodiazepines. In such cases, a rapid discontinuation of either medication is neither practical nor safe. Continued treatment must be accompanied by documented collaboration between the providers of each medication and a documented plan to taper one or both medications (or documentation of why this is impossible). Thorough documentation of medical decision making and the steps taken to protect the individual from harm is required. This includes education on the risks of overdose and provision of naloxone education and prescription.

GUIDELINE 5: PDMP REQUIREMENTS

Guideline 5: Benzodiazepines and other controlled substances will be prescribed in accordance with state requirements related to the Prescription Drug Monitoring Program (PDMP).

In 2014, the Pennsylvania State Legislature passed Act 191,[12] expanding the state's prescription drug monitoring program to include monitoring of all Schedule II–V controlled substances. Registration for the PDMP (required for all PA prescribers) and further information can be found here.

Beginning in August 2016, all prescribers have legal responsibilities related to the use of the PDMP. Providers should stay up-to-date and ensure their practices are complaint with all PA PDMP requirements. Additional information is available on the PA Department of Health website. An excerpt is quoted on the following page:

[11] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65:1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

[12] 2014 PA Act 191 :Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Enactment. https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2014&sessInd=0&act=191.

Per Act 191 of 2014, lawfully authorized prescribers are required to query the PDMP for an existing patient when the following clinical situations apply:

1. *For each patient the first time the patient is prescribed a controlled substance by the prescriber for purposes of establishing a baseline and a thorough medical record; or*
2. *If a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs; or*
3. *Each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber.*

These requirements apply (1) to inpatient or outpatient settings; to acute or anticipated chronic controlled substance(s) prescriptions; to new or established patients; and in situations where the prescriber is seeing his/her own patient or is covering for a colleague. Writing a controlled substance(s) prescription for the first time to a patient is the basis for checking the PDMP in (1) above.

However, as part of good clinical practice, the Department of Health recommends that health care professionals check the system every time before a controlled substance(s) is prescribed or dispensed in any clinical setting.

Act 191 0f 2014 states that a prescriber shall indicate the information obtained from the system in the individual's medical record if:

1. *The individual is a new individual; or*
2. *The prescriber determines a drug should not be prescribed or furnished to an individual based on the information from the system.*

CBH requests that, each time prescribers query the PDMP, they document in the medical record that this occurred. When query of the PDMP reveals potential concerns, and controlled substances are still to be prescribed, documentation that guidelines 1–4 are being adhered to will be required.

It is also important to note that controlled substances prescribed for some MAT of opioid use disorders (e.g. methadone) will *not* appear in PDMP reports, and this system cannot be relied upon for information about such medications.

CBH IMPLEMENTATION REVIEW

Providers must develop a policy to ensure the prescribing of benzodiazepines and other sedative-hypnotic medications (e.g. barbiturates, benzodiazepine receptor agonists, etc.) adheres to these guidelines. The policy and related practices must also align with relevant CBH, state, and federal regulations and standards, including CBH prescribing Bulletins, the Network

Inclusion Criteria Standards of Excellence,[13] and the DBHIDS Practice Guidelines for Resiliency and Recovery-oriented Treatment.[14]

The required policies will be reviewed by CBH and NIAC during initial and recredentialing for adequate incorporation of the prescribing standards discussed above and any alignment with relevant federal, state, and CBH guiding documents. Clinical documentation related to this policy may also be reviewed. CBH will monitor prescribing of benzodiazepines by providers via claims and pharmacy data across levels of care to assess adherence and for opportunities for quality improvement interventions. Some of the metrics monitored will include rates of benzodiazepine prescribing to members with a history of substance use disorder, rates of benzodiazepine prescribing to members with concomitant opioid prescription, methadone treatment, or buprenorphine treatment.

[13] Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), *Network Inclusion Criteria Standards of Excellence*, February 2019, or latest version.
[14] Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), *Philadelphia Behavioral Health Practice Guidelines*, 2013, or latest version.