Turning Point
TREATMENT · RESEARCH · EDUCATION

When Less is More – Deprescribing in the AOD context

AOD Collaborative ECHO
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Outline

- Why and when to taper
- General principles of medication management
- General principles of management approaches
- Specific focus on:
  - Benzodiazepines (Z-drugs)
  - Prescribed opioids

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Deprescribing

Planned and supervised process of reducing and stopping medications

Origins in geriatric medicine

Deprescribing is a key component of good prescribing

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When to deprescribe?

- High-dose prescribing
- Polypharmacy
- Drug-disease interaction
- Poor adherence
- Inappropriate indication/No current indication
- Patient/carer preference
- Condition improved, resolution of stressors or alternative coping strategies developed

'When harms outweighs the benefits'

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Benzodiazepines (& Z-drugs)

- Benefit in acute syndromes is clear
  - acute anxiety/agitation, epilepsy, insomnia, alcohol withdrawal, procedure pre-medication
- Harms of long-term prescribing widely accepted
  - Physical dependence and tolerance
  - Cognitive impairment
  - Delirium
  - Association with increased risk of dementia
  - Ataxia
  - Falls and fractures
  - Increased risk of MVA
  - *Poor sleep*
  - *Worse affective symptoms*
- Z-drugs are *not* the safer relatives

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Prescribed opioids

- Pain-related conditions - leading cause of disability and disease burden globally
- Opioids = effective component of acute pain management
- NOT as effective in chronic, non-cancer, nociceptive pain
- Significant risks of harm with opioids
- Long term exposure to opioids can cause opioid-induced hyperalgesia

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When to taper opioids?

- Inadequate pain relief despite high dose (100-120mg OMEDD)
- Risky comorbidities
- Concurrent hypnosedative use
- Lack of improvement in function/QoL
- Intolerable side effects
- Evidence of aberrant use
- Resolution of pain issue
- After definitive pain-relieving intervention

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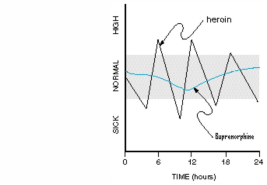
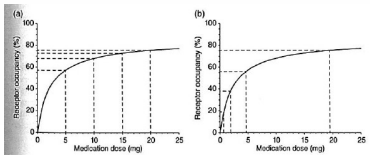
Principles of medications management

- Deprescribing plan at point of initiation
- Stabilize then reduce
- Go slow
- Taper at a tolerable rate
- Hyperbolic pattern
- Monitor and review regularly
- Collaborative process
- Know your local regulations





Horowitz, Taylor - Maudsley Deprescribing Guidelines 2024

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Barriers/facilitators to deprescribing

- Psychological/physiological
- Personal goals and motivations
- Perceptions of medications
- Information about discontinuation process
- Support network

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General management approaches

- Therapeutic alliance
- Optimize alternative/non-pharmacological treatments
- Bolster supports
- Avoid substituting with other sedatives
- Psychoeducation to patient/carers about:
  - Avoidance of sudden cessation
  - Self-monitoring
  - Plan if symptoms re-occur
- Consider written treatment plans and agreements
- Review, review, review

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Take home messages

- Deprescribing is a key component of good prescribing.
- It's always about the risk:benefit analysis
- Engagement can be tricky – be open, collaborative and patient centred
- Pair your medication management with broader psychosocial interventions and multi/interdisciplinary care teams
- Gradual tapers are usually optimal
- Dynamic process - review regularly

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Questions?

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