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Integrated Care Training Program

General Disclosures

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

Planner Disclosures

The following series planners have no relevant conflicts of interest to disclose:

- Denise Chang, MD
- Jessica Whitfield, MD, MPH
- Betsy Payn, MA, PMP
- Esther Solano
- Anna Ratzliff MD PhD

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Overview of Learning Collaborative

- Audience:
  - Psychiatric Consultants
  - Working or hoping to work in integrated care settings
- Goals:
  - Provide ongoing integrated care education (CME available)
  - Foster learning and support network
  - Support sustainment of integrated care
- Structure:
  - Monthly lunch hour on 2nd Tuesday
    - Didactic topic 20-30 mins
    - Open discussion remainder of time
  - Topics repeat every 6 months

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VA Forensic Mental Health Symposium

- Offering diverse presentations pertaining to **forensic mental health**
- Welcomes all trainees - any healthcare discipline, law, criminal justice, or related field-- to attend
- Friday, October 11, from 1pm-4:30pm virtually
- If you are a trainee interested in participating, please contact Center Director Jennifer Piel, MD, JD (piel@uw.edu) for details and link

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Integrated Care Conference 2025

Integrated Care Across the Lifespan: Serving the Behavioral Health Needs of All Ages

Thursday and Friday, June 5-6, 2025

In-person Seattle, Washington

- **Call for Presentations**
  - Integrated care is increasingly called upon to serve the behavioral health needs of people of all ages. We are especially interested in hearing your innovations:
    - to support our patients across the lifespan
    - to sustain your programs
    - to enhance clinical skills
    - to address treatment for special populations

Scan for more information

- **Submit your idea here: https://redcap.iths.org/surveys/?s=LDNPWWPLLFR3K3LK**
- Please email uwictp@uw.edu for more information or visit https://ictp.uw.edu/training/upcoming-conferences-events-training

Integrated Care Training Program

Last Session will be June 2025

Thank you all for attending and supporting UW PCLC!

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Alternatives to UW PCLC

- UW PACC
- UW Community-based Fellowship
- Collaborative Care Community through APA
- Conferences:
  - UW Integrated Care Conference
  - Collaborative Family Healthcare Association (CFHA)
  - Academy of Consultation Liaison Psychiatry
  - American Psychiatric Association
  - Mental Health Services Conference

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Resources

- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666
- UW TBI-BH ECHO

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Integrated Care Training Program

UW Psychiatry & Behavioral Sciences

Benzodiazepines
Continue or Taper?

Mark Duncan MD

10/8/2024

Objectives

- Describe the utility of benzodiazepine use in psychiatric conditions
- Walk through the assessment of someone on benzodiazepines
- Highlight concerning issues around benzodiazepine discontinuation
- Describe clinical considerations for ongoing benzodiazepine use

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47yo M with h/o anxiety and chronic pain

- Presents to establish care for chronic pain management and anxiety treatment. Previous provider has decided to move his practice to Texas abruptly. Looking for someone to take over the following meds.
- Oxycodone 10mg q6hr prn for the past 6 months
- Clonazepam 2mg TID x 10 months.

- PMH: HTN on HCTZ
- Substances: Alc: 2 a week, Drugs: none

- Question: PCP sends you a staff message and would like your input. They also want to know if the CoCM program can help with a taper?

Fears about Benzodiazepines

- Benzodiazepines have many risks
  - Use disorders
  - Overdose
  - Withdrawal and seizures
  - Falls
    - Geriatric preference: lorazepam
  - Medication interactions
  - Cognitive problems
  - Dementia
    - Mixed evidence base
    - Cumulative Risk?

https://www.psychiatrictimes.com/view/benzodiazepine-use-risk-dementia

Facts about Benzodiazepines

- Benzodiazepines are an evidence-based treatment for anxiety disorders, but not first line.
  - Best for panic disorder
  - Good or better vs SSRIs/SNRIs for GAD and Social Anxiety Disorder
  - Useful short term adjunct + antidepressants
    - PTSD: in rare cases and short term
  - Most patients being treated for anxiety disorders do not grow tolerant to anxiolytic effect

Slee A, Nazareth I, Bondaronek P, Liu Y, Cheng Z, Freemantle N. Pharmacological treatments for generalised anxiety disorder: a systematic review and network meta-analysis. Lancet. 2019 Feb 23;393(10173):768-777. doi: 10.1016/S0140-6736(18)31793-8. Epub 2019 Jan 31. Erratum in: Lancet. 2019 Apr 27;393(10182):1698. doi: 10.1016/S0140-6736(19)30857-8. PMID: 30712879.
Offidani E, Guidi J, Tomba E, Fava GA. Efficacy and tolerability of benzodiazepines versus antidepressants in anxiety disorders: a systematic review and meta-analysis. Psychother Psychosom. 2013;82(6):355-62. doi: 10.1159/000353198. Epub 2013 Sep 20. PMID: 24061211.
Gomez AF, Barthel AL, Hofmann SG. Comparing the efficacy of benzodiazepines and serotonergic anti-depressants for adults with generalized anxiety disorder: a meta-analytic review. Expert Opin Pharmacother. 2018 Jun;19(8):883-894. doi: 10.1080/14656566.2018.1472767. Epub 2018 May 28. PMID: 29806492; PMCID: PMC6097846.
Starcevic V. Benzodiazepines for anxiety disorders: maximising the benefits and minimising the risks. *Advances in Psychiatric Treatment*. 2012;18(4):250-258. doi:10.1192/apt.bp.110.008631

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Facts about Benzodiazepines

- Most who use benzodiazepines do NOT have a use disorder
  - 2015-2016 National Survey on Drug Use and Health
    - Estimated 30.6 million adults used benzodiazepines (12.6%)
    - 10.6% used as prescribed
    - 2.2% misused benzodiazepines
      - Highest among 18-25yo's
      - Lowest if >65yo (0.6%)
      - 70% got from a friend or relative
      - Alprazolam most commonly misused benzodiazepine
    - 0.2% have a benzo use disorder

2022-2023 Drug Combo Deaths, WA State

- Benzo + synthetic Opioid: 4.49%
- Meth + Opioids : 35.4%

- OUD and Benzodiazepines
  - Up to 30% of those on MOUD also on benzos and 1/3 of that sample will misuse them

- AUD and Benzodiazepines
  - Up to 30% in some samples of people in AUD treatment also have benzo misuse

Maust DT, Lin LA, Blow FC. Benzodiazepine Use and Misuse Among Adults in the United States. Psychiatr Serv. 2019 Feb 1;70(2):97-106. doi: 10.1176/appi.ps.201800321. Epub 2018 Dec 17. PMID: 30554562; PMCID: PMC6358464.
Blanco C, Han B, Jones CM, Johnson K, Compton WM. Prevalence and Correlates of Benzodiazepine Use, Misuse, and Use Disorders Among Adults in the United States. J Clin Psychiatry. 2018 Oct 16;79(6):18m12174. doi: 10.4088/JCP.18m12174. PMID: 30403446; PMCID: PMC10309967.
McHugh RK, Votaw VR, Taghian NR, Griffin ML, Weiss RD. Benzodiazepine misuse in adults with alcohol use disorder: Prevalence, motives and patterns of use.J Subst Abuse Treat. 2020 Oct;117:108061. doi: 10.1016/j.jsat.2020.108061. Epub 2020 Jun 22. PMID: 32811622; PMCID: PMC7438601.

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- Clonazepam 2mg TID x 10 months.

- PMH: HTN on HCTZ
- Substances: Alc-2-3 drinks Qnight, Drugs: none

- Question: PCP sends you a staff message and would like your input. They also want to know if the CoCM program can help with a taper?

Benzodiazepine Assessment

- What is the indication?
  - Is this the right med for the diagnosis?
- Is this an appropriate dose?
  - Too High→Taper to appropriate dose?
  - Appropriate→Continue?
- Has there been misuse or irregular behavior?
  - Is the PMP data reassuring?
  - Missed appointments but calling for prescriptions
- What are the risks and benefits of making a change?
  - Co-occurring conditions?
    - OUD
  - History of significant side effects?
    - Falls, MVAs
    - Cognitive slowing

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When is it withdrawal symptoms?

Benzodiazepine Discontinuation

- Rebound
  - Within hours to days, transiently more intense: insomnia and anxiety
  - Short duration, time-limited
- Symptom recurrence
  - Days to months, 60-80% for anxiety and insomnia disorders
  - Plan ahead!
- Pseudowithdrawal
  - Expectations of withdrawal
  - "Anxious state", personality structure, worry about alliance

Lader, M 1998 & 2011; Eickelberg, 2024 Principles of Addiction Medicine

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When do you need to worry about withdrawal symptoms?

- Withdrawal Phases
  - Physiologic Withdrawal
    - Therapeutic daily doses
    - Mild symptoms after 4-6 weeks of use
    - Clinically significant after 4-6 months
    - Protracted withdrawal after long-term use (1+ year)
      - Duration: weeks to months/waxing and waning
    - High daily doses (4-5x's of high dose range)
    - Moderate to severe withdrawal in all patients after 6 to 12 weeks
      - i.e. Clonazepam 24mg or Diazeapam 160mg

Soyka, M, 2017; Lader, M 1998 & 2011; Dickinson WE, 2014 Principles of Addiction Medicine

Table 3. Clinical Symptoms and Complications of Benzodiazepine Withdrawal.*

Psychopathologic symptoms
Increased anxiety
Nervousness
Sleep disorders
Inner restlessness
Depressive symptoms
Irritability
Psychosis-like conditions, delirium
Depersonalization and derealization
Confusion
Vegetative symptoms
Trembling
Sweating
Nausea and vomiting
Motor agitation
Dyspnea
Increased heart rate
Elevated blood pressure
Headaches
Muscle tension
Neurologic and physical complications
Increased risk of seizures
Impairment of voluntary movements
Cognitive impairments
Impairment of memory
Pronounced perceptual impairments
Hyperacusis
Photophobia
Hypersomnia
Dysesthesia, kinesthetic disorders, muscle twitching and fasciculations

* Data are from Soyka,[6] Ashton,[45] Lader and Kyriacou,[47] and Soyka and Batra.[49]

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When do you need to worry about withdrawal symptoms?

- Factors affecting w/d
- Pharmacokinetic
  - Short-acting: w/in 24 hours, peaks 1-5 days
  - Long-acting: w/in 5 days, peaks 1-9 days
- Higher dose and longer use→inc risk more severe
- Increase in psychopathology→more severe
- Other substances
- Older patients→more severe

Dickinson WE, 2014 Principles of Addiction Medicine

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When should you worry about seizures?

- Risks
  - High dose benzodiazepine
  - Short half-life of drugs
  - Abrupt discontinuation
  - Meds that lower seizure threshold

Exceptions
1987 48 case reports
- Dose: 5-20mg
- 6 cases sz's occurred 15days to 1 month after stopping med
- Multiple co-morbid problems
  - Insomnia
  - Alcohol
  - h/o seizures's

- Are rare: 2.5%- 8%
- Within 1-3 days, or longer
- Generalized and repetitive focal nonconvulsive

Martinez-Cano, H, et al 1995; Albiero, A, et al 2012; Fialip, J, et al 1987; Schatzberg, A, et al Manual of Clin Psychopharm 2010

Strategies for Taking a Pt off Benzodiazepines

- Minimal Intervention
  - Letter or office visit counseling patients about harms with recommendations to stop
    - 53/109 patients self-tapered and stayed off for > 2 years

Dickinson WE, 2014 Principles of Addiction Medicine; Schatzberg, A, et al Manual of Clin Psychopharm 2010; Soyka, M, et al 2017; Oude Voshaar, R, et al 2003

Strategies for Taking a Pt off Benzodiazepines (otpt ok for Diazepam equivalent of < 100mg)

- Cut-and-Hold: A % of the current dose (in mgs/fraction of mg) is reduced, then held until symptoms subside.
  - Pro: may be accomplished with existing forms of drug (e.g.¼ or ½ of scored 2 mg diazepam tablet).
  - Con: symptoms from larger dose reductions at once may be more intense.
  - Example: 20mg diazepam dose reduced 5% (1 mg) and held until withdrawal symptoms subside.
- Microtaper: Daily micro-reductions (µg in size), with % dose reduction (from current dose) calculated monthly.
  - Pro: may allow for finer adjustment and symptom control, since commercially available BZRA doses can be too large to taper comfortably. Many report better symptom tolerability with this method.
  - Con: off-label method that can be subject to accuracy issues.
  - Example: 20mg diazepam dose, 0.07 mg cut daily (~10% reduction over 1 month).

Dickinson WE, 2014 Principles of Addiction Medicine; Schatzberg, A, et al Manual of Clin Psychopharm 2010; Soyka, M, et al 2017; Oude Voshaar, R, et al 2003

Strategies for Taking a Pt off Benzodiazepines

- Tapering and Substitution
  - Switch to an equivalent dose of long-acting benzodiazepine
    - Clonazepam, Valium, Chlordiazepoxide
  - Consider giving a small prn amount of current short acting benzo until reach steady state
  - Reduce the dose weekly or every other week by 10% of the current dose for the first half
  - Last half→may need to slow taper by one-half
  - Closely followed and controlled→No refills or early refills
    - Set clear expectations at the beginning of the taper
    - Short duration of prescriptions
  - Duration 4-8 weeks
  - Why switch?
    - Better tolerated
    - Less misuse vs shorter-acting

Benzodiazepine Deprescribing Guidance (corxconsortium.org)

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Benzodiazepine Taper Adjunctive Meds

- Carbamazepine 200mg tid on own or with 3 day benzo taper x 2-3 weeks
- Propranolol 60-120mg/day, divided 3-4 times as adjunct to benzo taper
- Trazodone 25mg-150mg qhs
- Mirtazapine 7.5mg-45mg qhs – I like if also trying to treat depression, anxiety, or in elderly patients
- Gabapentin: pilot for tx of benzo misuse in methadone patients. Mean dose: 2666mg total daily dose. N=19, 50% retention

Dickinson WE, 2014 Principles of Addiction Medicine; Schatzberg, A, et al Manual of Clin Psychopharm 2010; Soyka, M, et al 2017; Oude Voshaar, R, et al 2003; Mariani, J, et al 2016

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Other Considerations

- Duration: will work with patient on setting a patient-centered goal
- Actively address pre-withdrawal symptoms
- CBT: for underlying symptoms. If anxiety-->CBT for Anxiety
- If misusing other substances
  - Recommend inpt detox
  - If the pt refuses and the PCP is looking for any kind of help, I will recommend a titration schedule and counsel pt that this is the last prescription.

Benzodiazepines and CoCM

- CoCM could provide support for a benzo taper
  - CBT can be useful for benzo tapering
  - Support prescribed medication taper plan
  - Allow psychiatric assessment and new med recommendation

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Case 2

- 58yo F with severe OUD on methadone and clonazepam 1mg BID. Her psychiatrist retired and she needs someone to continue her clonazepam for Generalized Anxiety Disorder. The patient has used both illicit and prescribed benzos in the past.

- Current medications
  - Methadone 140mg qday
  - Clonazepam 2mg TID

- Question: Should the Clonazepam be continued?

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Should I continue the Clonazepam?

A. **Yes**-she is stable right now
B. **Yes**-the combination of Bup and Benzo's are not that dangerous
C. **Yes**-but lower the dose
D. **No**-the combination of Bup and Benzo's are dangerous
E. You have it all wrong

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Benzos Detox vs Maintenance

- 2003, Israeli Methadone Clinic, N=66
  - All had documented benzo use disorder
- Clonazepam detox vs Clonazepam maintenance
  - Patient's choose which option
  - All started on 6mg total daily dose and then tapered off or down to maintenance dose (4-8 wks for maintenance dose)
  - Clonazepam given under daily supervision
  - Occasional misuse ok
- Failure
  - 2 daily benzo misuses above permitted dose
  - If continue to misuse→change modality of stop

Weizman T, Gelkopf M, Melamed Y, Adelson M, Bleich A. Treatment of Benzodiazepine Dependence in Methadone Maintenance Treatment Patients: A Comparison of Two Therapeutic Modalities and the Role of Psychiatric Comorbidity. Australian & New Zealand Journal of Psychiatry. 2003;37(4):458-463. doi:10.1046/j.1440-1614.2003.01211.x

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Detox vs Maintenance

Success: no benzos/no additional benzos

- 2003, Israeli Methadone Clinic, N=66
- Clonazepam detox vs Clonazepam maintenance

Mean maintenance dose: 2.64mg total daily dose
Co-occurring psych disorder: 64% (38%-mood, 32%-anxiety, 70% had personality disorder-antisocial most common)

Clonazepam Detox

Clonazepam Maintenance

Table 1. Success and failure rates of clonazepam detoxification (CDTX) and maintenance (CMT) at 2, 4, 6, 8, 10 and 12 months

	2 months	4 months	6 months	8 months	10 months	12 months
CDTX	n = 33	n = 31	n = 30	n = 30	n = 29	n = 29
Success	9 (27.3%)	7 (22.6%)	5 (16.7%)	5 (16.7%)	4 (13.8%)	4 (13.8%)
Failure	24 (72.7%)	24 (77.4%)	25 (83.3%)	25 (83.3%)	25 (86.2%)	25 (86.2%)
CMT	n = 33	n = 33	n = 32	n = 29	n = 28	n = 26
Success	26 (78.8%)	25 (75.8%)	24 (75%)	20 (69%)	19 (65.5%)	17 (65.4%)
Failure	7 (22.2%)	8 (24.2%)	8 (25%)	9 (31%)	9 (34.5%)	9 (34.6%)

CMT Success groups: had more mood and anxiety disorders
CDTX Success group: higher methadone doses

Weizman T, Gelkopf M, Melamed Y, Adelson M, Bleich A. Treatment of Benzodiazepine Dependence in Methadone Maintenance Treatment Patients: A Comparison of Two Therapeutic Modalities and the Role of Psychiatric Comorbidity. Australian & New Zealand Journal of Psychiatry. 2003;37(4):458-463. doi:10.1046/j.1440-1614.2003.01211.x

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Summary

- Benzodiazepines are an effective treatment for anxiety disorders
- Most people on benzodiazepines are not addicted, but some are
- Long term use of benzodiazepines can be considered from a risk/benefit perspective
- Outpatient tapering of benzodiazepines is doable in many situations. Slow and steady
- In some cases ongoing benzodiazepine prescribing may be the best option.

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Psychiatry Consultation Services for Washington State Healthcare Providers

Partnership Access Line (PAL)

- Psychiatry Consultation Line (PCL)
- for prescribing providers with adult psychiatry and/or addictions questions
- 877-WA-PSYCH (877-927-7924) | pclwa@uw.edu
- Staffed 24/7
- www.pcl.psychiatry.uw.edu

PAL for Moms

Psychiatry & Addictions Case Conferences (UW PACC-ECHO)

70 yo M with Parkinsons

- Presenting with lifelong anxiety in many different areas of his life. Multiple antidepressant trials with the most success with Escitalopram. He has been on and off benzodiazepines since 1971. Started on Clonazepam in 2005, which he has been on since. Denies any misuse…ever. + Tolerance.
- PMH
  - Parkinson's dx in 2011, Hypercholesterolemia, GERD
- Past Psych Hx
  - SA: none
  - PM: Imipramine, multiple SSRIs, Wellbutrin, Valium, Alprazolam
- Substances: none
- Meds: Sinemet, Escitalopram, Rasagiline, Clonazepam 1mg qday

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54yo M with h/o anxiety and depression

Presents for evaluation and treatment of his poorly controlled anxiety that has been worsening over the past 1 year. Has elevated periods of anxiety, but no panic attacks. Uses lorazepam 1mg 3-4 times a day for the past 6 weeks after dealing with a job loss 7 months ago and struggling financially. He had to change his PCP due to insurance and his new PCP is not comfortable prescribing this medication. PHQ9: 13 GAD7: 15

- PMH: HTN
- Past Psych History: Anxiety and Depression.
  - SA: none
  - Past Meds: Sertraline (5 years ago)
- Meds: Chlorthalidone, Lisinopril, Atorvastatin, Lorazepam
- Substances: Alc-2-3 drinks Qnight, Drugs: none

Consult Question: What are some better options for treatment of his anxiety? What is the best way to taper his Lorazepam?

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Additional Free Resources for Washington State Healthcare Providers

*No cost

EDUCATIONAL SERIES:

- AIMS Center office hours
- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO UW PACC
- UW TelePain series About TelePain (washington.edu)
- TeleBehavioral Health 101-201-301-401 Telehealth Training & Support - Harborview Behavioral Health Institute (uw.edu) | bhinstitute@uw.edu

PROVIDER CONSULTATION LINES

- UW Pain & Opioid Provider Consultation Hotline Consultation (washington.edu) – 844-520-PAIN 7246)
- Psychiatry Consultation Line - (877) 927-7924
- Partnership Access Line (PAL) (pediatric psychiatry) - (866) 599-7257
- PAL for Moms (perinatal psychiatry) - (877) 725-4666

Questions and Discussion

- Ask questions in the chat or unmute yourself

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