AN INTEGRATED APPROACH TO BENZODIAZEPINE DISCONTINUATION:

SHARED MEDICAL APPOINTMENTS FOR VETERANS CO-PRESCRIBED OPIOIDS AND BENZODIAZEPINES

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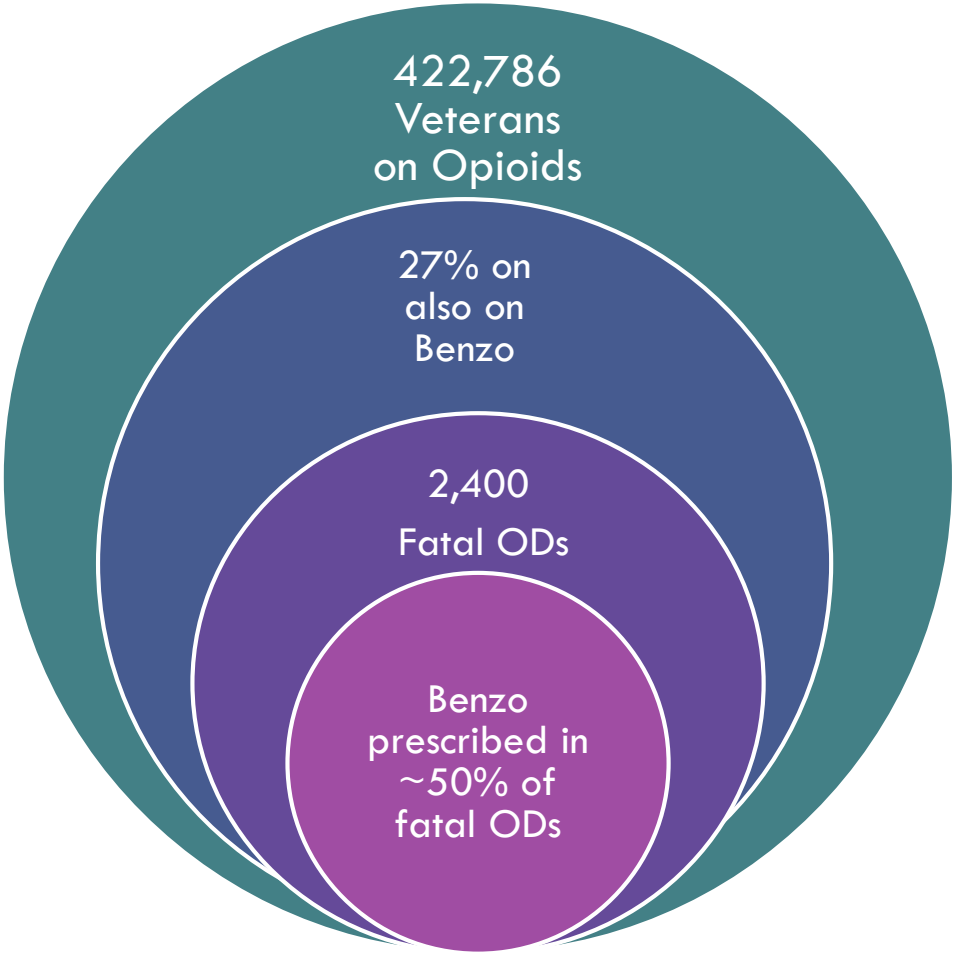
Objectives

- Review current relevance to Veteran healthcare
- Explain the importance of interdisciplinary efforts in benzodiazepine discontinuation
- Describe the Opioid/Benzodiazepine SMA
- Discuss conclusions and lessons learned

Opioid + Benzodiazepine Use in Veterans

Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. BMJ. 2015.



Park TW et al. BMJ. 2015

Benzodiazepine Discontinuation

Why Discontinue Benzos?

- No long-term indication
- Safety Concerns
  - Falls
  - Hip fractures
  - Sedation
- Psychological concerns
  - Cognitive impairment
  - Dependence
  - Barrier to psychotherapeutic progress

Benzodiazepine Discontinuation

- Gradual tapering alone has limited effectiveness
  - 50-60% of users resume medication

> "Providing individuals with advice to cease benzodiazepine use or with a more extensive intervention increases cessation rates significantly in comparison with routine care."

Parr et al. 2008.

Role of Psychology

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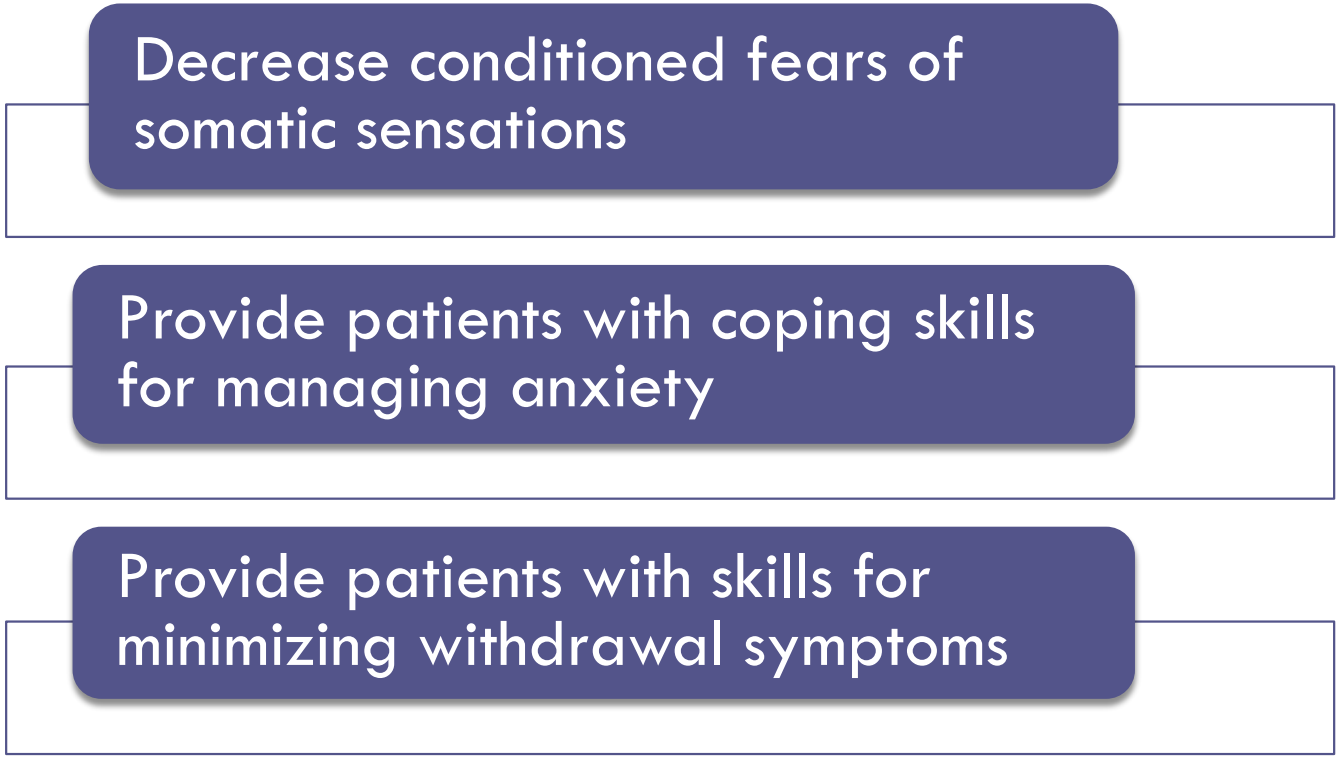
- Effective benzodiazepine discontinuation must include:



Otto et al., 2002

Role of Psychology

- General psychology skills
- Values and goals identification
- Motivational Interviewing

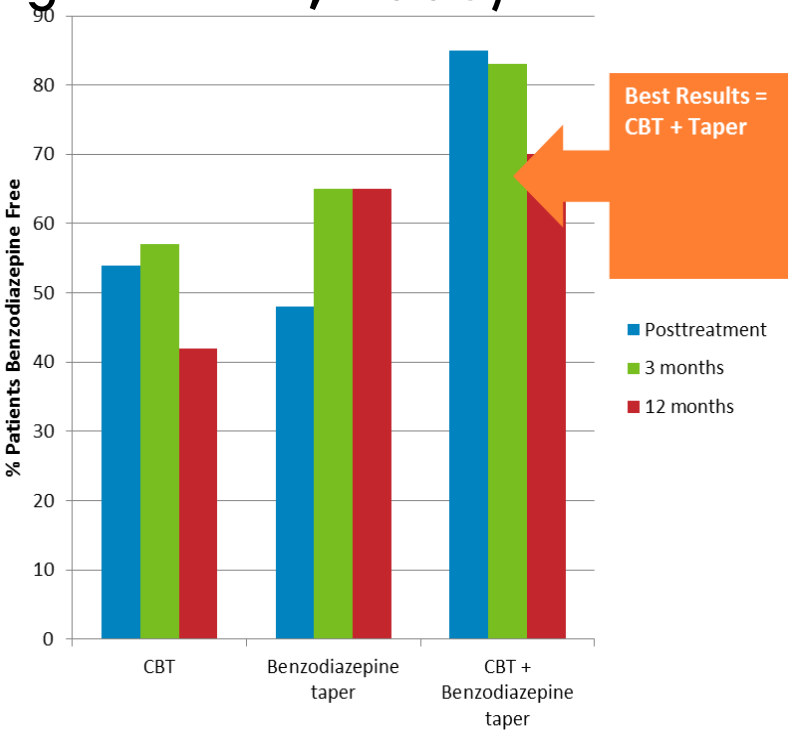
"The overdose problem is others misusing the medications and I'm being punished because of them!"

"…but I need my benzo, nothing else works!"

"But I have been on these medications for *years* and haven't had *any* problems!"

Role of Psychology

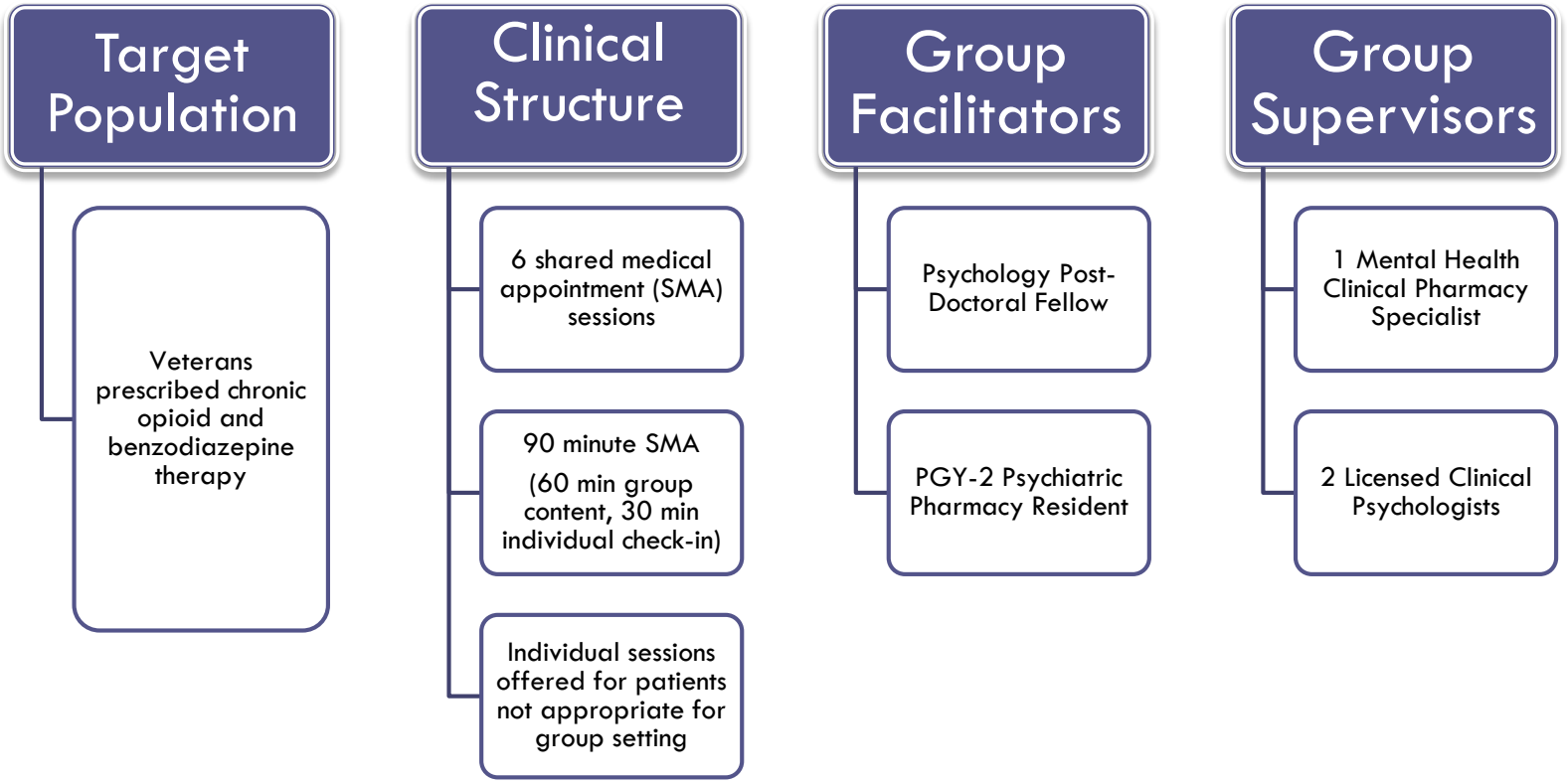
- Taper + CBT = Best Discontinuation Results (Morin et al., 2004; Baillargeon et al., 2003)



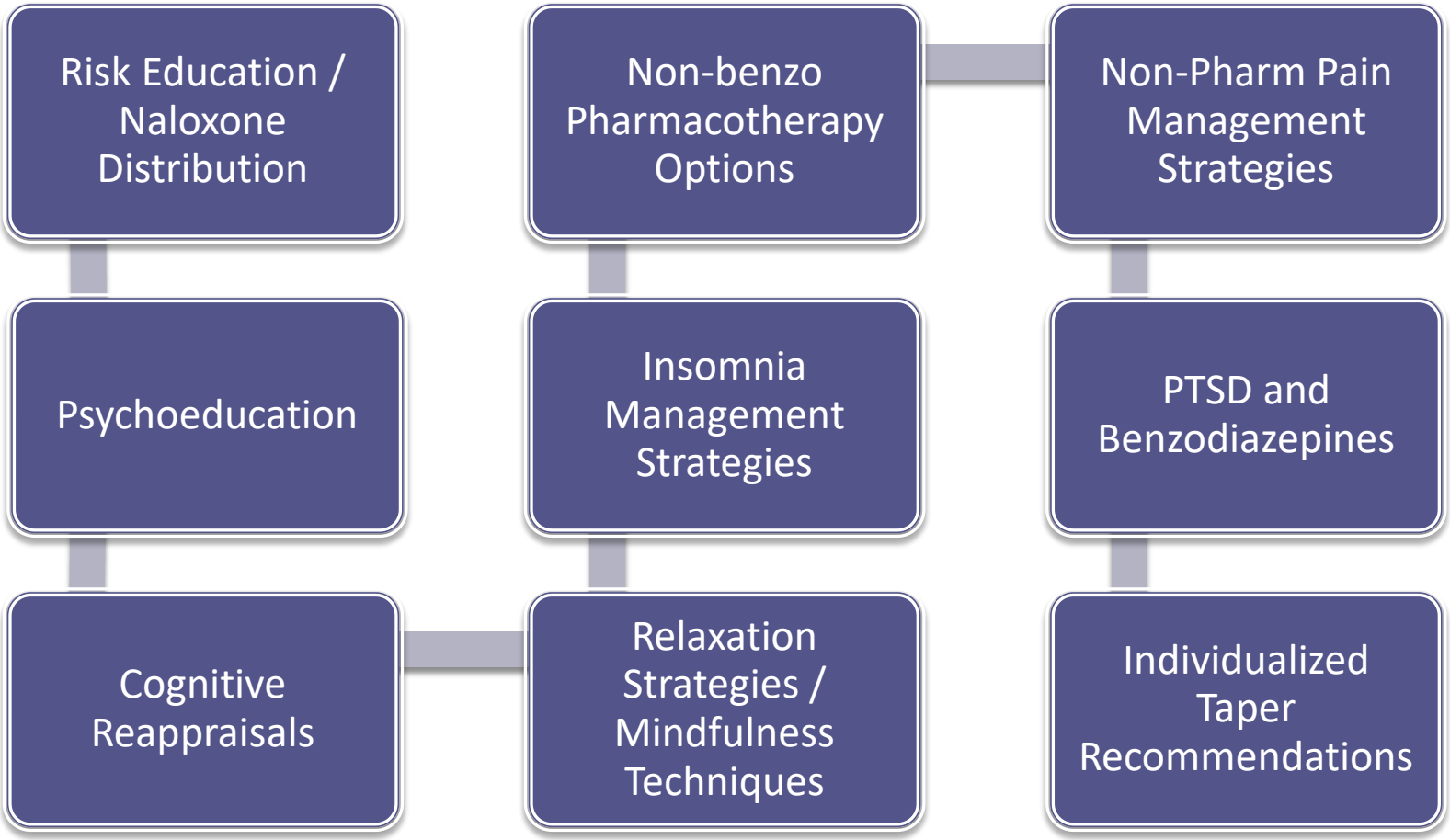
- Taper + CBT = More successful dose reduction than taper alone (Voshaar et al., 2003)

Shared Medical Appointment

SMA


Target Population
Veterans prescribed chronic opioid and benzodiazepine therapy
Clinical Structure
6 shared medical appointment (SMA) sessions
90 minute SMA
(60 min group content, 30 min individual check-in)
Individual sessions offered for patients not appropriate for group setting
Group Facilitators
Psychology Post-Doctoral Fellow
PGY-2 Psychiatric Pharmacy Resident
Group Supervisors
1 Mental Health Clinical Pharmacy Specialist
2 Licensed Clinical Psychologists

SMA Content


Risk Education / Naloxone Distribution
Non-benzo Pharmacotherapy Options
Non-Pharm Pain Management Strategies
Psychoeducation
Insomnia Management Strategies
PTSD and Benzodiazepines
Cognitive Reappraisals
Relaxation Strategies / Mindfulness Techniques
Individualized Taper Recommendations

SMA Results

Results: Interim Data

Baseline Characteristics (N = 11)	Average ± Standard Deviation (Range)
Male Gender	91%
Age (years)	64 ± 8.6 (50 – 74)
Race (Caucasian)	91%

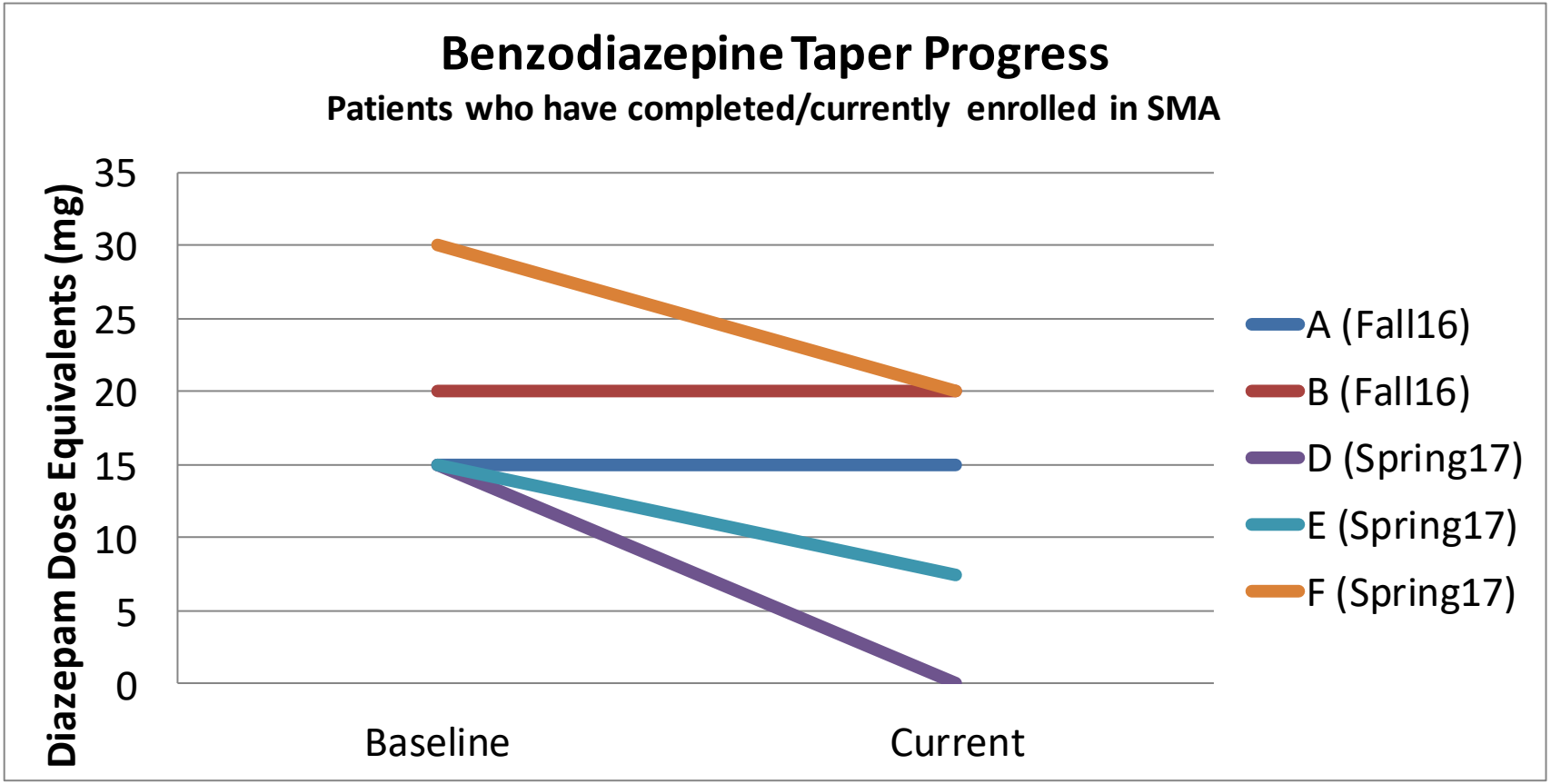
High Risk Comorbidity (N=11)	Percentage (n=number of patients)
PTSD	45.5% (n=5)
Chronic Respiratory Disease	36.4% (n=4)
Sleep Apnea	45.5%(n=5)
Elderly (>65 years)	54.5% (n=6)
Dementia	9.1% (n=1)
RIOSORD Score	48 ± 10.96 (34 – 65)

Results: Interim Data

Primary Psychiatric Diagnoses	Percentage (n = number of patients)
PTSD	27.3% (n=3)
Other specified trauma - and stressor-related disorder	9.1% (n=1)
General Anxiety Disorder	9.1% (n=1)
Unspecified Anxiety Disorder	36.4% (n=4)
Major Depressive Disorder	18.2% (n=2)

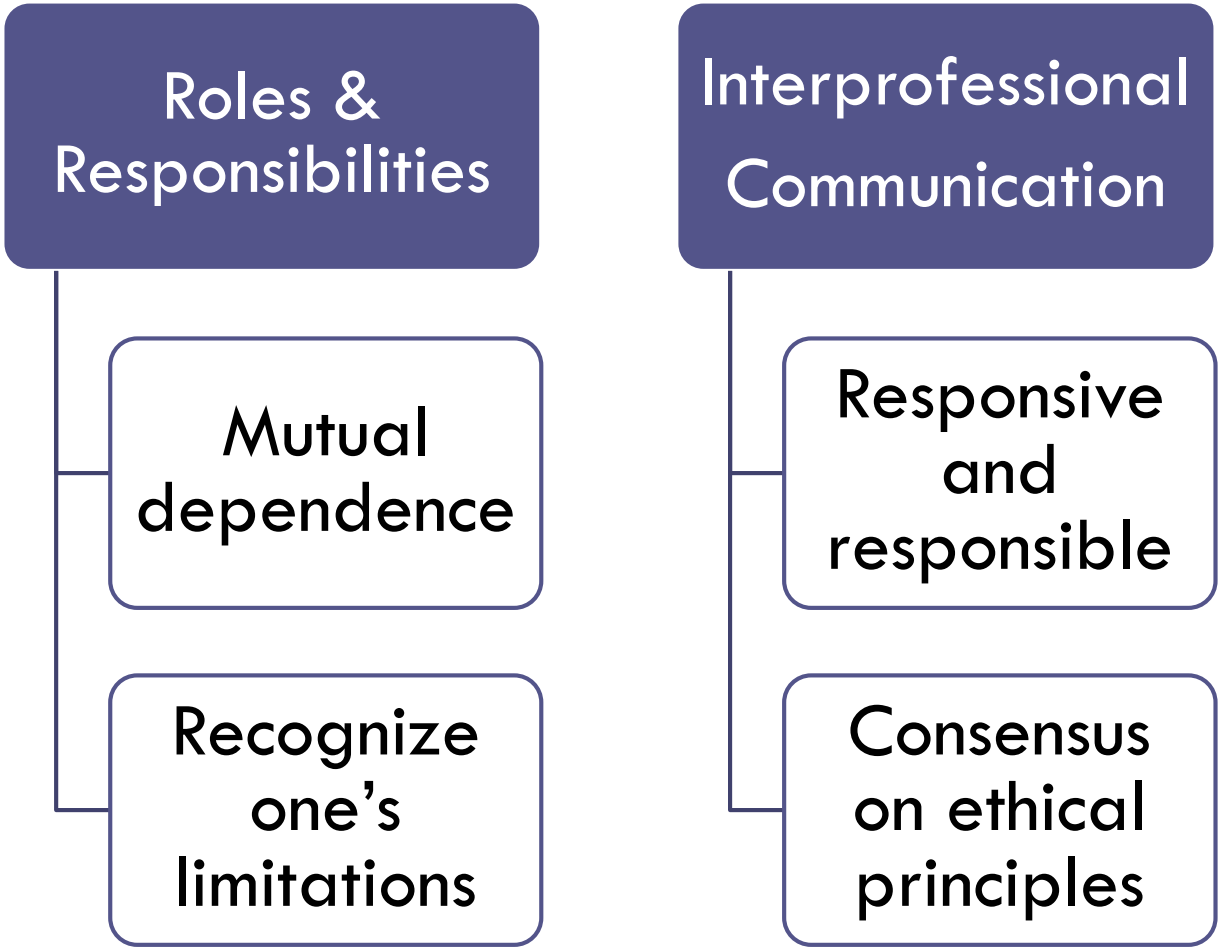
Baseline Assessment Scores	Average ± Standard Deviation
PHQ-9	9.7 ± 6.18
GAD-7	6.33 ± 6.03
PCL-5	22.62 ± 16.46
AUDIT-C	1 ± 1.63
ISI	12.9 ± 5.73
DAST-10	1 ± 0.41

Results: Interim Data



Lessons Learned

Lessons Learned: Interprofessional Competencies



Lessons Learned: SMA Content

Cognitive component: Taper-specific

Patient understanding: Repetition is key!

Lessons Learned: System-Level

Interprofessional emphasis of facility

Provider buy-in

Add psychiatry to SMA team

Various Modalities: Individual SMAs, CVT

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