Safe Tapering of Benzodiazepines: Insights from the Joint Clinical Practice Guideline on Benzodiazepine Tapering

ASAM Annual Conference
4/25/25

Presenters/Disclosures

- Emily Brunner, MD, DFASAM
  - No disclosures
- Chinyere Ogbonna, MD, MPH
  - No disclosures
- Tricia Wright, MD, MS, FACOG, DFASAM
  - No disclosures

Learning Objectives

- Apply the key clinical takeaways for safely tapering benzodiazepines based upon the Joint Clinical Practice Guideline for Benzodiazepine Tapering.
- Recognize strategies for patient engagement and shared decision-making during BZD tapering.
- Identify complications associated with rapid BZD discontinuation and how to prevent them.

Audience Poll

What is your professional background?

- Physicians
  - Addiction physician
  - Family medicine physician
  - Psychiatric specialist physician
- Advanced practice professional
  - Nurse practitioner
  - Physician associate
- Mental health professionals
  - Counselor,
  - Social worker
  - Therapist
- Peer professionals

Audience Poll

How many patients have you successfully treated?

- 0-20
- 21-100
- 100+

Benzodiazepine Use in the U.S.

- BZDs are approved by the US Food and Drug Administration (FDA) to manage a wide range of conditions, including acute conditions (eg, panic and acute anxiety, alcohol withdrawal, seizures) and common chronic conditions (eg, anxiety disorders, primary insomnia).
- Long-term BZD use is associated with increased risk of physical dependence and withdrawal and ongoing risk of adverse events such as falls, motor vehicle accidents, and cognitive impairment.

Rationale for Tapering Guideline

- Clinicians are asking for guidance
- Patients are reporting a desire for better treatment
- In 2020, A Black Box Warning was placed on benzodiazepines, due to the risk of serious problems while on the medication and the risk of serious withdrawal symptoms that can last months when discontinued abruptly

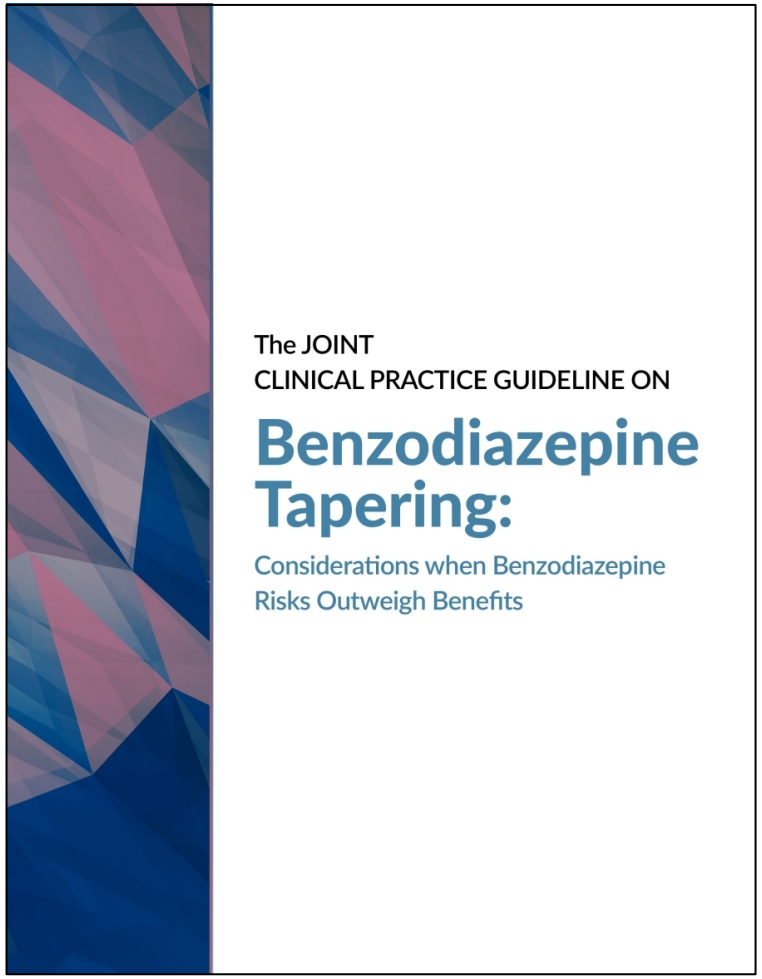
Avoiding Misapplication

- As observed with the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain, clinical practice guidelines can have *unintended consequences*
- Rapid BZD discontinuation or dose reduction can cause life-threatening withdrawal symptoms (e.g., seizures, delirium) and destabilization of mental health conditions

- **BZDs should not be discontinued abruptly in patients who are likely to have developed physical dependence.**

Joint Clinical Practice Guideline on Benzodiazepine Tapering

https://www.asam.org/quality-care/clinical-guidelines/benzodiazepine-tapering



Partner Organizations

AMERICAN PSYCHIATRIC ASSOCIATION

AMERICAN ACADEMY OF NEUROLOGY

AGS Geriatrics Healthcare Professionals

AAPA American Academy of Physician Associates

AAFP

ACOG The American College of Obstetricians and Gynecologists

American Association of Psychiatric Pharmacists aapp

AANP American Association of NURSE PRACTITIONERS®

AMERICAN SOCIETY OF ADDICTION MEDICINE FOUNDED 1954 ASAM

ASAM American Society *of* Addiction Medicine

ACMT | American College of Medical Toxicology

Advancing the toxicologic care of patients and populations

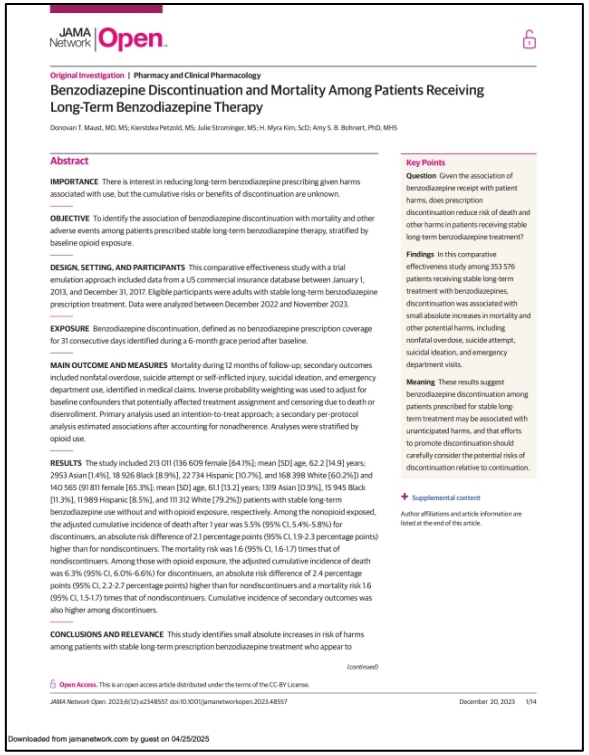
Intended Audience for Guideline

- Clinicians—including behavioral health professionals, physicians, advanced practice providers, and pharmacists—who prescribe BZDs or provide or support treatment for indications for which BZDs are often prescribed.
- Clinicians who practice in diverse settings such as primary care offices, ambulatory care clinics for a broad range of specialty clinicians, EDs, hospitals, and outpatient, and residential addiction and mental health treatment settings.
- Some recommendations only apply to specific settings (e.g., inpatient treatment, medically managed settings).

Note: These guidelines are **not meant to apply** to palliative and end-of-life care.

Potential Risks of Discontinuation

- Recent retrospective cohort study of U.S. commercial healthcare claims database of adults with long-term BZD prescription
- Mortality risk of people who discontinued medication was 1.6 times that of people who did not discontinue
- *However*, authors were not able to analyze <u>why</u> clinicians discontinued the BZD, or <u>how</u> the medication was discontinued (e.g., rate of tapering or discontinuation), which would be important to put the findings into context



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Original Investigation | Pharmacy and Clinical Pharmacology

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

Donovan T. Maust, MD, MS; Kierstdea Petzold, MS; Julie Strominger, MS; H. Myra Kim, ScD; Amy S. B. Bohnert, PhD, MHS

Abstract

IMPORTANCE There is interest in reducing long-term benzodiazepine prescribing given harms associated with use, but the cumulative risks or benefits of discontinuation are unknown.

OBJECTIVE To identify the association of benzodiazepine discontinuation with mortality and other adverse events among patients prescribed stable long-term benzodiazepine therapy, stratified by baseline opioid exposure.

DESIGN, SETTING, AND PARTICIPANTS This comparative effectiveness study with a trial emulation approach included data from a US commercial insurance database between January 1, 2013, and December 31, 2017. Eligible participants were adults with stable long-term benzodiazepine prescription treatment. Data were analyzed between December 2022 and November 2023.

EXPOSURE Benzodiazepine discontinuation, defined as no benzodiazepine prescription coverage for 31 consecutive days identified during a 6-month grace period after baseline.

MAIN OUTCOME AND MEASURES Mortality during 12 months of follow-up; secondary outcomes included nonfatal overdose, suicide attempt or self-inflicted injury, suicidal ideation, and emergency department use, identified in medical claims. Inverse probability weighting was used to adjust for baseline confounders that potentially affected treatment assignment and censoring due to death or disenrollment. Primary analysis used an intention-to-treat approach; a secondary per-protocol analysis estimated associations after accounting for nonadherence. Analyses were stratified by opioid use.

RESULTS The study included 213 011 (136 609 female [64.1%]; mean [SD] age, 62.2 [14.9] years; 2953 Asian [1.4%], 18 926 Black [8.9%], 22 734 Hispanic [10.7%], and 168 398 White [60.2%]) and 140 565 (91 811 female [65.3%]; mean [SD] age, 61.1 [13.2] years; 1319 Asian [0.9%], 15 945 Black [11.3%], 11 989 Hispanic [8.5%], and 111 312 White [79.2%]) patients with stable long-term benzodiazepine use without and with opioid exposure, respectively. Among the nonopioid exposed, the adjusted cumulative incidence of death after 1 year was 5.5% (95% CI, 5.4%-5.8%) for discontinuers, an absolute risk difference of 2.1 percentage points (95% CI, 1.9-2.3 percentage points) higher than for nondiscontinuers. The mortality risk was 1.6 (95% CI, 1.6-1.7) times that of nondiscontinuers. Among those with opioid exposure, the adjusted cumulative incidence of death was 6.3% (95% CI, 6.0%-6.6%) for discontinuers, an absolute risk difference of 2.4 percentage points (95% CI, 2.2-2.7 percentage points) higher than for nondiscontinuers and a mortality risk 1.6 (95% CI, 1.5-1.7) times that of nondiscontinuers. Cumulative incidence of secondary outcomes was also higher among discontinuers.

CONCLUSIONS AND RELEVANCE This study identifies small absolute increases in risk of harms among patients with stable long-term prescription benzodiazepine treatment who appear to

(continued)

Key Points

Question Given the association of benzodiazepine receipt with patient harms, does prescription discontinuation reduce risk of death and other harms in patients receiving stable long-term benzodiazepine treatment?

Findings In this comparative effectiveness study among 353 576 patients receiving stable long-term treatment with benzodiazepines, discontinuation was associated with small absolute increases in mortality and other potential harms, including nonfatal overdose, suicide attempt, suicidal ideation, and emergency department visits.

Meaning These results suggest benzodiazepine discontinuation among patients prescribed for stable long-term treatment may be associated with unanticipated harms, and that efforts to promote discontinuation should carefully consider the potential risks of discontinuation relative to continuation.

Supplemental content

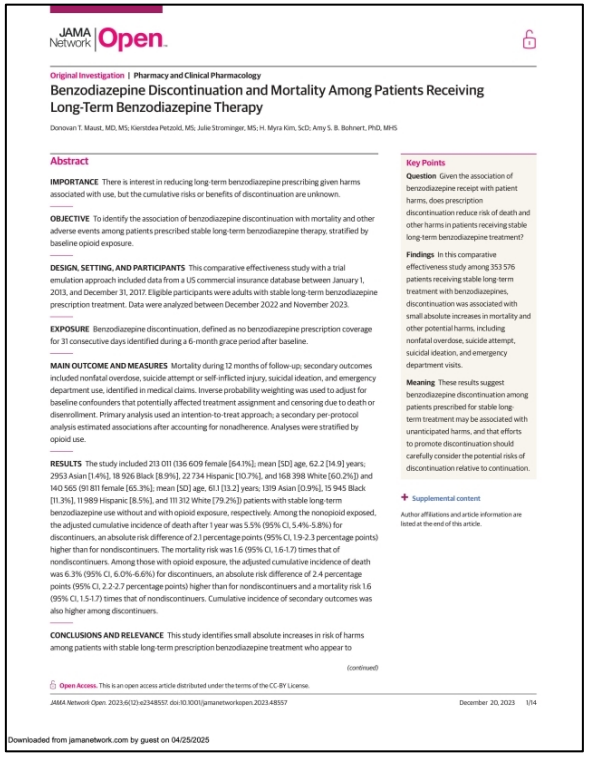
Author affiliations and article information are listed at the end of this article.

JAMA Network Open. 2023;6(12):e2348557. doi:10.1001/jamanetworkopen.2023.48557 December 20, 2023 1/14

Maust DT, Petzold K, Strominger J, Kim HM, Bohnert ASB. Benzodiazepine Discontinuation and Mortality Among Patients Receiving Long-Term Benzodiazepine Therapy. JAMA Netw Open 2023;6:e2348557.

Potential Risks of Discontinuation

- Main findings of this study were correlational, not causal
- Many confounders limited the ability to interpret the results of the study
- Dr. Maust was on the guideline committee; this study was discussed extensively and it was determined that while important, this study did not negate the overall literature, which generally points to risks for long-term BZD use that outweigh benefits



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Partnering with Patients

- Patient-centered
- Focus on education re BZD risks and benefits
- Discuss alternative options for symptom management

The recommendations in this Guideline should be interpreted in the context of shared decision-making with patients. In other words, when a recommendation says, “clinicians should consider,” it should be understood to include “in partnership with the patient.”

Recommendation for Partnering with Patients

- Clinicians should develop the BZD tapering strategy in coordination with patients and their care partners in a shared decision-making process whenever possible (*Clinical Consensus*, Strong Recommendation).

Implementation Considerations:

- Clinicians can consider utilizing educational resources when developing BZD tapering strategies with patients.
- Clinicians can consider utilizing a motivational interviewing (MI) framework, which is patient-centered and seeks to involve patients in resolving ambivalence to change.

Recommendations for Considerations for Tapering Benzodiazepines

- Clinicians should ideally assess the risks and benefits of ongoing BZD prescribing at least every 3 months for each patient taking BZD medications (*Clinical Consensus*, Strong Recommendation).
  - At a minimum, clinicians should assess the risks and benefits with each new BZD prescription or BZD prescription renewal (*Clinical Consensus*, Strong Recommendation).
  - Clinicians should review the information in the relevant prescription drug monitoring programs (PDMP) as part of the risk–benefit assessment (*Clinical Consensus*, Strong Recommendation).

Potential Benefits and Risks of Continued BZD Use and BZD Tapering

+ Potential Benefits	- Potential Risks	
BZD Use	**BZD Use**	**BZD Taper**
• Effectiveness in managing a patient's mental and physical health condition(s) • Related functional improvements • Quality of life improvements	• Oversedation, including consideration of use with other sedating medications, alcohol, or other drugs • Falls and related injuries • Memory and cognitive impacts • Motor vehicle accidents • Medical safety concerns (e.g., medication interactions) • Impacts on co-occurring mental and physical health conditions • Disrupted sleep patterns • Diversion • Substance use disorder • Overdose • Fetal harm • Suicidality	• Withdrawal symptoms including severe or complicated withdrawal (e.g., seizures, delirium) • Recurrence of the condition for which BZD was prescribed • Impacts on co-occurring mental and physical health conditions • Protracted withdrawal • Transition to illicit BZD use

Risk for Clinically Significant BZD Withdrawal

Duration of BZD Use	Frequency of BZD Use	Total Daily BZD Dose	Risk for Clinically Significant Withdrawal	**Need for taper?**
Any	≤3 days per week	Any	Rare	LOW
<1 month	≥4 days per week	Any	Lower risk, but possible	
1–3 months	≥4 days per week	Low‡	Lower risk, but possible	
1–3 months	≥4 days per week	Moderate§ to high**	Yes, with greater risk with increasing dose and duration	
≥3 months	≥4 days per week	Any	Yes, with greater risk with increasing dose and duration	HIGH

‡ A low daily dose is estimated as 10 mg diazepam equivalents or less (e.g., ≤0.5mg clonazepam, ≤2mg lorazepam, ≤1mg alprazolam). See Appendix H for BZD dose equivalents.

§ A moderate daily dose is estimated as 10-15mg diazepam equivalents (e.g., 0.1-1.5mg clonazepam, 2-3mg lorazepam, 1-2mg alprazolam). See Appendix H for BZD dose equivalents.

** A high daily dose is estimated as 15mg diazepam equivalents (e.g., 0>1.5 mg clonazepam, >3mg lorazepam, >2mg alprazolam). See Appendix H for BZD dose equivalents.

How to think about risks and benefits?

- Risks and benefits exist along a continuum.
- Before you can consider the benefits, **what is the condition that is being treated?**
- When determining the balance of risks and benefits, clinicians should consider the following:

How significant are the potential benefits?

How significant are the potential risks?

How imminent are the risks?

Could alternative interventions achieve similar benefits?

What are the risks of the alternative interventions?

How effectively can the risks be managed?

Physical Dependence vs Substance Use Disorder

Physical Dependence: A biological phenomenon that develops in response to repeated use of a medication.

Substance Use Disorder: A chronic disease associated with functional changes to the brain circuits that mediate stress, decision-making, and behavior reinforcement.

National Survey on Drug Use and Health suggests just **1.5%** of people who use BZDs **met criteria for a BZD use disorder**.

Recommendations for Considerations for Tapering Benzodiazepines

- Clinicians should avoid abruptly discontinuing BZD medication in patients who are likely to be physically dependent on BZDs and at risk for BZD withdrawal (**Low Certainty**, Strong Recommendation).
  - Tapering is indicated for patients who are likely to be physically dependent when the risks of BZD medication outweigh the benefits (**Low Certainty**, Strong Recommendation).
  - Clinicians should consider either discontinuation or a short taper for patients who are unlikely to be physically dependent when the risks of BZD medication outweigh the benefits (*Clinical Consensus*, Strong Recommendation).

Recommendations for Considerations for Tapering Benzodiazepines

- If the BZD medication is discontinued without a taper in patients who are unlikely to be physically dependent, clinicians should counsel patients to report the emergence of withdrawal and/or rebound symptoms (*Clinical Consensus*, Strong Recommendation).
  - If significant symptoms emerge, clinicians can consider using medications for symptom management or restarting the BZD medication and initiating a taper (*Clinical Consensus*, Conditional Recommendation).

Implementation Considerations

- There is potentially a large population of patients who would benefit from BZD tapering:
  - ~2 million older adults in the US taking BZD for >120 days.
- The healthcare system is ill-prepared to manage BZD tapering on a large scale.

We must not abandon these patients.

- Healthcare systems should consider how to triage those who would benefit most from tapering.
- Avoid measuring success based on prescribing data alone. Focus on patient-centered outcomes (e.g., adverse events, functionality, mental and physical health outcomes).

Group Discussion

- Fred R.: 59-year-old male, otherwise healthy, “inherited patient” who has been taking 2 mg clonazepam twice daily for an unknown number of years.
  - What other information would you want to know?
  - Is this someone who would be a candidate for tapering?

Recommendations for the Tapering Process

- Clinicians should generally consider dose reductions of 5% to 10% when determining the initial pace of the BZD taper. The pace of the taper should typically not exceed 25% every 2 weeks (*Clinical Consensus*, Strong Recommendation).

- Clinicians should consider the lower end of the dose reduction range (ie, 5%) for the first reduction to assess a patient's initial response, unless there are imminent safety concerns
- For patients who are likely to have strong physical dependence (eg, those who have been taking a high dose for more than a year), clinicians should consider a slower taper.

  For the first reduction, consider the lower end of the dose reduction range (eg, 5%).

  For further reductions, clinicians should adjust based on patients' initial response, considering reduction of 5% to 10% every 6–8 weeks, or slower as appropriate.

- Clinicians can consider the higher end of the dose reduction range (ie, 10-25%) for patients who are unlikely to have significant physical dependence but for whom tapering is indicated

Recommendations for the Tapering Process

- Clinicians can consider transitioning patients without contraindications to a comparable dose of a longer-acting BZD medication for the taper (*Clinical Consensus*, Conditional Recommendation).

Recommendations for the Tapering Process

- Clinicians should tailor tapering strategies to each individual patient and adjust the taper based on a patient's response (*Clinical Consensus*, Strong Recommendation).

Implementation Considerations:

Clinicians should consider pausing or slowing the pace of the taper and/or making smaller dose reductions for patients experiencing significant symptoms related to the BZD taper.

The BZD tapering process can be more difficult for patients as they approach the point of discontinuation. Clinicians should proactively consider smaller dose reductions and/or slowing the pace of dose reductions as the taper progresses.

Recommendations for the Tapering Process

- Clinicians should evaluate patients undergoing tapering for signs and symptoms related to the BZD taper with each dose reduction (*Clinical Consensus*, Strong Recommendation).

Implementation Considerations: Clinicians should monitor patients for symptoms of withdrawal and recurrence with each dose reduction. Virtual or telephonic check-ins can be leveraged for this purpose

Recommendations for Adjunctive Interventions

- Clinicians should offer patients undergoing BZD tapering behavioral interventions tailored to their underlying conditions (eg, CBT, CBT-I) or provide them with referrals to access these interventions (**Low Certainty**, Strong Recommendation).

- Clinicians should first consider pausing or slowing the pace of the BZD taper when patients experience symptoms that significantly interfere with the taper (eg, sleep difficulty, anxiety). However, clinicians can also consider use of adjunctive medications (*Clinical Consensus*, Conditional Recommendation).

Group Discussion

- Fred returns to the office for a follow up visit.
  - Discuss importance of patient engagement, shared decision making
  - Would this patient be a candidate for an extended taper process?

Recommendations for Management of Severe or Complicated Withdrawal

- Clinicians should manage patients experiencing severe or complicated withdrawal in inpatient or residential medically managed settings (eg, residential withdrawal management program) with:
  - Monitoring for signs and symptoms of BZD withdrawal, including regularly measuring vital signs and using structured assessment tools (*Clinical Consensus*, Strong Recommendation)
  - Assessments for seizure risk, managed as appropriate (*Clinical Consensus*, Strong Recommendation)

Recommendations for Management of Severe or Complicated Withdrawal

- Tapering with very long-acting agents such as phenobarbital:
    - Can be considered for BZD withdrawal management in inpatient settings (**Low Certainty**, Strong Recommendation).
    - Should only be conducted by or in consultation with clinicians experienced in the use of these agents for the purpose of BZD withdrawal management (*Clinical Consensus*, Strong Recommendation).

Implementation Considerations: When tapering with very long-acting agents, discharge planning should include an outpatient follow-up appointment, ideally within 7 days.

- Clinicians should assess patients for ongoing signs or symptoms related to discontinuation of the BZD, including re-emergence of symptoms for which the BZD was originally prescribed.
- Clinicians should consider medications and/or behavioral interventions to address ongoing signs or symptoms related to discontinuation of the BZD.

Other Population Considerations

- Patients co-prescribed BZD and opioids
- Patients with BZD or other substance use disorders
- Patients with co-occurring psychiatric disorders
- Older Adults
- Patients who are pregnant or lactating

Recommendations for Patients Co-Prescribed BZD and Opioids

- Because patients co-prescribed BZDs and opioids are at increased risk of respiratory depression, clinicians should assess the risks and benefits of continued BZD prescribing at least every 3 months or with every related clinical encounter or prescription renewal, whichever is more frequent (*Clinical Consensus*, Strong Recommendation).

- Clinicians should offer to provide or prescribe opioid overdose reversal medication (eg, naloxone) for all patients co-prescribed BZDs and opioids (*Clinical Consensus*, Strong Recommendation).

- Clinicians should consider additional strategies for mitigating risk, including using the lowest effective doses of BZD and opioid medications and optimizing non-opioid interventions (*Clinical Consensus*, Strong Recommendation).

Implementation Considerations for Patients Co-Prescribed BZD and Opioids

- Prior to initiating a BZD taper for patients who are co-prescribed BZDs and opioids, clinicians should seek to coordinate care with other clinicians who are prescribing BZDs or opioids to a given patient. This may entail obtaining releases or other agreements for clinicians to contact other prescribers and/or consulting the PDMP.
- Clinicians should conduct risk–benefit assessments more often when patients have additional risk factors for adverse events related to concurrent BZD and opioid use. Additional risk factors may include but are not limited to having an SUD, a bipolar disorder, or schizophrenia and/or taking fentanyl, morphine, or methadone.

Recommendations for Patients with BZD or Other Substance Use Disorder

- Clinicians should consider more frequent assessments of the risks and benefits of continued BZD prescribing for patients with co-occurring SUDs and/or other co-occurring addictions (eg, behavioral addictions) compared with the general guidance in Recommendation #1 (*Clinical Consensus*, Strong Recommendation).

Recommendations for Patients with BZD or Other Substance Use Disorder

- When tapering BZD medication in patients with SUD, clinicians should manage the underlying SUD concurrently with the BZD taper (*Clinical Consensus*, Strong Recommendation).
- Clinicians should not use BZD prescribing or tapering considerations as a reason to discontinue or disrupt a patient's medications for SUD treatment, including buprenorphine and methadone (*Clinical Consensus*, Strong Recommendation).

Recommendations for Patients with BZD or Other Substance Use Disorder

- When tapering BZD medication in patients with SUD, clinicians should manage the underlying SUD Following the taper, clinicians should continue to monitor and treat any underlying SUDs or refer patients to an appropriate level of care for continuing care (*Clinical Consensus*, Strong Recommendation).

Recommendations for Patients with BZD or Other Substance Use Disorder

- Clinicians should offer patients harm reduction services or provide them with referrals to access these services (*Clinical Consensus*, Strong Recommendation).
  - Clinicians should offer to provide or prescribe opioid overdose reversal medication (eg, naloxone) and provide or refer patients for related education (*Clinical Consensus*, Strong Recommendation).
  - Clinicians can consider providing or referring patients to community services for drug checking or other safe use supplies (eg, fentanyl test strips, xylazine test strips, sterile syringes) and related education (*Clinical Consensus*, Conditional Recommendation).

Group Discussion

- Sharon: 45 year old female with alcohol use disorder. Currently abstinent, but takes lorazepam 1mg 4-5 times/week for panic attacks
  - What other information would you want to know?
  - What would your initial approach to this patient be?

Recommendations for Patients with Co-Occurring Psychiatric Disorders

- Clinicians should optimize evidence-based treatment for any psychiatric disorder prior to the taper or concurrently if clinically indicated (*Clinical Consensus*, Strong Recommendation).

> Clinicians can consider offering patients with psychiatric disorders behavioral interventions (eg, CBT, CBT-I with sleep hygiene education) or providing them with referrals to access these interventions

Recommendations for Patients with Co-Occurring Psychiatric Disorders

- Clinicians should strongly consider tapering BZD medication in patients with posttraumatic stress disorder (PTSD; *Clinical Consensus*, Strong Recommendation).

> The VA recommends clinicians avoid prescribing BZDs to patients with PTSD, as they are ineffective for treatment of the core symptoms of PTSD and PTSD-related sleep disturbance

Recommendations for Patients with Co-Occurring Psychiatric Disorders

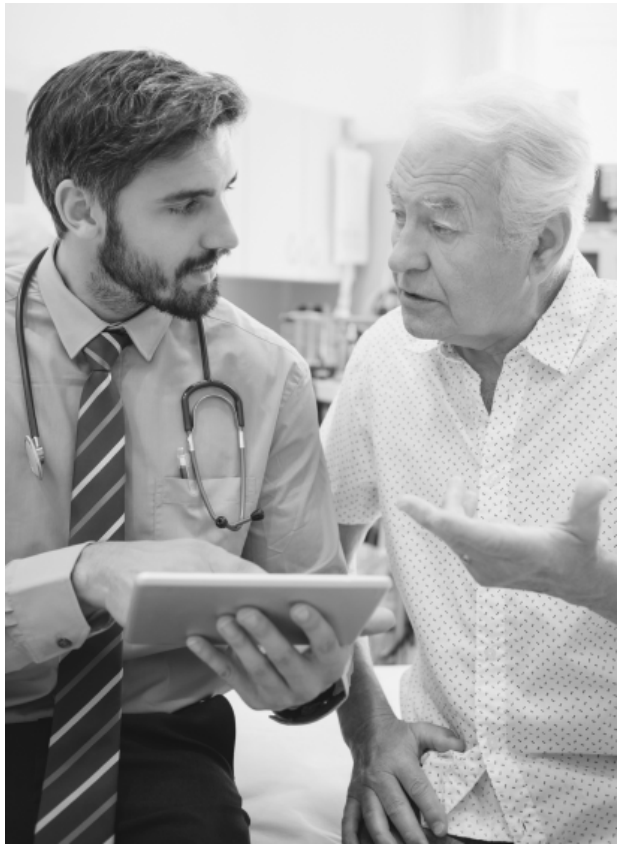
- Clinicians should monitor sleep closely during BZD tapering in patients with mood or psychotic disorders, particularly for patients with bipolar disorder as sleep disturbance can trigger episodes of mania (*Clinical Consensus*, Strong Recommendation).
  - If patients with a mood and/or psychotic disorder experience significant sleep disturbance, clinicians should pause the taper until the symptoms resolve due to the risk for destabilization (*Clinical Consensus*, Strong Recommendation).

Group Discussion

- Case: 35 y/o male veteran with severe PTSD taking 2mg alprazolam TID
  - What other information would you want to know?
  - How would you approach this patient?

Older Adults

- BZD use associated with risk of falls and cognitive impairment
- Adverse effects associated with BZD use have generally been shown to outweigh marginal, short-term benefits in older adults
- Polypharmacy is also a significant concern among older adults



Recommendation for Older Adults

- Clinicians should generally taper BZD medication in older adults unless there are compelling reasons for continuation (*Clinical Consensus*, Strong Recommendation).

Implementation Considerations:

- Goal of tapering may be discontinuation of the BZD, or reducing the dose to where the risks no longer outweigh the benefits
- Care should ideally be coordinated between the clinician managing the BZD taper and other clinicians managing conditions that may be impacted by BZD prescribing or the taper

Patients who are Pregnant or Lactating

- BZD use during pregnancy carries risk to the fetus, however untreated anxiety, mood, and sleep disorders also associated with risk
- BZD tapering can be done safely during pregnancy, however ACOG notes:

> *"[I]t is also critical to consider the risks of a taper for the pregnant individual and the fetus. For example, if attempts to taper the benzodiazepine precipitate re-emergence of anxiety, the benefits of continuation may outweigh the risks."*

Recommendations for Patients who are Pregnant or Lactating

- Clinicians should weigh the risks and benefits for the maternal–fetal dyad when considering continued BZD prescribing or tapering for pregnant patients (*Clinical Consensus*, Strong Recommendation).

Implementation Considerations:
- Monitor patients closely for emerging psychiatric symptoms, which may evolve more rapidly during pregnancy/postpartum period

Recommendations for Patients who are Pregnant or Lactating

- For infants who have been exposed to BZD in utero and are at risk for neonatal withdrawal, clinicians should:
  - Encourage breastfeeding, which can reduce neonatal withdrawal symptoms (*Clinical Consensus*, Strong Recommendation).
  - Communicate with the infant's healthcare provider (with parental consent) regarding exposure to BZDs (*Clinical Consensus*, Strong Recommendation).

Benzodiazepine Tapering Webinar Series

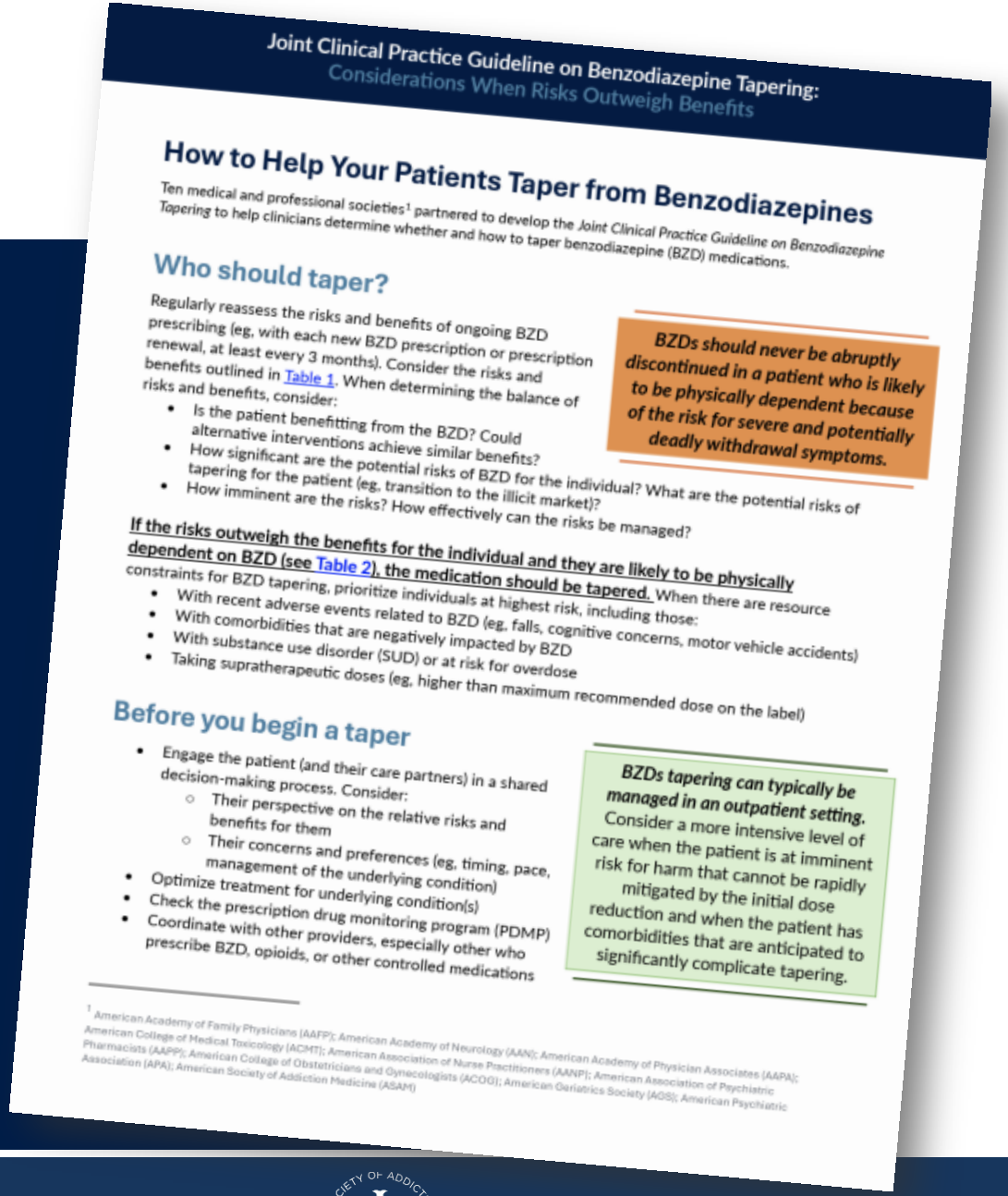
Topic	Date and Time
Considerations for Benzodiazepine Tapering	*April 7, 2025 @ 12PM ET*
Benzodiazepine Tapering for Older Adults	*May 5, 2025 @ 12PM ET*
Considerations for Tapering Benzodiazepines in Primary Care	*May 19, 2025 @ 12PM ET*
Addressing Benzodiazepine Tapering Challenges	*June 2, 2025 @ 12PM ET*

Scan to **Register!**

Other Resources

- Provider Pocket Guide
- Short guide: How to Help Taper Your Patients From Benzodiazepines
- Guide for Patients: Tapering Benzodiazepine Medications
- Quick-reference Tables and Charts:
  - BZD Dose Equivalents
  - Pharmacokinetic Properties
  - Pregnancy Considerations
- Patient Pocket Guide (Coming Soon)
- Patient Infographics (Coming Soon)
- Microlearning Videos (Coming Soon)

resources



Joint Clinical Practice Guideline on Benzodiazepine Tapering:
Considerations When Risks Outweigh Benefits

How to Help Your Patients Taper from Benzodiazepines

Ten medical and professional societies[1] partnered to develop the *Joint Clinical Practice Guideline on Benzodiazepine Tapering* to help clinicians determine whether and how to taper benzodiazepine (BZD) medications.

Who should taper?

Regularly reassess the risks and benefits of ongoing BZD prescribing (eg, with each new BZD prescription or prescription renewal, at least every 3 months). Consider the risks and benefits outlined in Table 1. When determining the balance of risks and benefits, consider:

- Is the patient benefitting from the BZD? Could alternative interventions achieve similar benefits?
- How significant are the potential risks of BZD for the individual? What are the potential risks of tapering for the patient (eg, transition to the illicit market)?
- How imminent are the risks? How effectively can the risks be managed?

BZDs should never be abruptly discontinued in a patient who is likely to be physically dependent because of the risk for severe and potentially deadly withdrawal symptoms.

If the risks outweigh the benefits for the individual and they are likely to be physically dependent on BZD (see Table 2), the medication should be tapered. When there are resource constraints for BZD tapering, prioritize individuals at highest risk, including those:

- With recent adverse events related to BZD (eg, falls, cognitive concerns, motor vehicle accidents)
- With comorbidities that are negatively impacted by BZD
- With substance use disorder (SUD) or at risk for overdose
- Taking supratherapeutic doses (eg, higher than maximum recommended dose on the label)

Before you begin a taper

- Engage the patient (and their care partners) in a shared decision-making process. Consider:
  - Their perspective on the relative risks and benefits for them
  - Their concerns and preferences (eg, timing, pace, management of the underlying condition)
- Optimize treatment for underlying condition(s)
- Check the prescription drug monitoring program (PDMP)
- Coordinate with other providers, especially other who prescribe BZD, opioids, or other controlled medications

BZDs tapering can typically be managed in an outpatient setting. Consider a more intensive level of care when the patient is at imminent risk for harm that cannot be rapidly mitigated by the initial dose reduction and when the patient has comorbidities that are anticipated to significantly complicate tapering.

[1] American Academy of Family Physicians (AAFP); American Academy of Neurology (AAN); American Academy of Physician Associates (AAPA); American College of Medical Toxicology (ACMT); American Association of Nurse Practitioners (AANP); American Association of Psychiatric Pharmacists (AAPP); American College of Obstetricians and Gynecologists (ACOG); American Geriatrics Society (AGS); American Psychiatric Association (APA); American Society of Addiction Medicine (ASAM)

ASAM American Society of Addiction Medicine

Q & A
Discussion

Thank You!