Why British Columbia Needs A Comprehensive Benzodiazepine Strategy

1. Benzodiazepines are near the top of their class in terms of pills dispensed in B.C. – 84 million in 2002. In 2003 Ativan (a benzodiazepine) was the third-most-prescribed drug in Canada.

2. Benzodiazepine use increased by 11% between 1996 and 2002 in B.C.

3. Popular sleeping pills — the "Z" drugs such as zopiclone and zalepon, i.e. Imovane, Ambien and Sonata — have the same effects on the same neuron receptors as benzodiazepines and the same potential for dependency and addiction.

4. 9.7% of the population of B.C. (400,000 people) received at least one prescription for a benzodiazepine in 2002. **170,000** people in B.C. received over 100 pills a year. It is very likely that this group is addicted and may be suffering many other health problems.

5. The two groups most vulnerable to adverse effects, women and the elderly, are the highest users of benzodiazepines in B.C.

6. Over time, benzodiazepines lose their effectiveness. **Over the long term they have little effect on sleep, although they are prescribed frequently for sleep problems among the elderly. Tolerance to the anti-anxiety components occurs over a few months. Long-term use does little to control anxiety and often aggravates it.**

7. There is compelling evidence that benzodiazepine users become poly-drug users. As a person becomes tolerant, higher doses or other drugs are often prescribed because the patient or her/his doctor does not understand the mechanics of tolerance.

8. Studies of long-term users have shown deficits in learning, memory, attention and visuo-spatial ability. Benzodiazepines cause pseudo-dementia among the elderly and this is often misdiagnosed, especially in care facilities.

9. One dose of a benzodiazepine has been shown to cause loss of balance leading to falls and fractures. Hip fractures among elderly women cost the B.C. health care system $131 million in 1998. **Benzodiazepine use is strongly associated with falls, injuries and fractures.**

10. Benzodiazepines are associated with traffic and other accidents. People using benzodiazepines should ***not*** drive or operate heavy machinery.

Source documents include: The diagnosis and management of benzodiazepine dependence (Ashton, 2005) Therapeutics Initiative Letter (November-December, 2004) and Manufacturing Addiction (Women's Centre of Excellence/Currie/ 2003)

11. People on long-term benzodiazepines frequently have serious chronic health problems (pain, chronic fatigue, gastric problems, chest pains, irritable bowel) which lead to frequent use of the health care system – tests, hospitalizations, diagnostics, other drug treatment, surgery, etc.

Longer-term benzodiazepine users use a disproportionate amount of health care resources.

12. Longer-term users develop psychological problems which are wrongfully interpreted as mental illness. They often become increasingly agitated, depressed (benzodiazepines are central nervous system depressants), fearful, enraged, agoraphobic, socially dysfunctional or paranoid. **These symptoms (which are drug-related) are usually interpreted as "mental health problems," leading people into the mental health system where more drugs — even electroshock — may be given.**

13. Benzodiazepines are associated with many other **societal costs**: family violence and breakdown, criminal activities and shoplifting, disability pensions and unemployment payments (chronic users often become unable to work).

14. Benzodiazepines are frequently used as a component of street drug use — they potentiate other drugs. **Benzodiazepines are taken by 50-80% of opiate, cocaine, amphetamine and other illegal drug users, and by alcoholics. Often they are used by people with dual disorders (e.g., mental illnesses, substance abuse). These users also experience severe withdrawal symptoms and may be using other drugs to mask these effects.**

The Need for a Comprehensive Benzodiazepine Strategy

- Despite individual, family, and social costs associated with benzodiazepines, there has never been a strategy to address the *over-prescribing* and *mis-prescribing* of benzodiazepines or to provide *appropriate assistance* to people who wish to withdraw from benzodiazepines or need to withdraw because of serious ill health.

- Unlike other addictive drugs such as cocaine or heroin, benzodiazepines or sleeping pills **cannot** be stopped abruptly. Tapering must be slow, and transference to a long-term acting benzodiazepine is optimal. **Tapering is likely to take 4 to 6 months, with a recovery period of 1 to 2 years post-withdrawal.** There is some evidence that certain aspects of neuron damage may never completely be remedied.

- Many physicians are concerned about benzodiazepines but do not recognize the symptoms of tolerance and are not well-informed about tapering. They are also not well-equipped to provide the long-term support and reassurance required during tapering. Most tapering can be done "at-home" with some low-cost assistance provided by telephone or occasional ambulatory visits. For patients on multiple, high-dose drugs, respite care in hospital may be required. **We believe that physicians and mental health professionals would welcome the development of a supportive withdrawal structure for themselves and their patients.**

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