



Montgomery Cares

Behavioral Health Program Update

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Use Of Benzodiazepines In Primary Care The Behavioral Health Program's Lessons Learned and Current Practices with Clonazepam (Klonopin) and Aprazolam (Xanax)

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The Behavioral Health Program is often asked for guidance on patients who have been using benzodiazepines. Some patients have been using benzodiazepines to treat insomnia, anxiety, depression or to control panic symptoms. However, these drugs are controlled substances and pose a risk for dependency and abuse and care needs to be taken to ensure that patients are not inappropriately seeking and using these medications in the context of addiction. Also, there may be an alternative treatment for the underlying mental health problem that is safer and more effective in the long-term. The MCBHP evaluates patients using these medications MCBHP are evaluated. The programs recommendation to the primary care providers may involve continuing the benzodiazepine, cross tapering the patient to a different longer acting medication such as an SSRI, or offering the patient a slow and safe taper off the benzodiazepine completely.

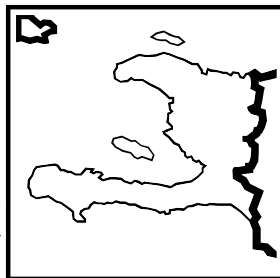
The following clinical information includes some tips based on current MCBHP practice :

- *Benzodiazepines are useful and effective treatment for **insomnia**, better used with short term duration as dependency and tolerance develops with long term use. For longer term treatment of insomnia, other medications such as Trazodone or Rozerem are effective, and have lower risk of dependency and tolerance.*
- *For anxiety and depression, **long term treatment with an SSRI is first line**. However, use of benzodiazepines for acute relief from anxiety, particularly panic disorder, is also (continued on page 2)*

The Behavioral Health Program has delivered care to over 800 patients in the first three quarters of this fiscal year. This is as many patients as the program served in the entire prior fiscal year!

My Visit to Haiti

Pat DeLeon, RN, is Nurse Care Manager for the MCBHP at Holy Cross Clinic. She recently took leave to provide services at a medical clinic in Haiti. A brief account of her experience is below.



In many ways, my years of living and working in Guatemala prepared me for the poverty and harsh living conditions I encountered in Haiti, but I was still taken back by the magnitude of the devastation left by the earthquake. One could drive for miles, hours, without resting one's eyes on something beautiful. There was stark poverty, the smell of rotting food sold

in the market, whole families living in the streets under torn blankets for cover, houses and schools crushed to the ground with reports that children and neighbors still lay within its grave.

Before arriving in Haiti, I met up with 12 other people, some from the DC area and others from various other states. While I had never met any of them before, by the end of our trip we felt like family. Once in Haiti, our team grew larger. We joined a medical team from Singapore and several other individuals including engineers, disaster relief-workers, and missionaries. While our roles were fluid, we worked together as a team to meet the overwhelming needs before us. I was especially impressed by a large group of young adult Haitians who never left our side. Serving as our interpreters, they tirelessly worked with us in the pharmacy, makeshift clinic, with crowd) control, wound care, and in whatever other capacity (continued on page 3)

Benzodiazepines, continued from front page

considered standard of care. Used cautiously and appropriately, these medications can greatly improve treatment outcomes, patient compliance and reduce visits to the ER. When patients present with moderate to severe anxiety and depression and/or panic disorder, starting both an SSRI and Klonopin is often indicated. After the SSRI is at a therapeutic dose/level, in approximately 4-6 weeks, patients can be slowly tapered off a benzodiazepine to an as-needed-basis only.



- Abruptly stopping a benzodiazepine that a person has used for a long time can be dangerous; instead they should be started on an appropriate SSRI and the dose and frequency of the benzodiazepine be reduced gradually over a period of one to two months.
- Studies have shown that patients with true anxiety disorders have low potential to abuse benzodiazepines, even if used in the long term.
- **Clonazepam** (generic) or **Klonopin** is a subclass 3 benzodiazepine; long acting, i.e. it has a long half-life of 20-50 hours. Starting dose is 0.25-0.5 mg bid. It is indicated in the treatment of seizure disorder, panic disorder, anxiety, restless leg syndrome, and neuralgia. Because of its slower rate of onset and longer half-life, Klonopin results in less of a 'high', and thus has less potential for addiction. Some patients find it sedating, particularly in the beginning and cannot tolerate the daytime sedation side effects. Starting with half doses initially during the daytime, or using Klonopin only QHS, can help with this issue. The BHP tends to use this to address initial acute symptoms of panic attacks or severe anxiety symptoms of PTSD.
- **Aprazolam** (generic) or **Xanax**, is a subclass 1 benzodiazepine; short-acting, with a shorter half-life of 11-16 hours, and is faster acting than clonazepam. Starting dose is 0.25mg-0.5mg bid-tid. It is indicated for treatment of anxiety and panic disorder. The BHP in general recommends use of Klonopin first, however, for cases of acute and clearly identifiable situational anxiety (i.e. test anxiety, fear of medical tests), specific phobias (flying, etc), Xanax may be helpful. Because most patients do not find Xanax sedating it is also a viable option for patients with acute anxiety and no substance abuse history who do not tolerate Klonopin.
- Both Klonopin and Xanax are metabolized by the **liver** extensively; through CYP450:3A4, as a result, due to its long half life, Klonopin is contraindicated with significant liver disease, while Xanax can be hepatically dosed with gradual titration relatively safely even with advanced liver disease.
- Both can be rather **expensive** for this patient population. A 30 day supply of 0.5mg of either, dosed twice daily, can range in price from \$20-\$50. Neither is on the medbank list, but the pharmacy Rx card may provide a discount.
- Many of these drugs are available over the counter in other countries. Ask patients about them when addressing anxiety.
- As with many medications, patients do become dependent on benzodiazepines. However, addiction is a pattern of behavior, and is very different from dependency. Addiction behaviors include development of tolerance, taking higher dose than prescribed, unsuccessful efforts to cut down on use, spending a lot of time obtaining a substance; visiting multiple doctors or ER's, "lost" prescriptions, and continued use of a substance despite negative social, occupational, physical or personal consequences. These patients are often unwilling to have a mental health evaluation, or to consider alternative treatments for an anxiety or panic disorder, and can be demanding and manipulative. Options with these patients range from offering a limited quantity of the medication while they obtain a mental health evaluation, offering to prescribe an SSRI while they reduce the benzodiazepine, or, refusing to prescribe benzodiazepines for these patients. **It is OK— although not easy— to say no!**

Famous Depression Quotes:

"Good morning, Eeyore," said Pooh.
"Good morning, Pooh Bear," said Eeyore gloomily. "If it is a good morning, which I doubt," said he.
"Why, what's the matter?"
"Nothing, Pooh Bear, nothing. We can't all, and some of us don't. That's all there is to it."
"Can't all what?" said Pooh, rubbing his nose.
"Gaiety. Song-and-dance. Here we go round the mulberry bush."

A. A. Milne, From the book *Winnie the Pooh*

Haiti, continued from front page

the situation called for. I think their best contribution was their sense of humor and joy, very-needed virtues in the face of all Haiti the sadness we faced daily.

Most of my days in Haiti were spent in the clinic that the Singapore team had put together in the foyer of the church weeks before we arrived. They were the ones that were on site in those first horrific days after the earthquake. By the time I arrived, most real emergencies had already been dealt with. Everyday we saw hundreds of people who stood in line for hours to be seen. Underfed mothers brought in their babies who were in fragile condition, weak and dehydrated. For those, we started IV's and if too sick, had them transported to the German Red Cross tent hospital that had opened the week we arrived. We shared hospital equipment with them in exchange for needed medicines that seemed to run out quickly at first.

Between clinic days, I had an opportunity to visit a nearby tent city where hundreds of displaced people lived crowded together. When our van first arrived, people came running up, asking if we had food. We felt sad to have to say no, but were able to set up a mobile clinic, organizing our medicines and bandages on an old wobbly wood table. People immediately formed large lines in the beating hot sun. We treated a young girl who had lost an ear in the earthquake and needed her wound cleaned. My first patient was three-year old Alexandra, who had a large, healing wound on the

top of her head. Her mother shared with me that Alexandra had been buried in the rubble of the quake and when pulled out with a gaping head wound and lifeless body, was tagged and thrown in with the dead. That was where her mother found her. She immediately took off Alexandra's death tag and prayed for a miracle. With Alexandra's eyes fixed on me, her mother concluded, "I now keep that tag in my Bible as a reminder of that miraculous day."

One Sunday afternoon, I tagged along with two engineers who wanted to check on the water filtration system they had installed at one of the nearby orphanages. This particular orphanage housed 55 children, at least one who was HIV positive. The orphanage had been damaged by the earthquake, so they now lived in an open field sheltered only by two large tents given to them by the U.N. When we arrived, the women were cooking over an open fire and the children were eating large helpings of spaghetti, balancing their plates either on their laps. Peace and quiet joy permeated the atmosphere. After lots of hugs and photos, we finally ended our visit that afternoon with the echo of the children's voices thanking us for the clean water. I wondered as we drove off, "When was the last time I was thankful for clean water?"

I have been home from Haiti a couple of weeks now and still find my thoughts filled with many faces and images encountered during the two and a half weeks spent there. It was an amazing time and privilege for which I am so grateful to have had. I have tried to capture and share as much of my time in Haiti as possible, but some things I am still

The Working Group on Behavioral Health For the Uninsured: An Agenda For Collaboration

On March 11th the Primary Care Coalition and Child Center and Adult Services co-sponsored the first meeting of the Working Group on Behavioral Health for the Uninsured. Over 20 representatives of County agencies, core service agencies, private mental health organizations, and community clinics met to discuss how to set an agenda for addressing the behavioral health needs of the uninsured of Montgomery County. Despite extremely difficult financial situations in many of the organizations, energy was raised to come together and begin to discuss the scope of the problem. Hopefully the group will identify ways to strengthen existing services and identify new collaborations or approaches that might lead to expanded services at some point in the future.

Our Working Vision Statement for Today: "Our community will have the capacity to provide efficient, cost effective and evidence-based behavioral health care to the uninsured population of Montgomery County."

The following two questions were posed to breakout groups for discussion and idea generation:

- 1. Keeping the long-term vision in mind, what can we do now to:
 - A. Improve linkages and collaboration among primary and behavioral care providers, and to*
 - B. Identify ways to creatively leverage funding sources.**
- 2. What will it take – and what will the components be – to attain this vision?*

Several participants agreed to meet the following month as a small group to review the responses of the participants to these questions. They will set up a process for moving forward on both short and long-term projects. It is hoped the concrete steps can be identified, and the energy, knowledge and resourcefulness of those who attended the meeting and those who were not able to will be able to be used in the future.

Behavioral Health Program Goal

To establish an evidence-based collaborative care model in community-based primary health care settings serving Montgomery Cares patients to:

- *Identify patients with mental health needs;*
- *Evaluate the patients to determine diagnoses and appropriate levels of care; and*
- *Collaborate with primary care providers to provide appropriate treatment including medication, support, social service intervention, and/or referral to primary psychiatric or substance abuse services.*

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Medscape On-Line Trainings Address Identification and Treatment of Depression in Primary Care Settings

<http://www.medscape.com/>

*Go to the MedscapeCME tab and
select "Depression" topic.
Registration and CME are free.*

[*Keys to Successful Treatment of
Depression in Primary Care*](#)

[*Screening for Major Depressive
Disorder: Tools for Primary Care*](#)

[*Antidepressants Ease Depression in
Patients With a Physical Illness*](#)



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