Is It Time to Wean?
Engaging the Benzodiazepine Epidemic

An Introduction to the Outpatient
Benzodiazepine Engagement & Safer Taper/Transition Program (BEST-T)

Med Chi Opioid, Pain & Addiction Committee
May 20th, 2025

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BrightWell RECOVERY HEALTH

Disclosures

Shannon Tieman - Nothing to Disclose

Drew Fuller - Founder BrightWell Health

Benzodiazepines in US (Adults)

13% of adults were prescribed a BZD in 2020

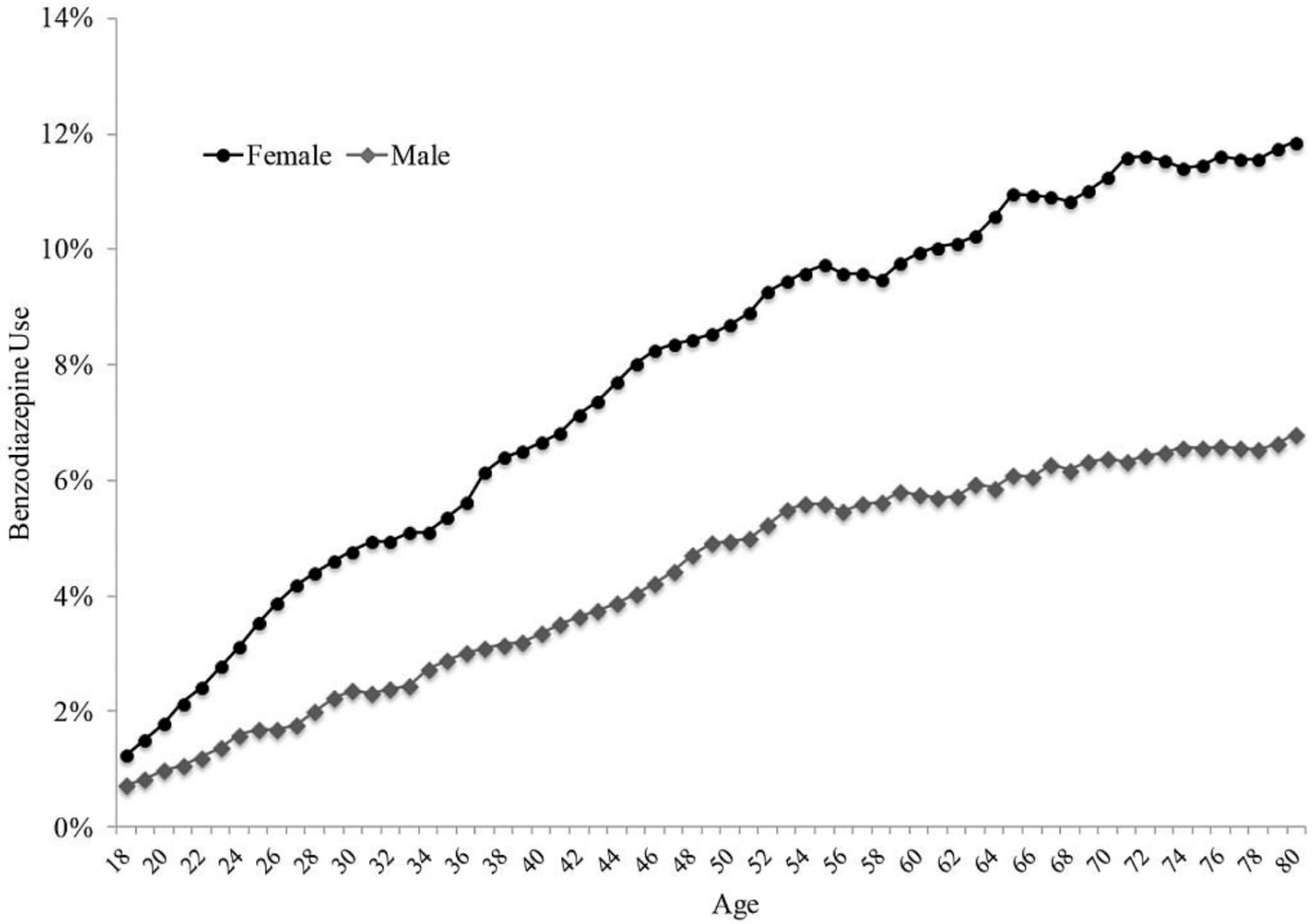
- Doubled from 10 years prior

66 million ever prescribed

Elderly with highest rates

(CDC, 2020) and (Maust et al., 2019)
Kevin Xu JAMA Open 2020

Use Highest in Elderly (Despite Risks)



Percent by age prescribed a BZD in the year 2008

JAMA Psychiatry.
doi:10.1001/jamapsychiatry.2014.1763

At-Risk Groups

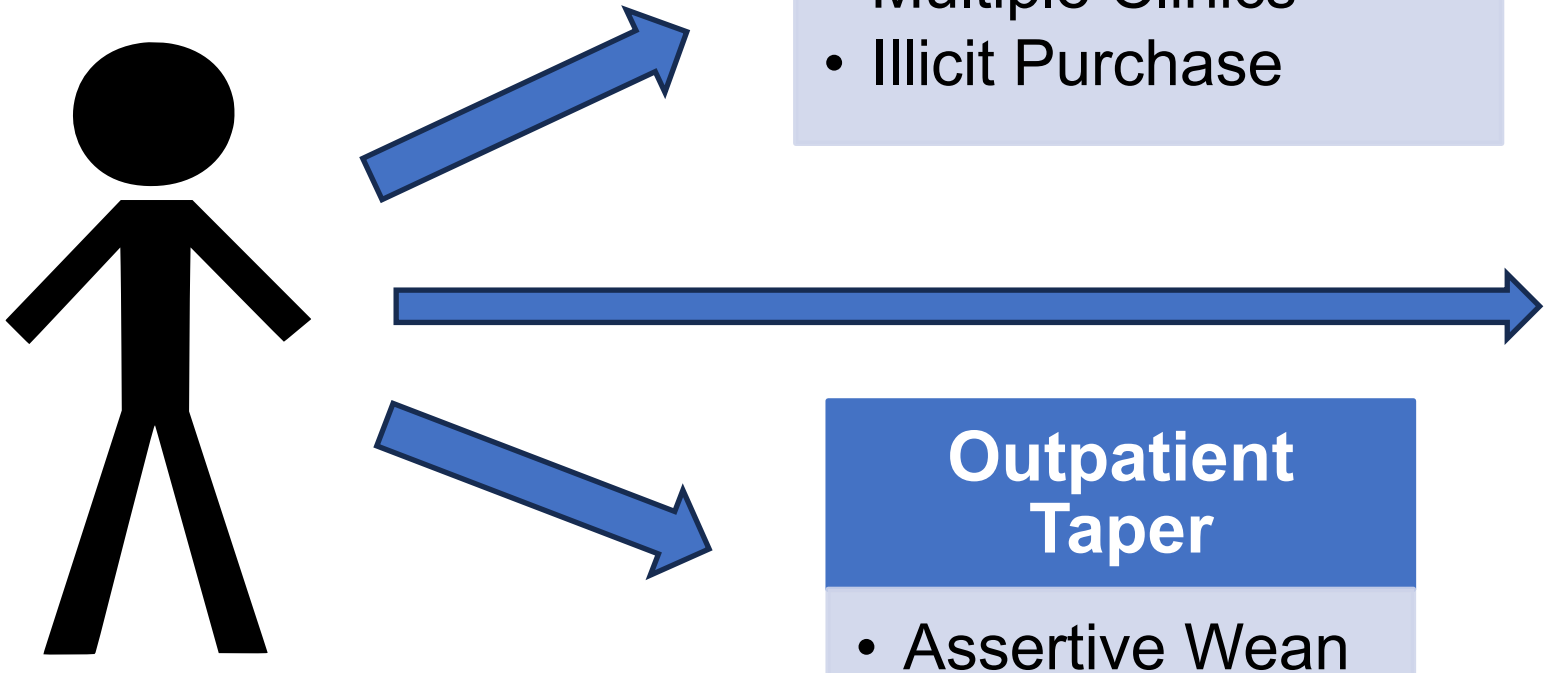
- Elderly (BEERS)
- SUD
- 20-30 years of use
- Opioid Users
- Illicit use
- Pregnancy

Reported/Assumed Risks with Chronic BZD Use

- Trauma
- Higher All-cause mortality (Double)
- OD Risks
- Depression
- Dementia

JAMA Psychiatry.
doi:10.1001/jamapsychiatry.2014.1763

Options for People on Benzodiazepines



Stay on BZD

- Single Clinic
- Multiple Clinics
- Illicit Purchase

Inpatient Taper

- Rapid Wean

Outpatient Taper

- Assertive Wean
- Slow wean

News Headlines - Risk of Tapering Off

Psychiatry > General Psychiatry

Planning to Stop That Benzodiazepine? Think Twice

— Patients who discontinued long-term benzodiazepines had a higher risk of death

by Michael DePeau-Wilson, Enterprise & Investigative Writer, MedPage Today
December 20, 2023

Stopping long-term benzodiazepine treatment was tied to a higher risk of death, according to a comparative effectiveness study using claims data.

Retrospective Analysis - Showed Higher Associated Mortality once weaned off BZD

Original Investigation | Pharmacy and Clinical Pharmacology

December 20, 2023

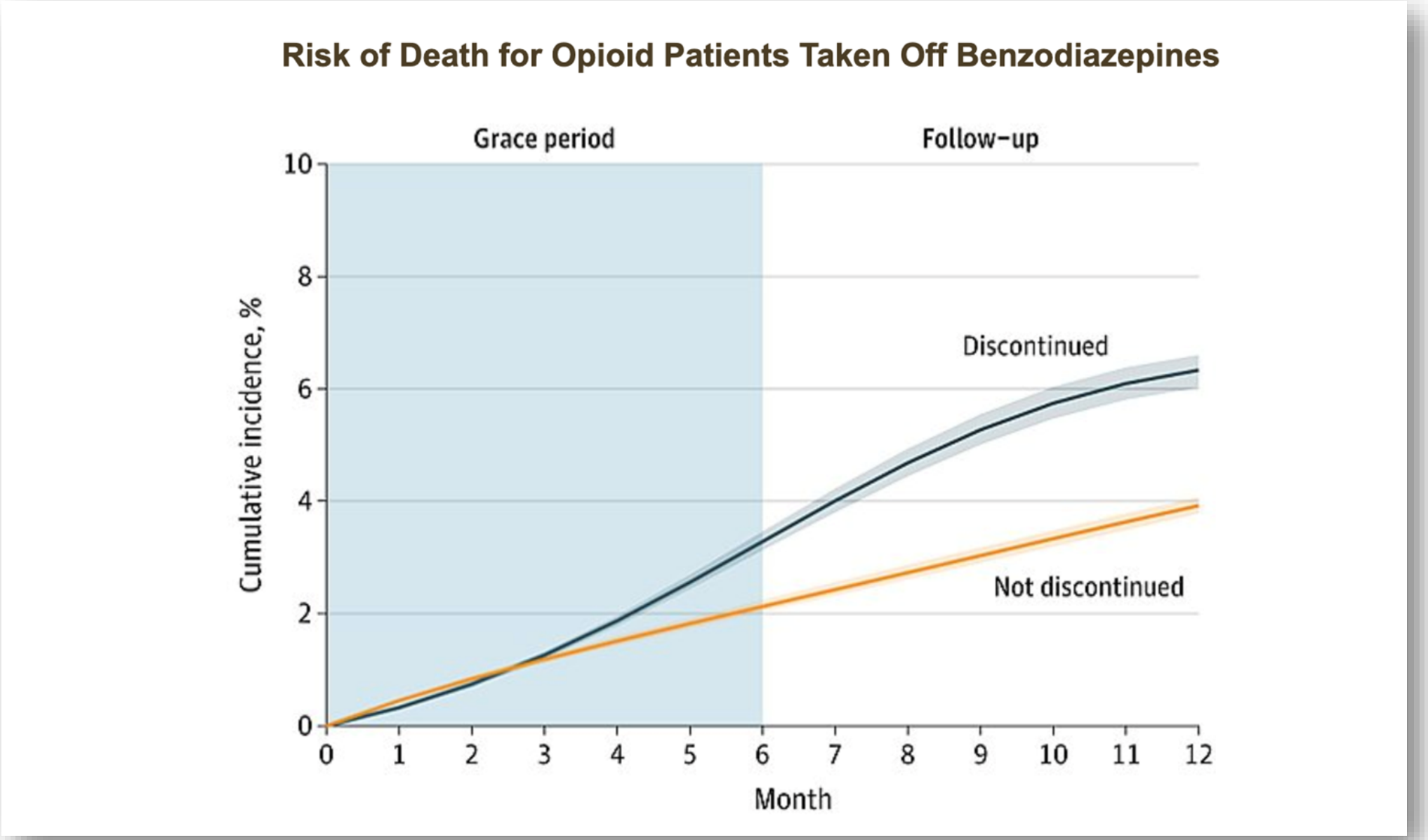
Benzodiazepine Discontinuation and Mortality Among Patients Receiving Long-Term Benzodiazepine Therapy

Donovan T. Maust, MD, MS[1,2,3]; Kierstdea Petzold, MS[2]; Julie Strominger, MS[2]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2023;6(12):e2348557. doi:10.1001/jamanetworkopen.2023.48557

Higher Post-Wean Mortality for Persons on Opioids



Post Wean Mortality/Morbidity
(Persons on Opioids)

1.6x Higher Relative Risk of Death

at 12 months

Other Adverse Outcomes

- **Suicidality**
- **Overdose**
- **Emergency Department Visits**

Why an INCREASE Association with Death after weaning off BZD?

Why Were the BZDs discontinued?

- Unstable – Psychiatric – Medical - Social
- Compliance
- Loss of access to care

How Were the BZDs STOPPED?

- Sudden - Managed or unmanaged
- Inpatient
- Outpatient

What Factors Contributed to the Deaths?

- Withdrawal
- Medical or psychiatric related
- Overdose

Point to Consider

Assumption -

Stable, compliant patients who are doing well (Medically and psychiatrically) with good continuity of care usually don't get weaned/taken off their benzodiazepines.

…..It's the HIGH-RISK patients that are taken off or drop out of care

What Happens If Not Treated

- Clinical withdrawal
- Worsening mental health states
- Lack of coordinated care
- Unsupervised care by Telehealth providers
- Illicit (Fentanyl Exposure Risks)
- Other substance use

Pick the Fake

A

B

Why a Tapering/Deprescribing Program

2022 - Inherited a large panel of patients on concurrent Alprazolam and Buprenorphine

- The Primary physician released his DEA license

Other community providers declined to manage benzodiazepines

Safety Concerns

- Need for Close Management (Co-Occurring Conditions)
- Risk with outside providers (telehealth)
- Risk if pressed pills

Co-Occurring SUD Medical/MH Practice

2022 -What Protocols were available?

No Clear US Guideline at the time

(The ASAM Guide will not be released until 2025)

Consulted with the Maryland Addiction Consultation Service (MACS)

Discussion with regional addiction medicine specialists

Benzodiazepine Engagement and Safer Taper/Transition (BEST-T) - Program

- Early Program – “**BEST Option” for many at the time**
- Evidence-based Approach - (Ashton)
- Patient - Centered
- Patient Safety Focus

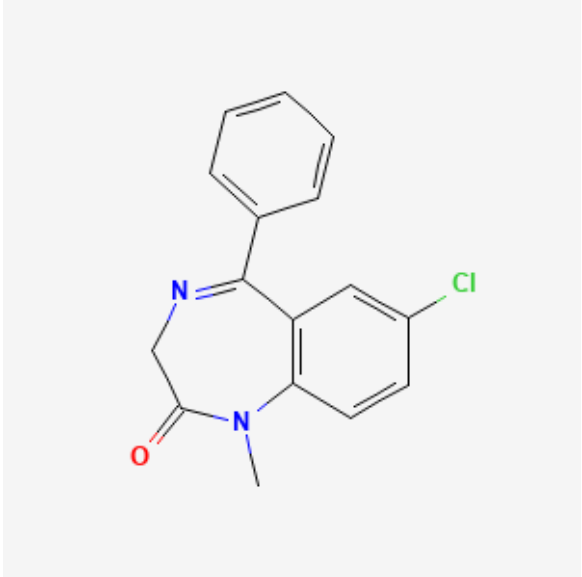
Ashton Method

Dr. Heather Ashton weaned 300 patients off benzodiazepines from 1982-1994 (specialty clinic)

- Key Distinction - Patients sought the deprescribing

Published the Ashton Method in 1999

Treatment is transitioned over to diazepam, then slowly tapered



Diazepam

(Ashton, 2002)

Why Diazepam for Weaning?

Long Half Life

Smoother Transitions

Less Concentrated

Permits Micro Adjustments

Diazepam Less Concentrated

	Ashton	Clin Calc	Med Calc
	Conversion to Diazepam		
Alprazolam 1mg	20mg	15mg	10mg
Clonazepam 1mg	20mg	15mg	10mg

Why Not Use Clonazepam to Wean?

Highly Concentrated

difficult to make micro-adjustments (5-10%)

What to do with Higher Dose Transition?

Ex. 40yo on alprazolam 2mg TID

BZD Dose equivalence of 90-120mg if diazepam a day

Key Points

- Where do you start?
- Is that safe for the outpatient setting?
- Is inpatient an option?
- Will Inpatient work?

Starting Conversion Dose

(from Clonazepam or alprazolam)

Avoid blending the prescribing of benzodiazepines

(Using both diazepam and alprazolam together as with Ashton)

- Pharmacists Concerns
- Insurance coverage
- Patients do well with conversion directly to diazepam

Can START with a 10:1 ratio and follow daily, if WD sz then increase to 15:1 ratio

Need a New Model – Multiphase Approach

Inpatient Care (Phase 1)

- Conversion to a long-acting agent
- Critical dose reduction
- Coordinated Transition to Outpatient Care

Outpatient Care (Phase 2)

- Long-term, slow wean
- Continue supportive care
- Co-manage mood disorder

What about the Elderly Population?

Diazepam has 4 metabolic pathways and active metabolites

Is temazepam a better option?

Key Components of ‘BEST-T’ Program

Patient-centered approach

- **Reassurance & Rapport Building**

Modified Ashton

Start Low and Go SLOW

Pause for periods of stress, holidays, adjust as needed

SMALL changes in weaning down

5-10% change 1-3 months (1-2 mg changes at a time)

Co-management of Anxiety – Depression

Co-management of other SUD (OUD)

Informed Consent (Patient-Centered Discussion)

BrightWell RECOVERY HEALTH

Client: _____

Provider Reviewing Agreement: _____

Benzodiazepine Engagement & Safer Transition Treatment Agreement

The Brightwell Health Benzodiazepine Engagement & Safer Transition Program (BEST) has been developed to help patients comfortably and safely wean down and ultimately off benzodiazepines and other similar sedative medications while treating their anxiety and/or other conditions with more effective evidenced-based medications and therapies.

The aim of weaning off benzodiazepines medications is supported by decades of evidence that indicates significantly higher risk of dementia, trauma, overdose, decreased functioning and depression with these medications. The risk may be further increased with advancing age and use of other medications with sedative properties or alcohol.

It is generally accepted that benzodiazepines are most effective in short term use (less than several weeks) or occasional intermittent use. There is little evidence to support long term effectiveness, as often the anxiety condition will worsen over time.

Some common safety concerns with use of benzodiazepines may include:

- Sedation
- Memory impairment
- Increased anxiety
- Aggression
- Trauma from falls, accidents, motor vehicle collisions
- Effects on pregnancy including neonatal complications to the newborn.
- Increased tolerance potentially leading to dependence and withdrawal.
- Drug interactions.
- Severe withdrawal including seizures or death if stopped suddenly.

I understand and acknowledge the following:

_____ The Benzodiazepine Transition Program is an optional and special qualification program and that it may be stopped at the discretion of the clinical team if safety or compliance is a concern. Brightwell Recovery Health does not provide chronic benzodiazepine treatment outside of this program. I have a right to obtain these medications from other practices and will notify Brightwell Recovery Health if doing so.

_____ I am aware that benzodiazepines may compromise alertness and possibly judgement.

_____ Benzodiazepines have been linked to dementia, increased falls, trauma, and depression.

_____ The safety concerns and restrictions are not limited to those listed in this agreement.

_____ I will not take the medications more than the dose or frequency prescribed.

_____ Requests for early refills may NOT be possible and that consideration for refills requests will be on a case-by-case basis at the discretion of the provider.

_____ I will remain responsible for the safe and secure storage of my medications. I will keep these medications away from children or avoid situations where they may be lost or stolen. If a medication lock box is needed, I will ask staff for resources or suggestions on obtaining one.

_____ Lost or stolen medications may NOT necessarily be replaced and consideration for such will be on a case-by-case basis and at the discretion of the provider. Police report numbers may be required for insurance/pharmacy records.

_____ I will arrange for medication requests at the prescribed interval, during scheduled visits or operational hours.

_____ I will not request benzodiazepine or potentially sedative medications from other healthcare providers without the prior approval of my Brightwell Recovery Health provider. I will promptly report if I received benzodiazepines or sedative medication by another provider.

_____ I will keep my medication lists updated with Brightwell Recovery Health and will notify my physician/provider if I am taking or prescribed other sedation medication (prescribed, not prescribed and over the counter).

_____ I agree to avoid alcohol and other sedating substances as they can cause complications, sedation, accidents, and possible death.

_____ I agree not to use illicit benzodiazepines, opioids (including fentanyl, oxycodone, methadone), and/or any other sedative-type medications. I am aware that such combinations may be harmful or fatal.

_____ I understand that use of illicit stimulants (including cocaine and methamphetamines) may lead to discharge from the BEST Program and benzodiazepines may not be prescribed by Brightwell Recovery Health providers.

_____ I will avoid driving, dangerous or high-risk conditions or work if I feel potentially compromised or sedated by my medications.

_____ This program utilizes multi-team management and that I will agree to treatment with a substance use provider, a psychiatric provider and a counselor as requested.

_____ I will actively participate in the treatment plan as described by my team at Brightwell Health. This may include individual sessions, group sessions, or other recommended services from my Brightwell Health team.

_____ I agree to have routine and random urine drug screenings as well random medication counts to help assure compliance and safe use. Random pill counts and urine testing should be completed within the time frame determined by the care provider (usually 24-48 hours).

_____ If medication counts, urine drug testing or other clinical criteria indicate that I am not taking these medications or taking in excess, my provider may decrease or discontinue these medications, the program may be terminated and I may be referred to another program, an inpatient program, or other services for safe weaning/withdrawal management.

_____ I will agree to consent for my Brightwell Recovery Health and other healthcare providers to share information if medically necessary. I understand that a copy of this treatment agreement may be provided to my healthcare providers and/or my pharmacy.

_____ I understand that failure to comply with the above or if my care team is concerned about potential harm or safety issues, then the program may be terminated or that I may be referred for inpatient withdrawal management.

I have read this agreement and agree to all the outlined terms and conditions.

Patient Name (Print): _____ Signature: _____ Date: _____

Clinicians Guide

Note – Initial Conversion Ratio at 10:1 and not 20:1 (Ashton)

Clinician's Guide - Benzodiazepine Engagement Safer Transition (BEST) Program

Initiation Date: 10/22/2024
Completion Date:
Revision Date: 7/14/2024; 10/08/2024; 10/10/2024; 10/22/2024

Approach with Patients

- Discuss concerns about chronic BZD therapy, inform of benefits of transitioning and reassure the patient on the utilization of a patient- centered process. Share patient information found at the top of the BEST Program Patient Agreement form
- Patient ***MUST*** be stabilized on buprenorphine prior to prescribing ANY benzodiazepines
- Share guidelines for transition process from BZD to other treatments (pharmacological and counseling)
- Consider starting the process on the next visit (within 2 weeks)
- Discuss the BEST Program and how it's purpose and goal is for safe weaning of benzodiazepines
- Provide comfort and build patient rapport by ensuring that underlying mental health ***MUST*** be comanaged by Brightwell Recovery Health's psychiatric providers who will evaluate, monitor, and treat other mental health diagnoses
- **Recommend and highly encourage that formal counseling is essential for this approach.**
- This is to be used as a guide, providers may use their discretion and collaboration with another provider

Clinical Steps

1) **Convert to Diazepam**

*Please note that some insurances may not allow blending of multiple benzodiazepines.
*Some insurances may require clinical prior authorization if patient is prescribed potentially interacting medications

Short Acting Benzo Use (e.g. - Alprazolam) Convert to diazepam in 2 steps.

Daily dose of diazepam shall not exceed 40mg - unless clinically indicated and approved by the Medical Director (due to higher risks)

- Alprazolam (Xanax, Temazepam)
  - Step 1 convert 50% of alprazolam (1 mg dose) to diazepam in 1-2 weeks.
  - Step 2 convert the remaining dose diazepam.
  - Focused Follow-up TH visits within 48 hours to assess impact.

Long-Acting Benzo Use (Clonazepam, oxazepam)

- Convert in single step - completed conversion to Diazepam.

If complex/long-term poly benzodiazepine history:

- Approximation of conversions:

Current Dose	Current Benzodiazepine		Average Equivalent Dose of Valium (diazepam)	Dose Ranges of Valium (diazepam)
1mg	Klonopin (clonazepam)	=	10mg	2.5mg- 20mg
1mg	Xanax (alprazolam)	=	10mg	5mg-20mg
25mg	Librium (chlordiazepoxide)	=	8mg	5mg-20mg
1mg	Ativan (lorazepam)	=	6mg	2.5mg-10mg
10mg	Serax (oxazepam)	=	5mg	2.5mg- 20mg
10mg	Restoril (temazepam)	=	5mg	2.5mg- 20mg
0.25mg	Halcion (triazolam)	=	5mg	2.5mg-10mg

For patient specific conversions with higher complexity, please utilize MedCalc Benzodiazepine Conversion Calculator

- MDCalc Benzodiazepine Conversion calculator and Ashton Method *should* be utilized for weaning with patients.
- Weaning case by case basis depending on patient complexity and risks for taper plan
- Include information in the instructions section to the pharmacist.
- After 1-3 months on a new dose, continue to discuss the slow reduction procedure.
- When possible, avoid large decreases at any step unless clinically indicated.
- Consider 1-2 mg decrease at a time every 4-12 weeks (earlier if indicated).

2) **Weaning Process:**

- Wean as tolerated, can go as slow as 1mg-2mg every 4-12 weeks.

3) **Anxiety Co-management:**

Optional medication used in assistance to wean:

- Seroquel 25 mg
- Vistaril 25-50 mg or Atarax 10 mg TID prn
- Clonidine 0.1 mg TID prn
- Propranolol (avoid with asthma or patients on any beta blockers)
- (avoid gabapentin given sedation, synergism with opiates, and overdose risk)

Psych Providers - Aim for utilizing longer acting medications.

- SSRI SNRI
- TCAs
- Buspirone
- Mood stabilizer - Lamictal, Trileptal.
- Serotonin Modulators - Trintellix/Viibryd.
- "Antipsychotics" Rexulti, Abilify, Vraylar, Latuda, Seroquel.

Monitoring Benzodiazepine UDS:

- Oxazepam is a diazepam/Valium metabolite in urine.
- A-OH alprazolam is a Xanax metabolite in urine.
- Nordiazepam is chlordiazepoxide/Librium in urine.
- 7-aminoclonazepam is clonazepam/Klonopin in urine

4) **Termination of program - Clinical Considerations:**

- Taking other benzodiazepines not prescribed by Brightwell Recovery Health providers
- Illicit benzodiazepine use
- Using cocaine
- Running out of scripts early
- Requiring alternative benzo bridging
- Diversion

4) **Rapid Wean Process Clinical Steps:**

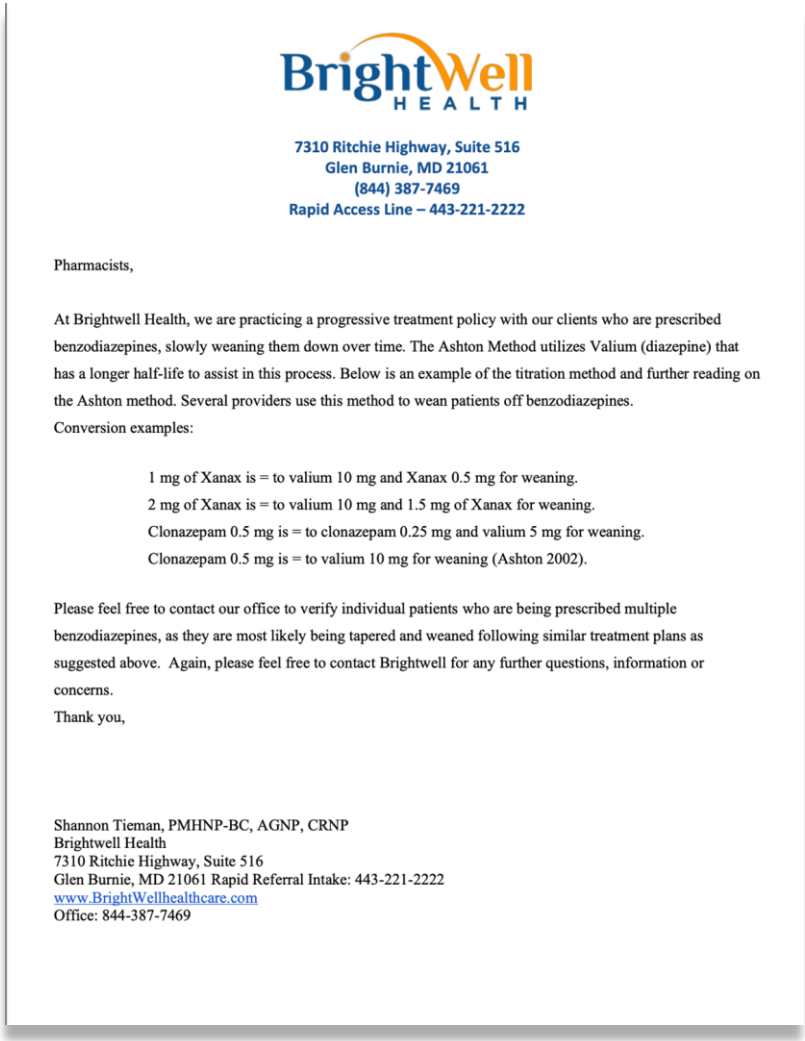
ALL rapid wean patients must be overseen by the Medical Director

- Recommend inpatient and consent for refusal of inpatient care.
- Frequent follow ups every 2-3 days with telehealth and weekly in person urine levels.
- Weekly visits with cocaine use.
- Rapid weaning with valium as clinically indicated by the provider.

Pharmacy Notification

Proactive Approach

Invited Discussion & Collaboration



BrightWell HEALTH

7310 Ritchie Highway, Suite 516
Glen Burnie, MD 21061
(844) 387-7469
Rapid Access Line – 443-221-2222

Pharmacists,

At Brightwell Health, we are practicing a progressive treatment policy with our clients who are prescribed benzodiazepines, slowly weaning them down over time. The Ashton Method utilizes Valium (diazepine) that has a longer half-life to assist in this process. Below is an example of the titration method and further reading on the Ashton method. Several providers use this method to wean patients off benzodiazepines.
Conversion examples:

1 mg of Xanax is = to valium 10 mg and Xanax 0.5 mg for weaning.
2 mg of Xanax is = to valium 10 mg and 1.5 mg of Xanax for weaning.
Clonazepam 0.5 mg is = to clonazepam 0.25 mg and valium 5 mg for weaning.
Clonazepam 0.5 mg is = to valium 10 mg for weaning (Ashton 2002).

Please feel free to contact our office to verify individual patients who are being prescribed multiple benzodiazepines, as they are most likely being tapered and weaned following similar treatment plans as suggested above. Again, please feel free to contact Brightwell for any further questions, information or concerns.
Thank you,

Shannon Tieman, PMHNP-BC, AGNP, CRNP
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Few Patients Proactively Wanted to Come off Benzodiazepines

Patients presenting to BrightWell Health to wean off BZD

ONE

BEST-T - Preliminary Data

Prescribed #2 BEQ	Total Prescribed BEQ	MedCalc Prescribed BEQ	Clinicalc Prescribed BEQ	Ashton Prescribed BEQ	Claimed #1 BZD	Claimed #1 BZD Daily Dose (mg)*	Claimed #1 BZD BEQ	Claimed #2 BZD	Claimed #2 BZD Daily Dose (mg)*	Claimed #2 BZD BEQ	Total Claimed Daily BEQ	MedCalc Claimed BEQ	Clinicalc Claimed BEQ	Ashton Claimed BEQ	Program Start Date	Initial #1 BZD	Inital #1 BZD Daily Dose (mg)	Inital #1 BZD BEQ	Initial #2 BZD	Initial #2 BZD Daily Dose (mg)	Total Daily BEQ	Current #1 BZD	Current #1 BZD Daily Dose (mg)	Current #1 BZD BEQ	Current Status	MedCalc % of Decrease	Clinicalc % of Decrease	Ashton % of Decrease
		15	22.5	30								FALSE	FALSE	FALSE	2/14/2023	Alprazolam	0.5	5	Diazepam	10	15	Alprazolam	0.5	5	Actively Enrolled	-66.67%	-77.78%	-83.33%
		20	20	20								FALSE	FALSE	FALSE	9/13/2022	Diazepam	14	14			14	Diazepam	8	8	Actively Enrolled	-60.00%	-60.00%	-60.00%
		10	15	20								FALSE	FALSE	FALSE	9/12/2023	Diazepam	5	5			5	Diazepam	2	2	Actively Enrolled	-80.00%	-86.67%	-90.00%
		12.5	12.5	12.5	Alprazolam	10	100					100	150	200	11/16/2023	Diazepam	20	20			20				Completed Program	-100.00%	-100.00%	-100.00%
		10	15	20	Alprazolam	4	40					40	60	80	9/4/2024	Diazepam	25	25			25	Diazepam	24	24	Actively Enrolled	-52.00%	-68.00%	-76.00%
		10	15	20	Clonazepam	1	10					10	15	20	12/14/2022	Clonazepam	0.75	7.5	Diazepam	5	12.5	Diazepam	10	10	Actively Enrolled	-50.00%	-66.67%	-75.00%
		10	15	20								FALSE	FALSE	FALSE	12/11/2023	Diazepam	20	20			20	Diazepam	20	20	Actively Enrolled	100.00%	33.33%	0.00%
		20	30	40								FALSE	FALSE	FALSE	12/19/2022	Diazepam	5	5			5	Diazepam	2	2	Actively Enrolled	-90.00%	-93.33%	-95.00%
		20	30	40								FALSE	FALSE	FALSE	12/27/2022	Diazepam	20	20			20			FALSE	Completed Program	-100.00%	-100.00%	-100.00%
		5	7.5	10								FALSE	FALSE	FALSE	9/12/2024	Diazepam	5	5			5	Diazepam	5	5	Actively Enrolled	0.00%	-33.33%	-50.00%
		10	15	20								FALSE	FALSE	FALSE				FALSE			0			FALSE				
		FALSE	FALSE	FALSE	Alprazolam	10	100					100	150	200	12/5/2022	Alprazolam	3	30	Diazepam	30	60	Diazepam	25	25	Actively Enrolled	-75.00%	-83.33%	-87.50%
		20	30	40								FALSE	FALSE	FALSE	12/27/2024	Diazepam	20	20			20	Diazepam	20	20	Actively Enrolled	0.00%	-33.33%	-50.00%
		FALSE	FALSE	FALSE	Alprazolam	3	30					30	45	60	12/13/2024	Diazepam	20	20			20	Diazepam	20	20	Actively Enrolled	-33.33%	-55.56%	-66.67%
		20	30	40								FALSE	FALSE	FALSE	9/13/2022	Clonazepam	4	40			40	Diazepam	23	23	Actively Enrolled	15.00%	-23.33%	-42.50%
		FALSE	FALSE	FALSE	Alprazolam	6	60					60	90	120	12/6/2022	Alprazolam	1.5	15	Diazepam	10	25				Completed Program	-100.00%	-100.00%	-100.00%
		30	45	60								FALSE	FALSE	FALSE	1/13/2025	Diazepam	30	30			30	Diazepam	30	30	Actively Enrolled	0.00%	-33.33%	-50.00%
		20	30	40								FALSE	FALSE	FALSE	4/28/2024	Diazepam	20	20			20			FALSE	Discharged from Pro...			
		40	60	80								FALSE	FALSE	FALSE	1/18/2024	Clonazepam	2	20	Diazepam	10	30	Diazepam	40	40	Actively Enrolled	0.00%	-33.33%	-50.00%
		FALSE	FALSE	FALSE								FALSE	FALSE	FALSE	11/30/2023	Diazepam	10	10			10	Diazepam	9	9	Actively Enrolled	-10.00%	-45.00%	-60.00%
		10	15	20								FALSE	FALSE	FALSE	2/8/2023	Diazepam	15	15			15	Diazepam	10	10	Actively Enrolled	0.00%	-33.33%	-50.00%
		FALSE	FALSE	FALSE	Alprazolam	6	60	Clonazepam	2	20	80	80	120	160	3/18/2023	Diazepam	30	30			30	Diazepam	25	25	Actively Enrolled	-68.75%	-79.17%	-84.38%
		20	30	40								FALSE	FALSE	FALSE	3/15/2023	Clonazepam	2	20			20	Diazepam	10	10	Actively Enrolled	-50.00%	-66.67%	-75.00%
		30	45	60								FALSE	FALSE	FALSE	2/9/2023	Diazepam	30	30			30	Diazepam	14	14	Actively Enrolled	-53.33%	-68.89%	-76.67%
		5	7.5	10								FALSE	FALSE	FALSE	1/5/2023	Alprazolam	0.25	2.5	Diazepam	5	7.5	Diazepam	2	2	Actively Enrolled	-60.00%	-73.33%	-80.00%
		24	32	48								FALSE	FALSE	FALSE	4/15/2024	Diazepam	30	30			30	Diazepam	23	23	Actively Enrolled	-4.17%	-28.13%	-52.08%
		30	45	60								FALSE	FALSE	FALSE	11/25/2024	Diazepam	20	20			20	Diazepam	20	20	Actively Enrolled	-33.33%	-55.56%	-66.67%
		20	30	40								FALSE	FALSE	FALSE	11/21/2022	Alprazolam	1.5	15	Diazepam	10	25	Diazepam	5	5	Actively Enrolled	-75.00%	-83.33%	-87.50%
		60	90	120								FALSE	FALSE	FALSE	11/7/2022	Diazepam	20	20			20	Diazepam	6	6	Actively Enrolled	-90.00%	-93.33%	-95.00%
		12	16	24								FALSE	FALSE	FALSE	12/14/2023	Diazepam	15	15			15	Diazepam	13	13	Actively Enrolled	8.33%	-18.75%	-45.83%
		60	90	120								FALSE	FALSE	FALSE	8/5/2023	Diazepam	30	30			30	Diazepam	9	9	Actively Enrolled	-85.00%	-90.00%	-92.50%
		10	15	20								FALSE	FALSE	FALSE	11/7/2022	Clonazepam	0.75	7.5	Diazepam	5	12.5	Diazepam	4	4	Actively Enrolled	-60.00%	-73.33%	-80.00%
		50	75	100								FALSE	FALSE	FALSE	2/23/2023	Alprazolam	0.5	5	Diazepam	20	25				Completed Program	-100.00%	-100.00%	-100.00%
		FALSE	FALSE	FALSE	Alprazolam	4	40					40	60	80	9/6/2024	Diazepam	20	20			20	Diazepam	38	38	Actively Enrolled	-5.00%	-36.67%	-52.50%
		30	45	60								FALSE	FALSE	FALSE	10/20/2022	Alprazolam	0.5	5	Diazepam	30	35	Diazepam	20	20	Actively Enrolled	-33.33%	-55.56%	-66.67%
15	35	27.5	39.9	55								FALSE	FALSE	FALSE	8/2/2022	Clonazepam	2	20			20	Diazepam	24	24	Actively Enrolled	-12.73%	-39.85%	-56.36%
		3	4	6								FALSE	FALSE	FALSE				FALSE			0	Lorazepam	0.5	3	Actively Enrolled	0.00%	-25.00%	-50.00%
		FALSE	FALSE	FALSE	Alprazolam	0.5	5					5	7.5	10	10/7/2024	Diazepam	5	5			5	Diazepam	10	10	Actively Enrolled	100.00%	33.33%	0.00%
		30	45	60								FALSE	FALSE	FALSE	12/13/2022	Alprazolam	2.5	25	Diazepam	10	35	Diazepam	5	5	Actively Enrolled	-83.33%	-88.89%	-91.67%
		FALSE	FALSE	FALSE	Alprazolam	4	40					40	60	80	7/29/2024	Diazepam	20	20			20	Diazepam	35	35	Actively Enrolled	-12.50%	-41.67%	-56.25%
		40	60	80								FALSE	FALSE	FALSE	2/21/2024	Diazepam	30	30			30	Diazepam	30	30	Actively Enrolled	-25.00%	-50.00%	-62.50%
		10	10	10								FALSE	FALSE	FALSE	10/5/2023	Diazepam	10	10			10				Completed Program	-100.00%	-100.00%	-100.00%
		5	7.5	10								FALSE	FALSE	FALSE	4/12/2024	Diazepam	4	4			4	Diazepam	3	3	Actively Enrolled	-40.00%	-60.00%	-70.00%
		30	45	60								FALSE	FALSE	FALSE	3/13/2023	Clonazepam	1.5	15	Diazepam	10	25	Diazepam	36.5	36.5	Actively Enrolled	21.67%	-18.89%	-39.17%
		5	7.5	10								FALSE	FALSE	FALSE	9/11/2024	Diazepam	5	5			5	Diazepam	4	4	Actively Enrolled	-20.00%	-46.67%	-60.00%
		30	45	60								FALSE	FALSE	FALSE	1/9/2023	Clonazepam	2.5	25	Diazepam	10	35	Diazepam	6	6	Actively Enrolled	-80.00%	-86.67%	-90.00%
		FALSE	FALSE	FALSE	Alprazolam	10	100					100	150	200	4/24/2024	Diazepam	30	30			30	Diazepam	2	2	Actively Enrolled	-98.00%	-98.67%	-99.00%
		5	7.5	10								FALSE	FALSE	FALSE	12/3/2024	Diazepam	5	5			5	Diazepam	5	5	Actively Enrolled	0.00%	-33.33%	-50.00%
		FALSE	FALSE	FALSE								FALSE	FALSE	FALSE	7/22/2024	Diazepam	32	32			32	Diazepam	30	30	Actively Enrolled			
																									Averages:	-36.98%	-56.84%	-67.51%

BEST - Preliminary Results

Category	Clin. Calc	Ashton Calc
	Amount of DECREASE	
Active BEST-T Program	57%	68%
Prior Prescriptions Verified (CRISP)	54%	65%
Claimed Street/Illicit Use	62%	71%
> 12 months in Program	60%	73%

Decreasing Benzodiazepine Dose
(12 months)

60-73% reduction

Benzodiazepine Weaning for People on Buprenorphine

Approx 2/3 Current BZD Buprenorphine

- Safety Considerations and Balancing the Risk
- Risks of Sedation
- Risks of not weaning
- Risks of not coordinating care

FDA Clarification: BZD and Buprenorphine

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FDA Drug Safety Podcast: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks

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FDA Drug Safety Podcasts

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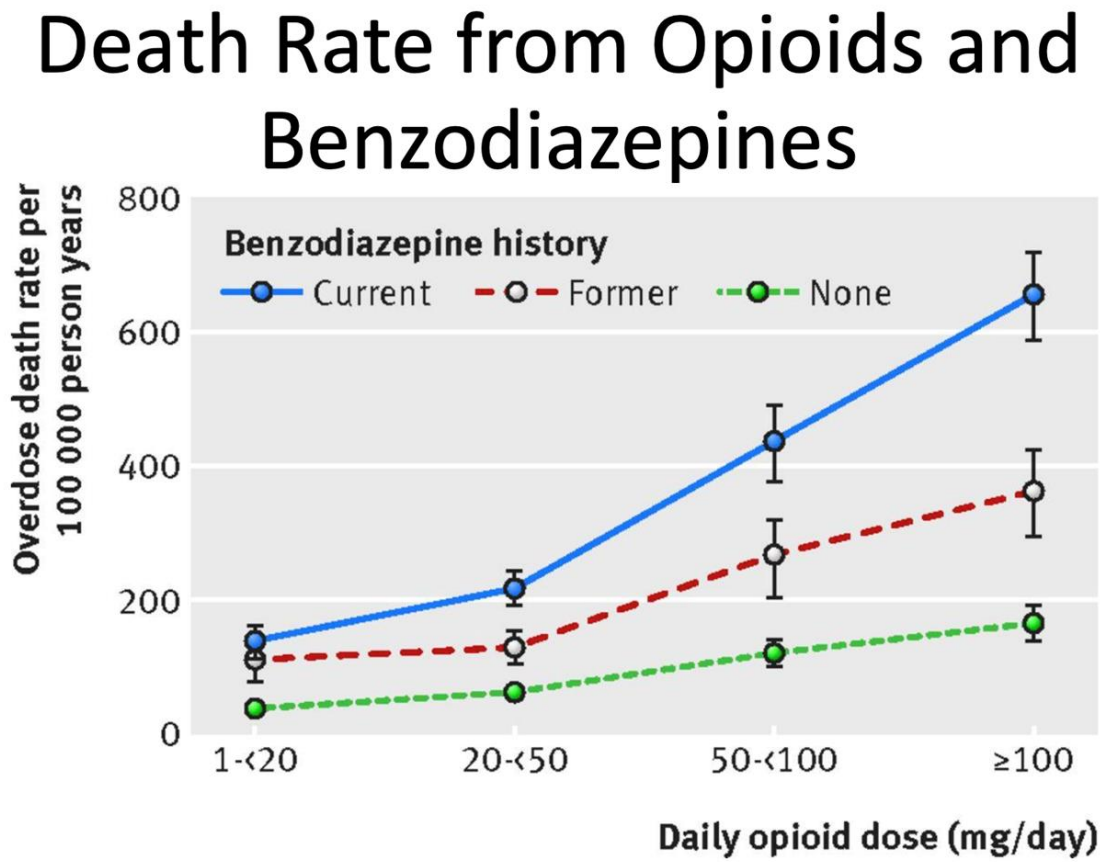
Welcome to the FDA Drug Safety Podcast for health care professionals from the Division of Drug Information.

On September 20, 2017, based on additional review, the FDA advised that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system. The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks. Careful medication management by health care professionals can reduce these risks. We are requiring this information to be added to the buprenorphine and methadone drug labels along with detailed recommendations for minimizing the use of medication-assisted treatment (or MAT) drugs and benzodiazepines together. Many patients with opioid dependence may also use benzodiazepines or other CNS depressants, either under a health care professional's direction or illicitly. Although there are serious risks with combining these medicines, excluding patients from MAT or discharging patients from treatment because of use of benzodiazepines or CNS depressants is unlikely to stop them from using these drugs together.

Buprenorphine and methadone help people reduce or stop their abuse of opioids.

Content current as of:
01/19/2022

BZD Users May be Higher Risks Groups (past and present)

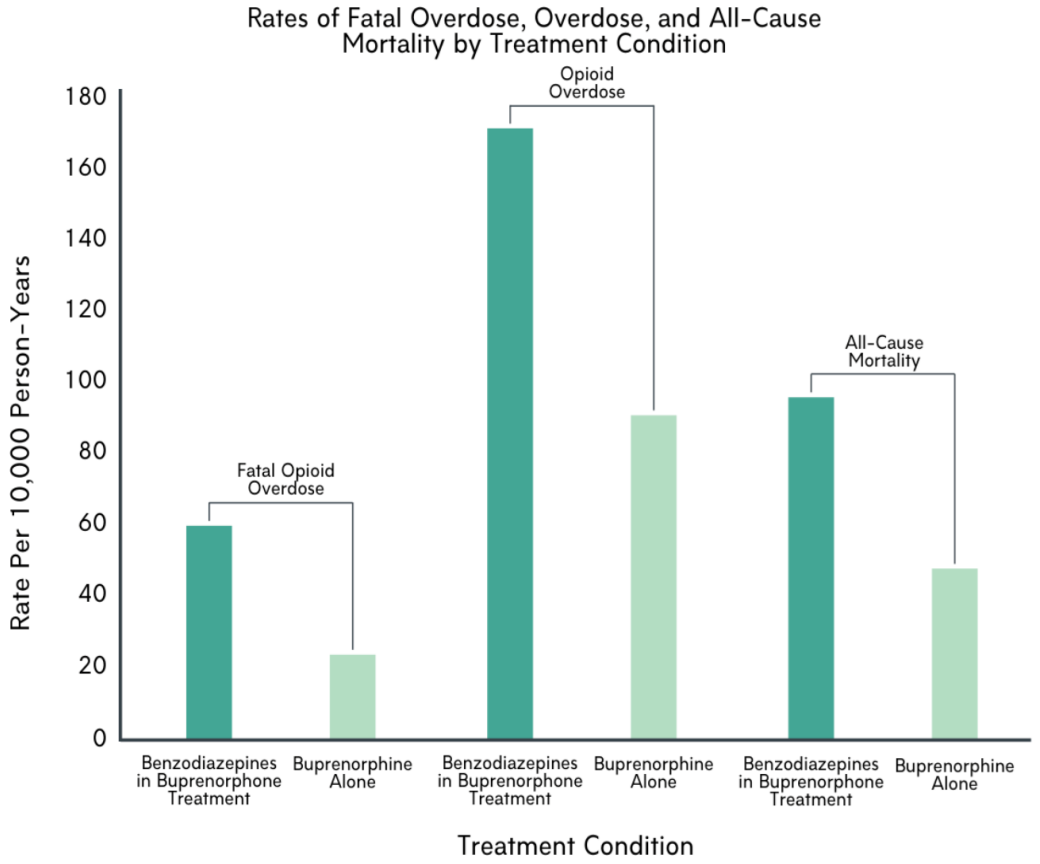


Park, T. W., Saitz, R., Ganoczy, D., Ilgen, M. A., & Bohnert, A. S. (2015). Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. *Bmj*, *350*, h2698.

Slide Credit - Brian Hurley, Center for Innovation 2017

Association vs Causation

- Retrospective analysis
- Unclear association and timing
- Past - Europe, 90s, IDU both BZD & Bup
- Few deaths in the US due to Bup
- People on BZDs - higher risk groups
- More study is needed to understand the actual risks



Practice Guideline - Tapering

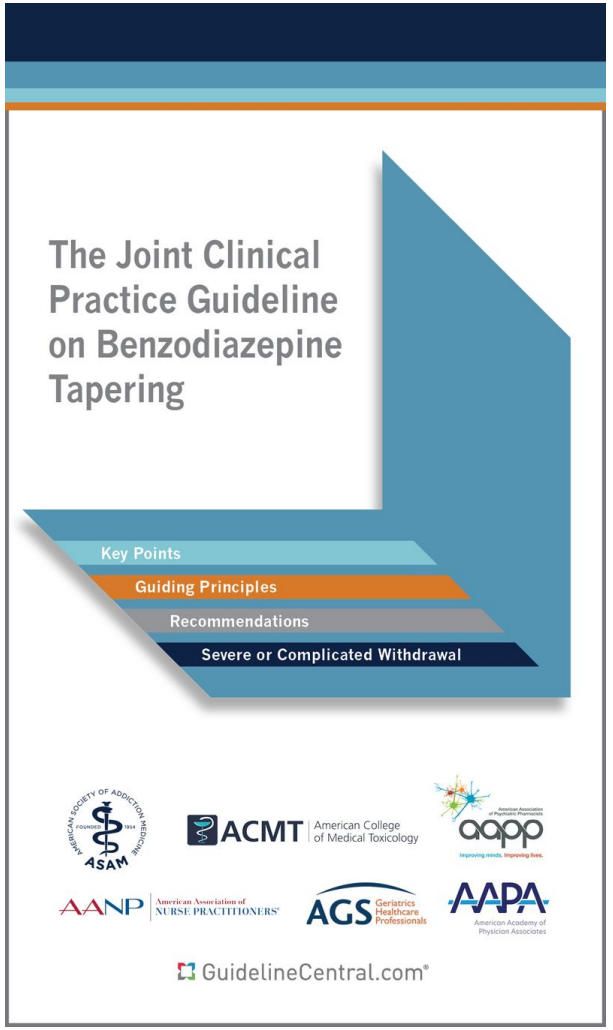
Joint Practice Guideline

- ASAM
- APA
- 8 other Prof. Societies

Released 2025

29 recommendations

- Patient-centered
- Go Slow
- Co-manage anxiety, MH



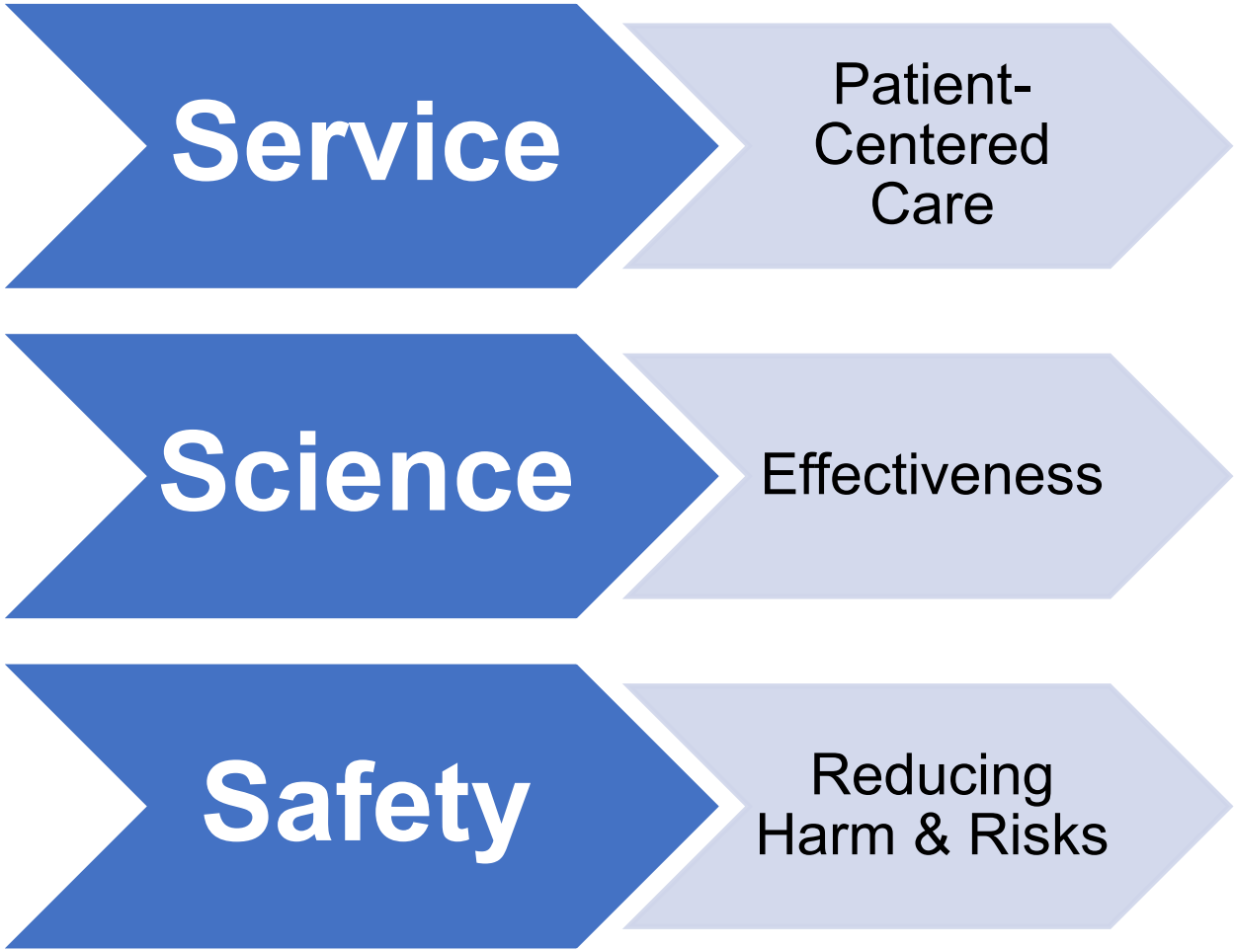
Lessons Learned

- Collaborative engagement—The patient is in control of the weaning
- Go Slow—Months—Years is okay (what is the alternative?)
- Pause if needed (Stress, worsening symptoms, Life events)
- Close monitoring – other sedative medications, substance use
- Refer to inpatient if compliance or safety concerns

Future Considerations

- Need to assess - Satisfaction and Impact
- Medication options for the elderly and special populations
- Further understanding of the risks of weaning vs not weaning
- Collaboration with medical & professional organizations
- Collaboration with Pharmacies
- Collaboration with State Agencies
  - Department of Health (Behavioral Health)
  - Office of Controlled Substances Administration (OCSA)
  - Board of Physicians and Board of Nursing

Essential Components for Balanced Care



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