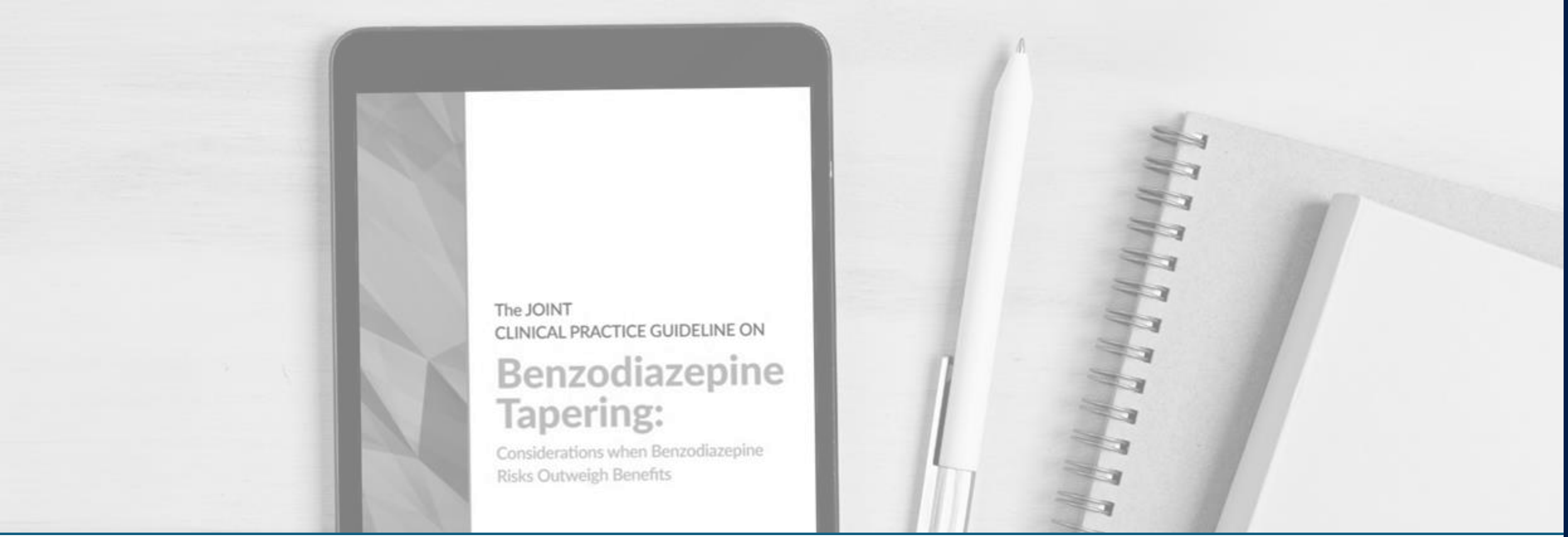

Slow and Patient Centered: A new Clinical Practice Guideline on Benzodiazepine Tapering

Donovan Maust, MD, MS
Maureen Boyle, PhD
June 24, 2025

FACULTY

Donovan Maust, MD, MS

Dr. Donovan Maust is a geriatric psychiatrist and health services researcher. A primary focus of his research is psychotropic prescribing to older adults in community and residential settings. His work also examines the influence of caregivers and clinicians on the care that older adults with mental health and cognitive disorders receive.

Dr. Maust earned his medical degree from Johns Hopkins University, completed his psychiatry residency and geriatric psychiatry fellowship at the University of Pennsylvania, and trained in health services research at the University of Michigan. He is a professor there in the Department of Psychiatry and a research scientist in the Center for Clinical Management Research of the VA Ann Arbor Healthcare System.

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- Funding from National Institute on Aging (U54AG084520, RF1AG082011, R01AG074957)
- Predictably Human (stock, consultant)

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Maureen Boyle, PhD

Maureen Boyle, Ph.D., is the Chief Quality and Science Officer at the American Society of Addiction Medicine (ASAM) where she oversees development of clinical guidelines and other tools to promote evidence based addiction treatment. She is the managing editor for the 4th edition of The ASAM Criteria and provides strategic oversight for ASAM's suite of tools for supporting implementation of The ASAM Criteria standards. Dr. Boyle has over 20 years of experience in research, public health, and health policy including prior positions with SAMHSA and NIDA. She holds a PhD in Neuroscience from the Washington University School of Medicine and she completed a postdoctoral fellowship at the Allen Institute for Brain Science and a Science and Technology Policy Fellowship through the American Association for the Advancement of Science (AAAS).

Disclosures:

- None

Webinar Learning Objectives

01 Apply key clinical takeaways and strategies for safely tapering benzodiazepines as outlined in the Joint Clinical Practice Guideline on Benzodiazepine Tapering.

02 Employ a collaborative, patient-centered approach to actively engage patients in care decisions.

03 Identify potential implementation challenges and their implications for patients, providers, healthcare systems, and policy makers.

04 Consider high priority research gaps and potential strategies to address them.

Webinar Agenda

High-Level Overview:

- Guideline Overview
- Patient Engagement and Individualized Care
- Implementation Challenges
- Research Gaps

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

Guideline Committee

Name	Representing
Emily Brunner, MD, DFASAM (*Chair*)	ASAM
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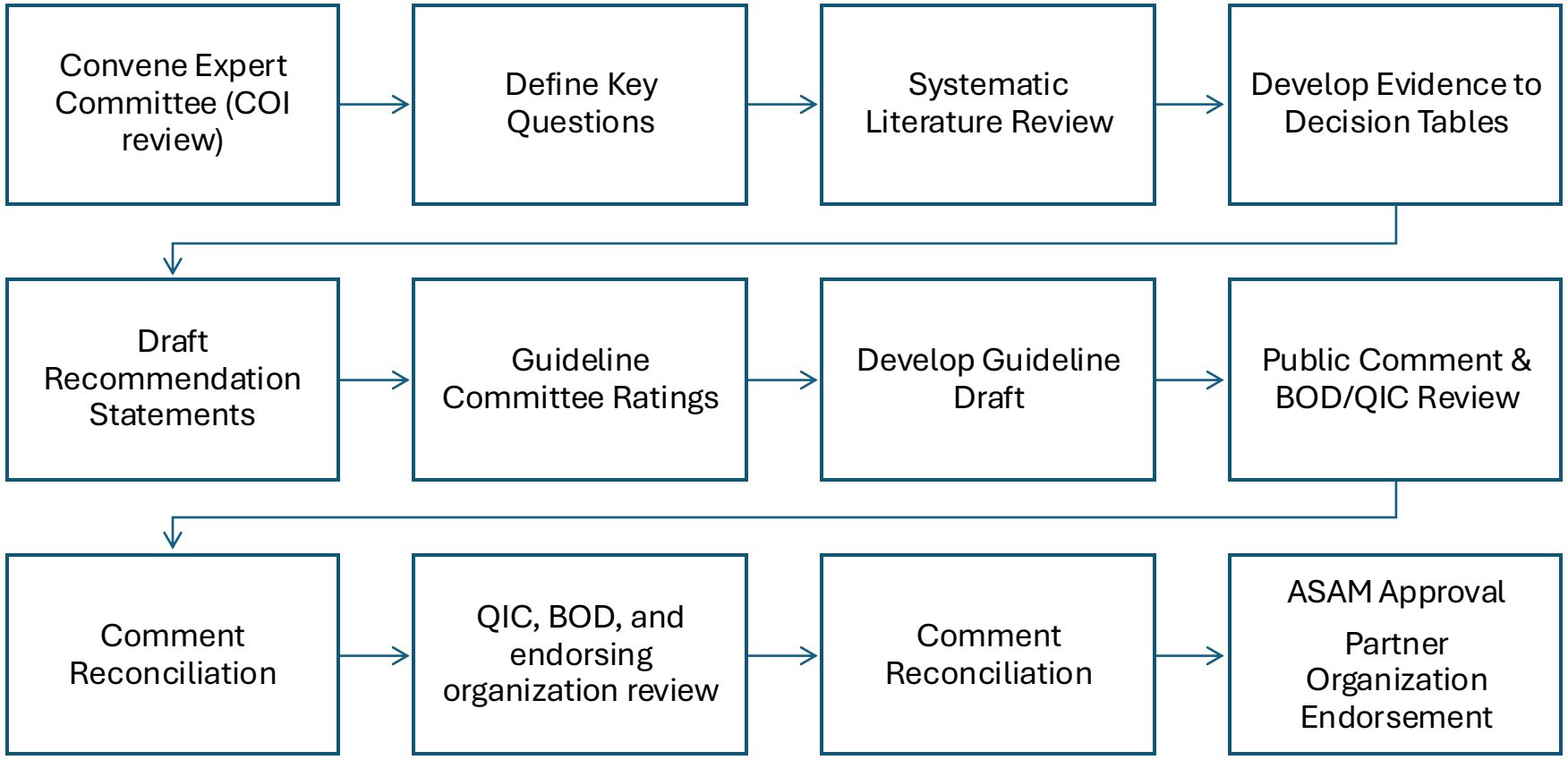
Amy VandenBerg, PharmD, BCPP	AAPP
Tricia Wright, MD, MS, FACOG, DFASAM	ACOG

CPG Methodology



~ 2 year process of development

Disclaimer

The Guideline reflects the work of the Committee, which we will try to convey accurately. However, some webinar content is based on our own understanding of the literature and should not be taken as the position of the Guideline Committee or ASAM.

The JOINT
CLINICAL PRACTICE GUIDELINE ON

Benzodiazepine Tapering:

Considerations when Benzodiazepine Risks Outweigh Benefits

Scan to **Download** the Guideline

Guideline Sections

Patient Engagement and Shared Decision-Making

Considerations for Tapering BZD

- Determining Whether to Taper
- Partnering with Patients
- Level of Care Considerations

Benzodiazepine Tapering Strategies

- Tapering Process
- Adjunctive Interventions During The Tapering Process
- Management of Severe or Complicated Withdrawal Symptoms
- Management of Protracted Withdrawal

Population-Specific Considerations

- Patients Co-Prescribed Benzodiazepines and Opioids
- Patients with Benzodiazepine or Other SUDs
- Patients with Co-Occurring Psychiatric Disorders
- Older Adults
- Patients Who Are Pregnant and/or Lactating

Health Disparities

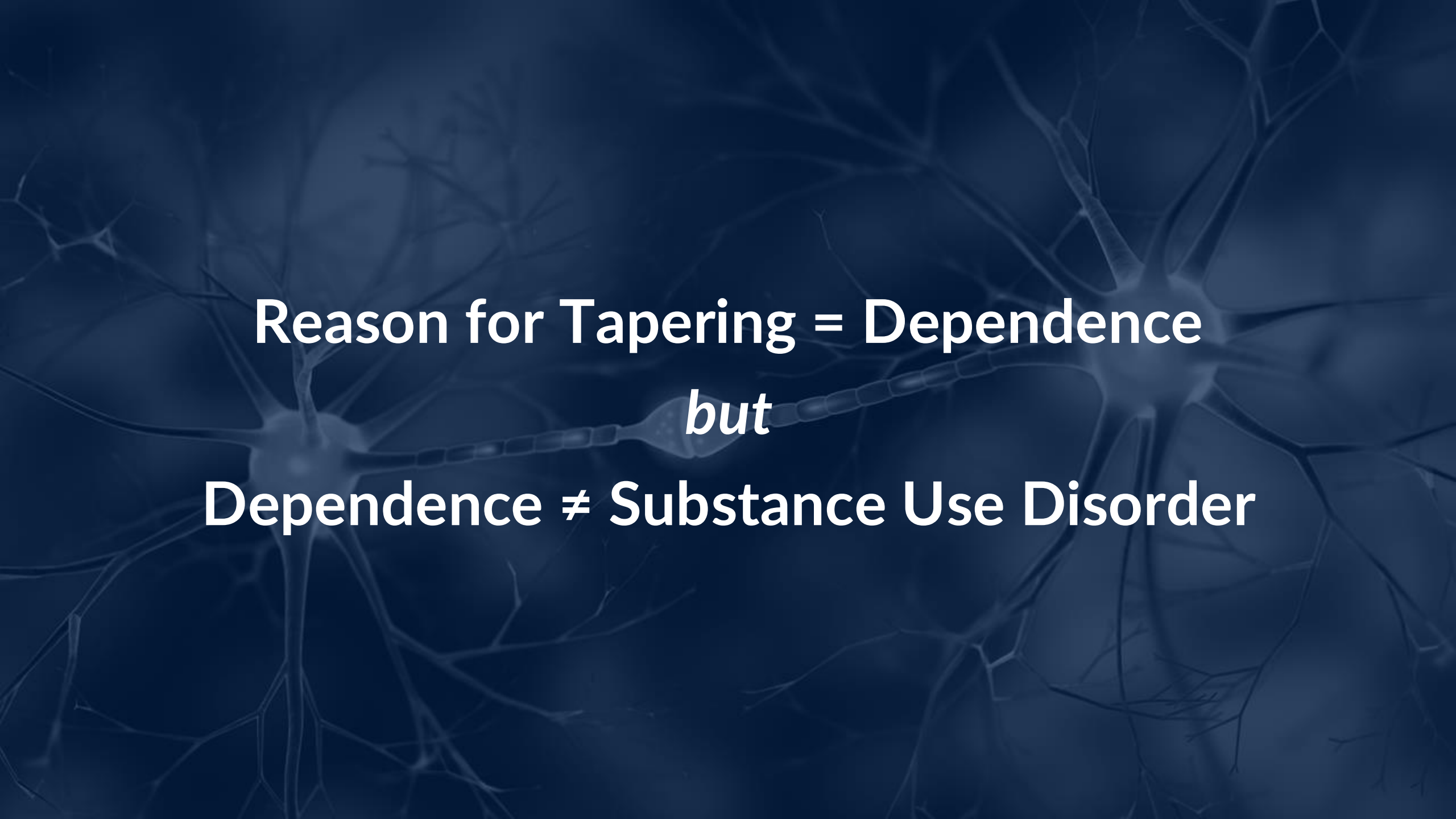
Tapering Without Patient Agreement

- Patient Safety
- Community Safety
- Considerations for Emergency Departments
- Strategies for Preventing Diversion

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.

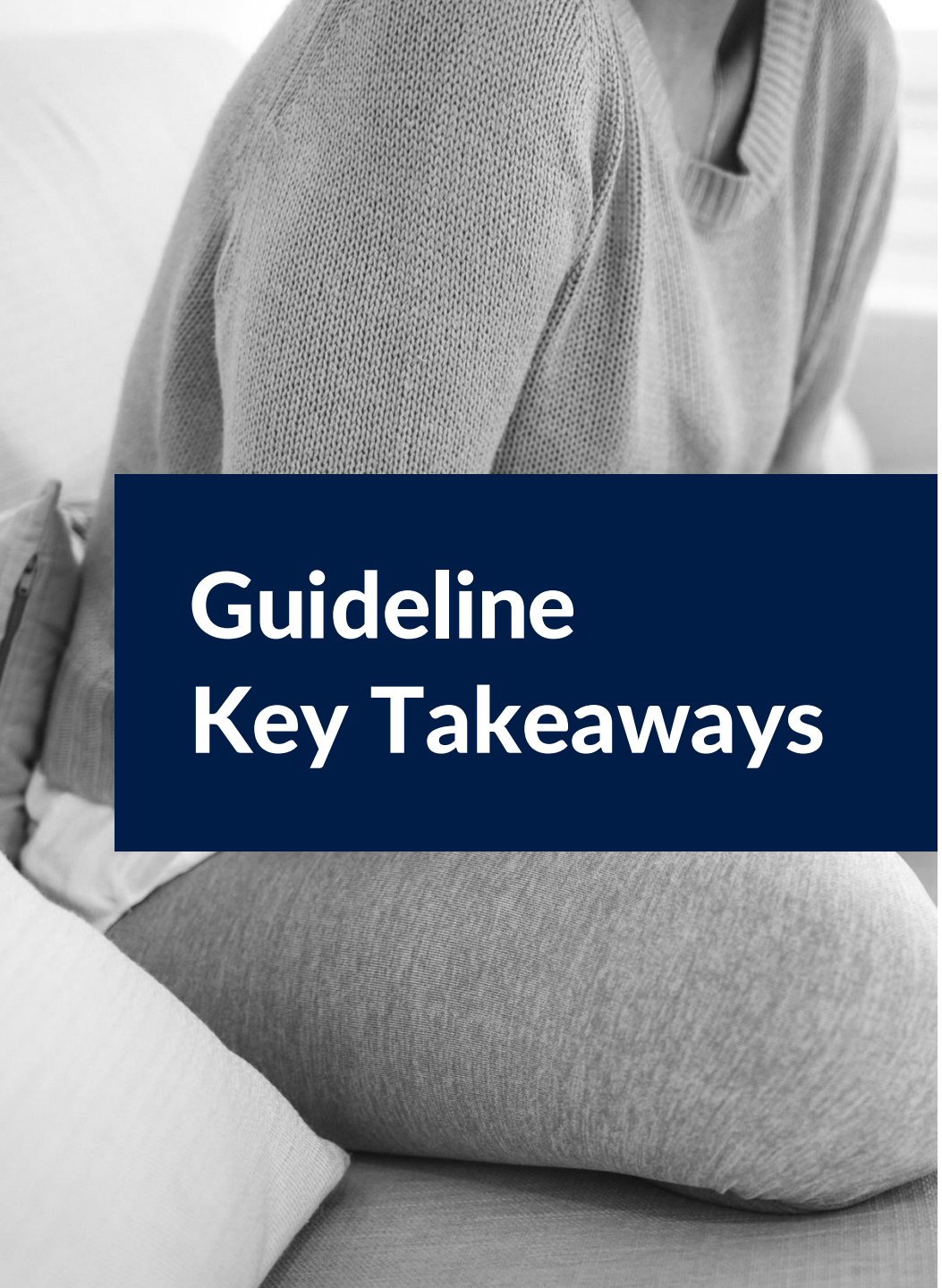

Reason for Tapering = Dependence
but
Dependence ≠ Substance Use Disorder

Physical Dependence vs SUD

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**.



Guideline Key Takeaways

01:

BZDs should not be discontinued abruptly in patients who are likely to be physically dependent on the medication and at risk for withdrawal (Guideline page 229).

So, who is that?

Likelihood of Physical Dependence

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.

A few more things before we go further with the guidelines...

Addressing Taper-Related Anxiety #1

Curran et al., Psychol Med 2003.

- N=104 chronic users of BZD hypnotics (avg = 13.5 years)
  - Double-blind taper (i.e., placebo pills during taper) over 2 months
  - Comparison group of N=34 who preferred to continue BZD treatment

Outcomes:

- Those that ***stopped*** had ***improved*** performance on cognitive function compared to continuers.
- Those that ***continued*** had ***worse*** anxiety, irritability, and more lack of energy.
- "Withdrawers and continuers **did not differ** in sleep or BZD withdrawal symptoms."

Addressing Taper-Related Anxiety #2

Vicens et al., BJP 2014.

- 532 chronic users, 3 arms:
  1. Usual care
  2. Structured intervention with follow-up visits
  3. Structured intervention with written instructions

a) Information on benzodiazepine dependence, abstinence, and withdrawal symptoms;

b) The risks of long-term use, memory and cognitive impairment, accidents, and falls;

c) Reassurance about reducing medication;

d) A self-help leaflet to improve sleep quality if patients were taking benzodiazepines for insomnia.

Outcomes at 12 months:

- **Usual care:** 15% discontinue
- **Intervention arms:** 45% discontinue
- *"No increase in HADS [Hospital Anxiety and Depression Scale] scores, sleep dissatisfaction or alcohol consumption compared with baseline, with all groups improving slightly in these parameters over time."*

Benzodiazepine Discontinuation and Mortality

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.

- US commercial insurance database between 1/1/13 and 12/31/17.
  - Adults with stable long-term benzodiazepine prescription treatment:
    - BZD coverage for ≥90% of days in one year
    - No gaps in BZD coverage > 30 consecutive days
    - Year-long baseline w/ monthly average daily doses within 30% of the baseline grand mean

- Adjusted cumulative incidence of death after 1 year was 5.5% (95% CI, 5.4%-5.8%) for discontinuers vs 3.5% (95% CI, 3.4%-3.6%) for nondiscontinuers (among the nonopioid exposed)
  - An absolute risk difference of 2.1 percentage points (95% CI, 1.9-2.3 percentage points) higher than for nondiscontinuers
  - Mortality risk was 1.6 (95% CI, 1.6-1.7) times that of nondiscontinuers

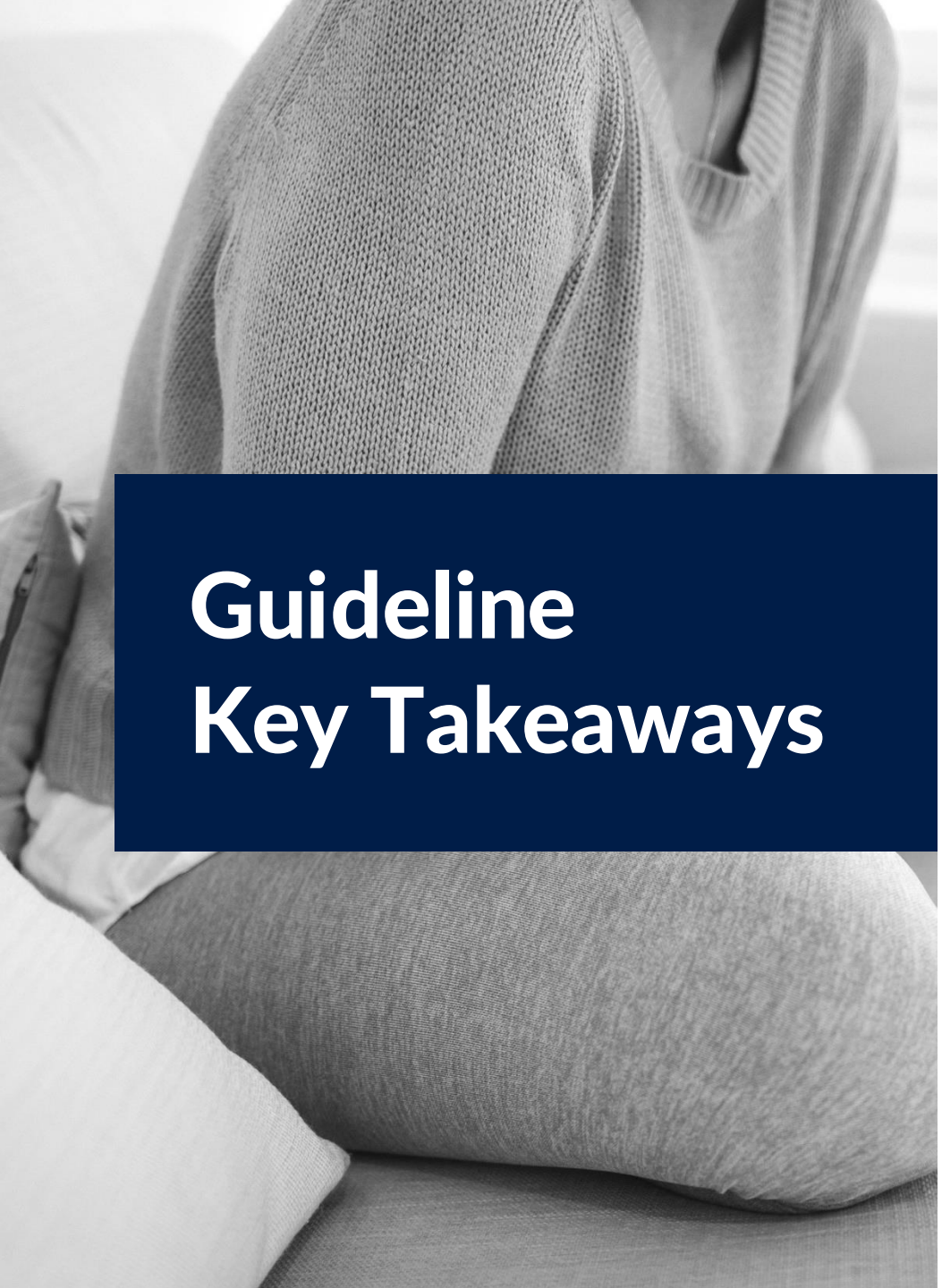
Benzodiazepine Discontinuation and Mortality

How I put these results into context:

1. This is science. This is a first finding that needs to be replicated.
2. The few discontinuation trials we have do not suggest increased risk of harms.
3. There are a number of critical things that we could not and did not look at in this analysis:
   a) Could not?
      - There is no way to know ***why*** these clinicians chose to discontinue BZD for these patients.
   b) Did not?
      - Pace/duration of tapers

Bottom line: At this point, there continues to be far more evidence of harms ***from prescribing*** (or at least associated with) than ***from tapering***.

But also: Primary prevention is best… Be judicious when starting (and continuing) a BZD.



Guideline Key Takeaways

01:

BZDs should not be discontinued abruptly in patients who are likely to be physically dependent on the medication and at risk for withdrawal.

From the guidelines: *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).*

Likelihood of Physical Dependence

Duration of BZD Use	Frequency of BZD Use	Total Daily BZD Dose	Risk for Clinically Significant Withdrawal	Need for taper?
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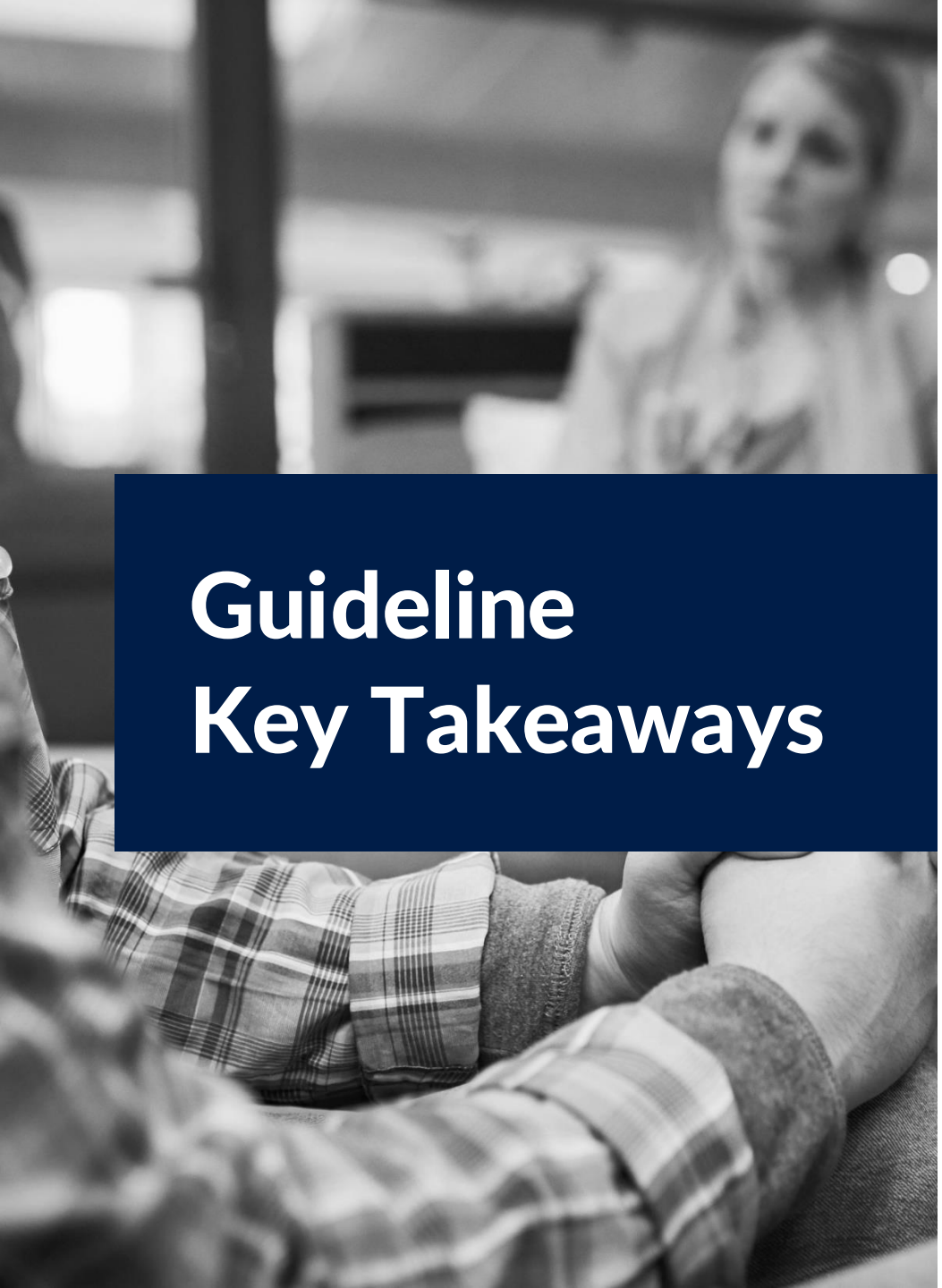


Guideline Key Takeaways

02:

Continued BZD prescribing should be guided by ongoing risk/benefit assessment of continued BZD use vs tapering/discontinuation.

From the guidelines: *Clinicians should ideally assess the risks and benefits of ongoing BZD prescribing at least every 3 months for each patient taking BZD medications (see Table 2 and Table 3; 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).*

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?

Risk/Benefit Analysis

+ 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

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?**
- Whe… …e follow…

Bottom line:

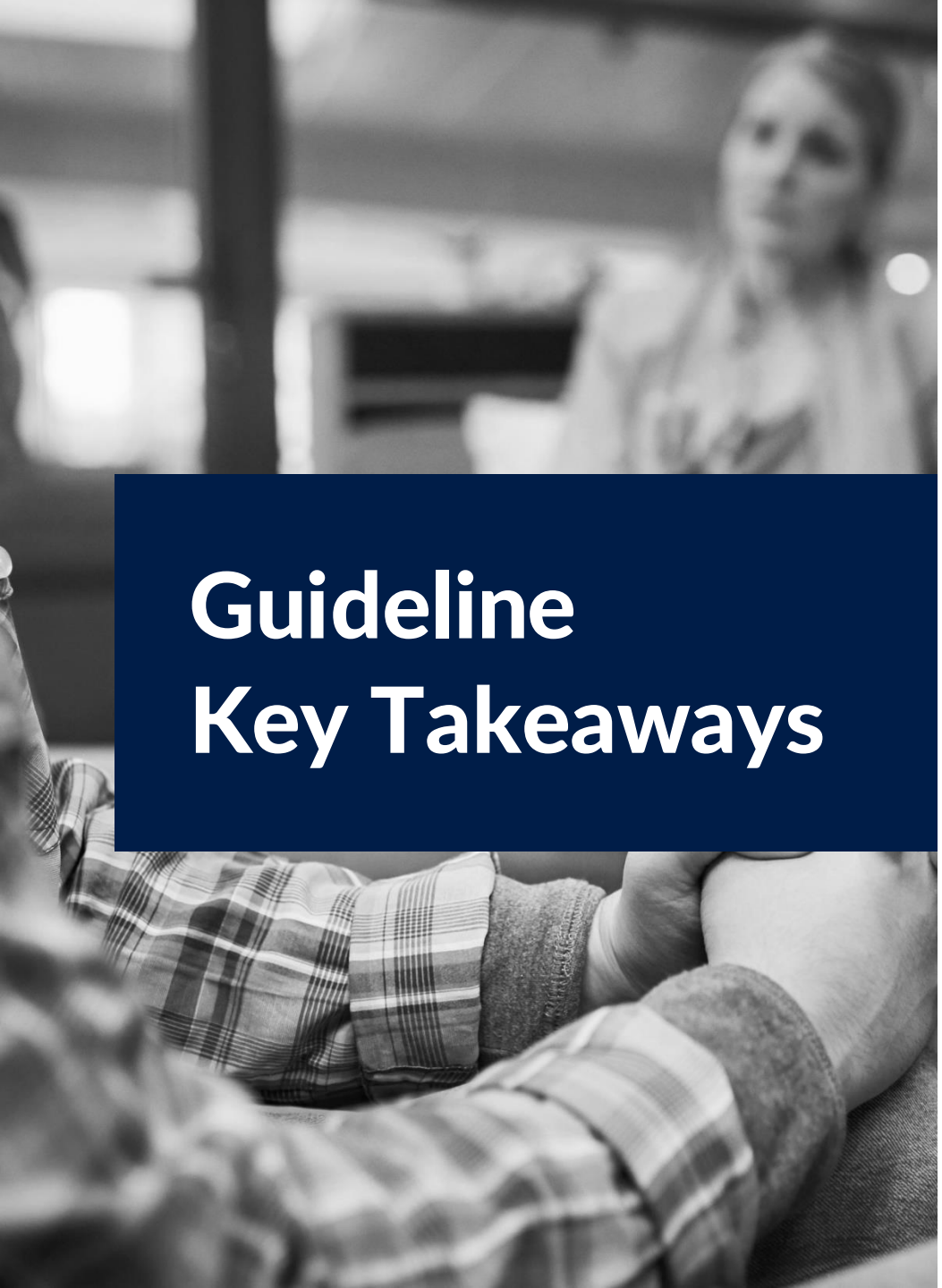
1. The risk/benefit balance will be unique for every patient.
2. It is not static.

How significant are the potential risks?

What are the risks of the alternative interventions?

How imminent are the risks?

How effectively can the risks be managed?



Guideline Key Takeaways

02:

Continued BZD prescribing should be guided by ongoing risk/benefit assessment of continued BZD use vs tapering/discontinuation.

- Risk-benefit assessments should be more frequent [than every 3mos] for patients who:
  - Are concomitantly taking opioid medication.
  - Have an SUD.
  - Have additional risk factors for adverse effects, such as co-occurring physical conditions or mental health conditions.

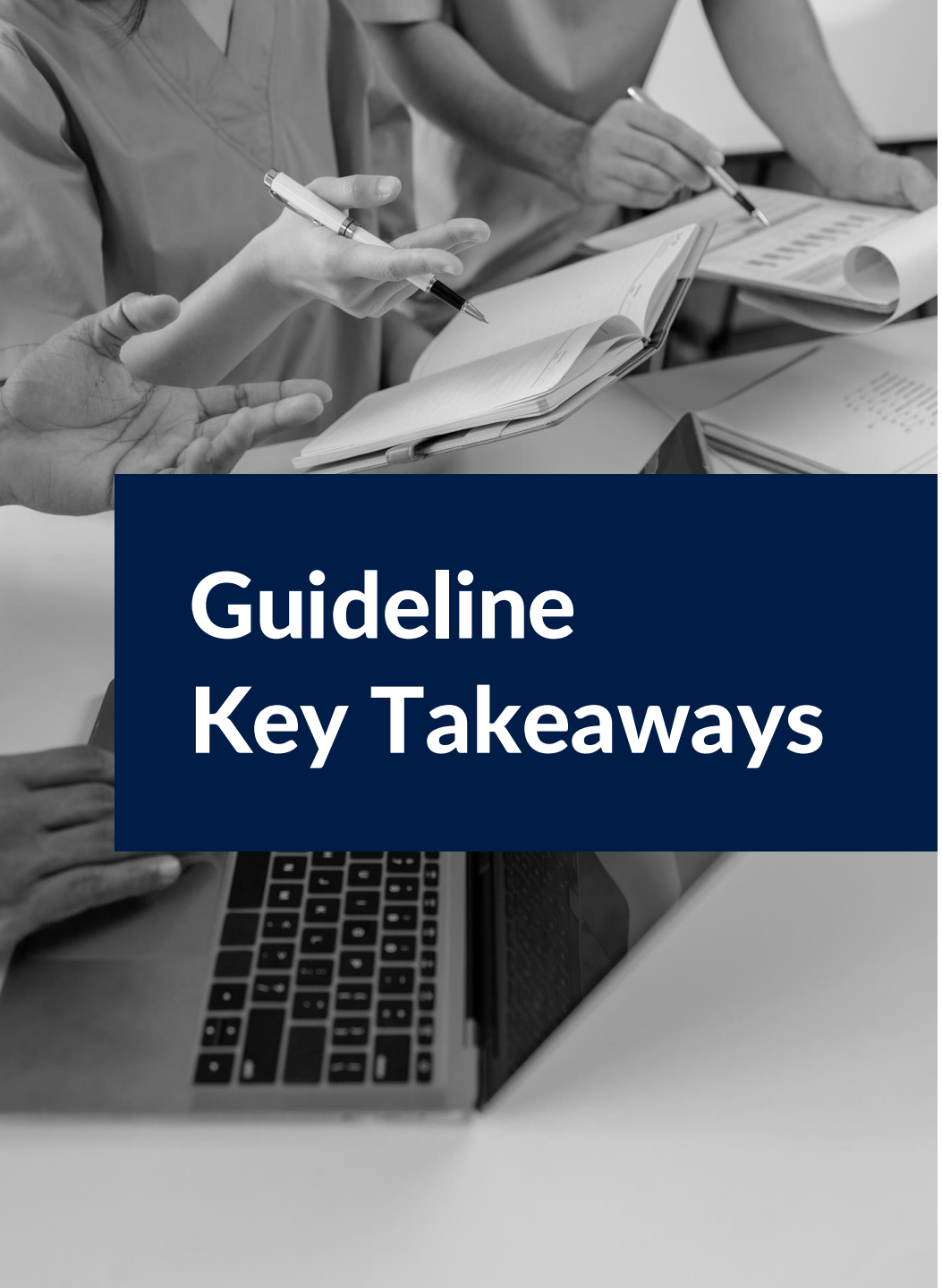
Clinicians should consider the risks and benefits of continued BZD vs. tapering for a given patient and **should not assume tapering is the right choice for all patients.**

Guideline Key Takeaways

03:

Clinicians should consider approaches to BZD tapering in collaboration with patients and their care partners utilizing shared decision-making strategies.

- Everywhere a recommendation says, “clinicians should consider,” the phrase **“in partnership with the patient”** should be understood.



Guideline Key Takeaways

04:

Design a tapering strategy to minimize harms from both continued BZD use and the tapering process (e.g., withdrawal symptoms or recurrence of symptoms for which the BZD was originally prescribed).

a. i.e., dose reductions of **5–10%** every **2–4 weeks**.
b. The taper should typically **not exceed 25% every 2 weeks**.
c. Patients who have been taking lower doses for a relatively short period of time (i.e., <3 months) may be able to taper more quickly.

Guideline Key Takeaways

05:

Clinicians should tailor tapering strategies to each individual patient and **adjust tapering** based on patient response.

- Monitor patients for the emergence of BZD withdrawal signs and symptoms with each dose reduction.
- If significant signs or symptoms emerge—even with gradual tapering—the taper should be **slowed or paused**.
- Provide concurrent treatment for any co-occurring physical health conditions and psychiatric disorders, including SUDs, that could interfere with the BZD taper.
- Offer patients undergoing BZD tapering adjunctive psychosocial interventions to support successful tapering (e.g., CBT-i for insomnia).
- May consider transitioning patients without contraindications to a comparable dose of a longer-acting BZD medication for the taper.
    - ***Caution:*** achieving a “comparable dose” may not be straightforward.

Guideline Key Takeaways

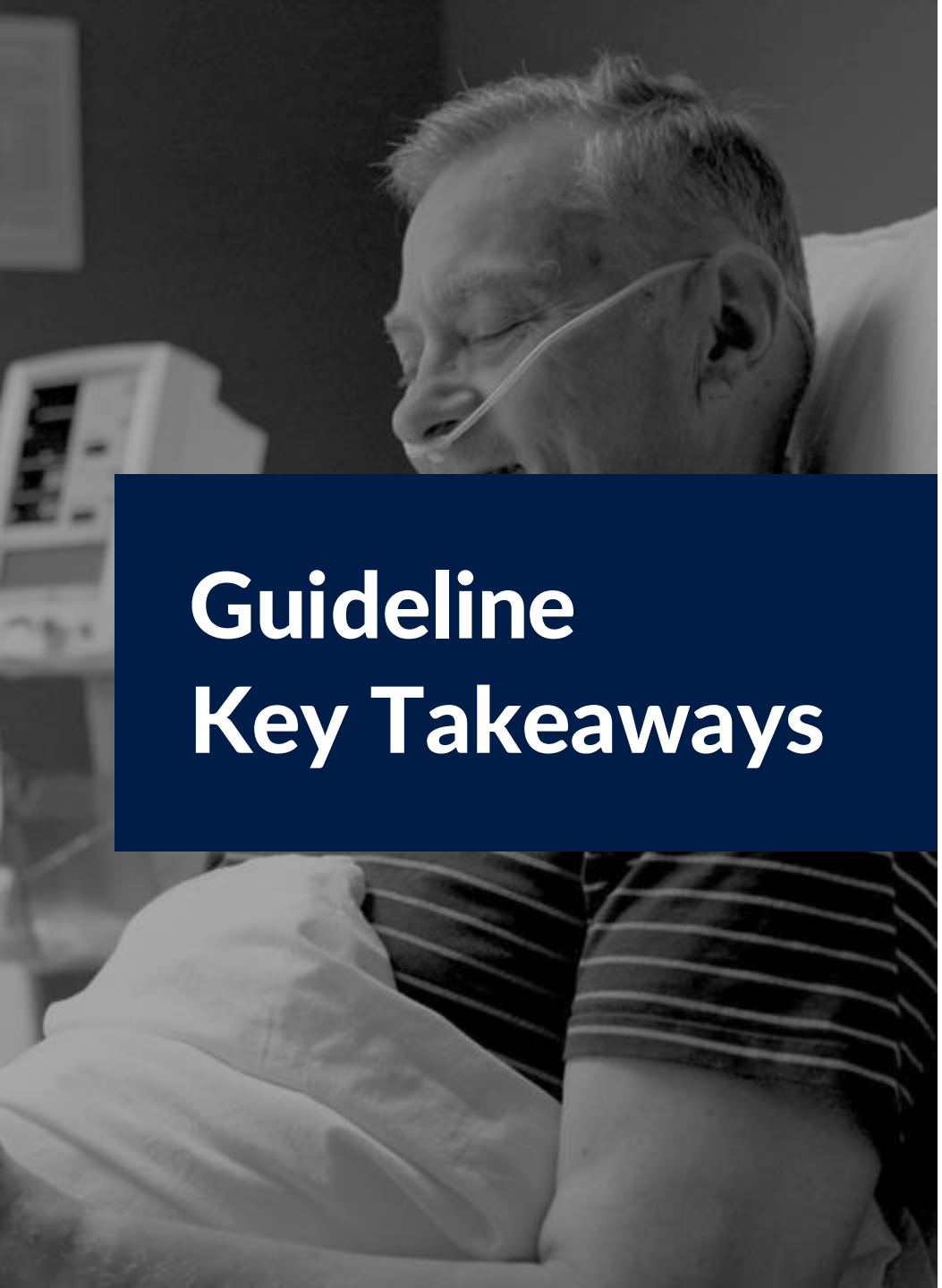
06:

In some cases, maintaining a patient on a lower dose may be sufficient to reduce the current risks such that they no longer outweigh the benefits.

- And even if risks still outweigh benefits… Lower dose = lower risks.

07:

It may take months to years to fully taper off BZDs, particularly if patients have been taking a high dose for an extended period of time.



Guideline Key Takeaways

08:

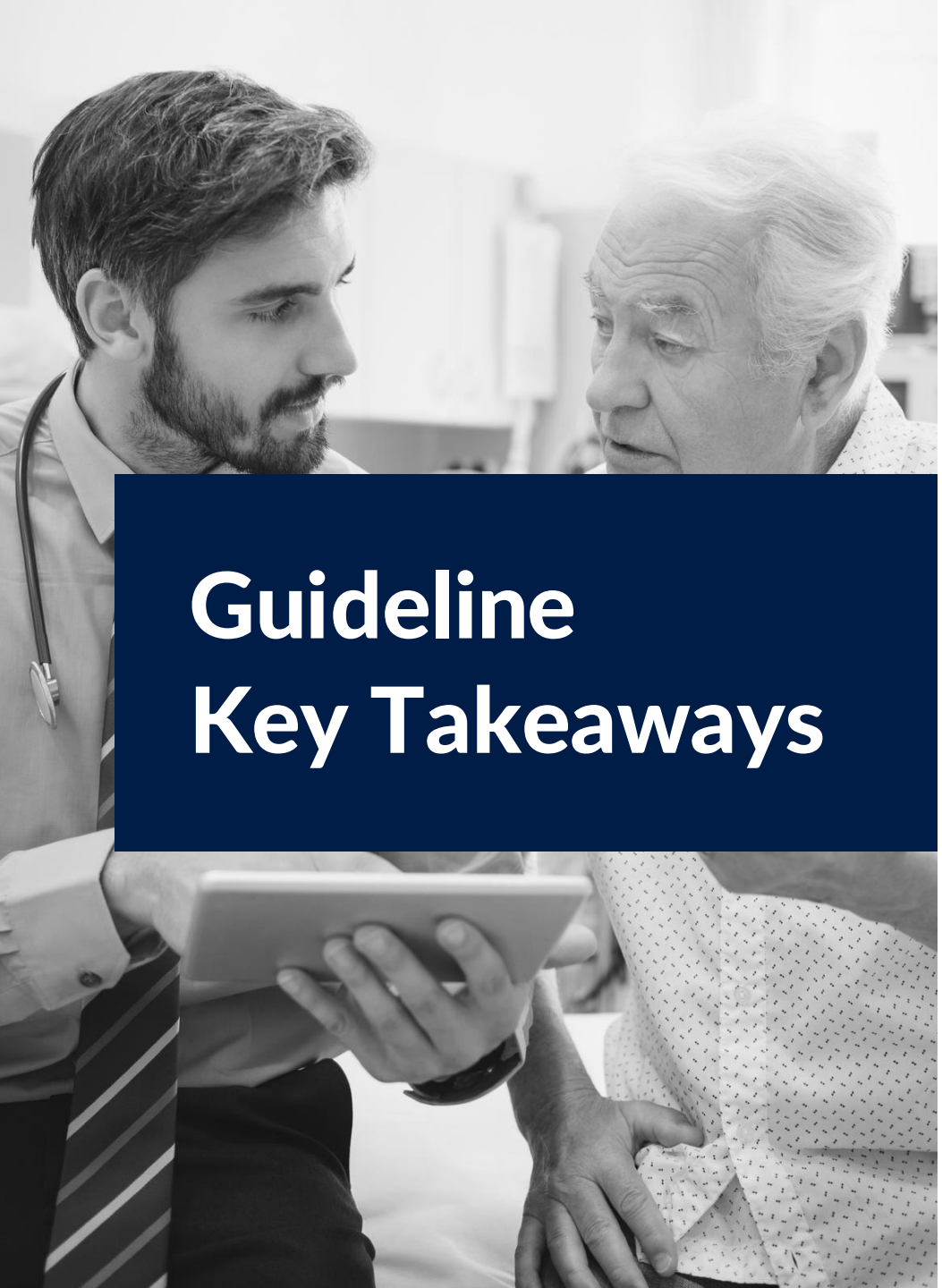
Although most patients can complete BZD tapering in outpatient settings, clinicians should consider inpatient or medically managed residential care when patient presentation indicates a significant risk that cannot be safely managed in outpatient care.

09:

Clinicians should use caution if utilizing urine drug screen immunoassays for BZDs due to known limitations.

10:

Clinicians should consider the maternal-fetal dyad when assessing the risks and benefits of continued BZD prescribing in patients who are pregnant.



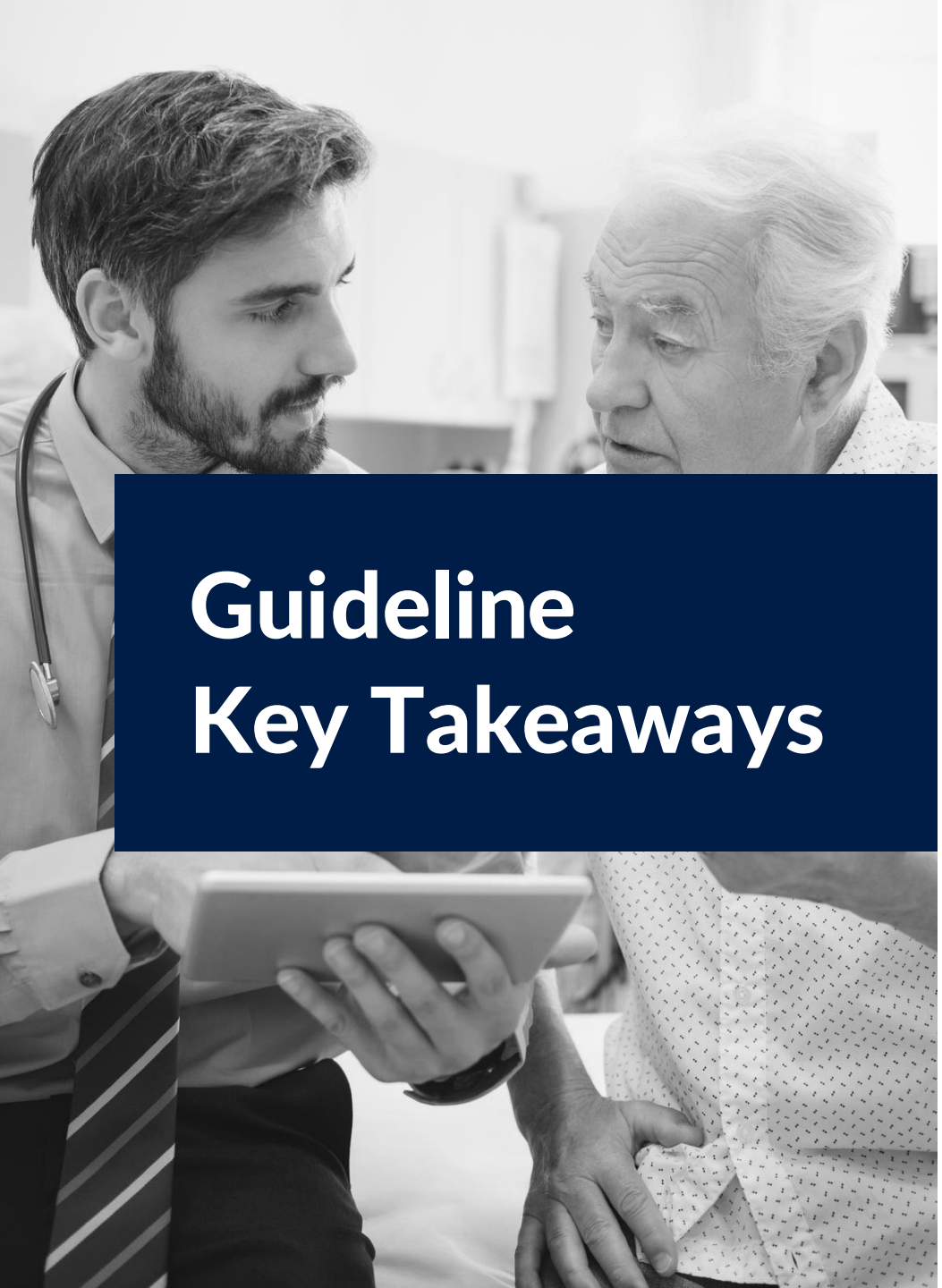
Guideline Key Takeaways

11:

Clinicians should taper BZDs in most older adults (i.e., ≥65 years) unless there are compelling reasons for continuation.

12:

Clinicians should employ harm reduction strategies – such as providing opioid overdose reversal medication to those concomitantly taking opioids or otherwise at risk for opioid overdose, connecting patients to local resources, and providing patient education – based on each individual patient's risks.



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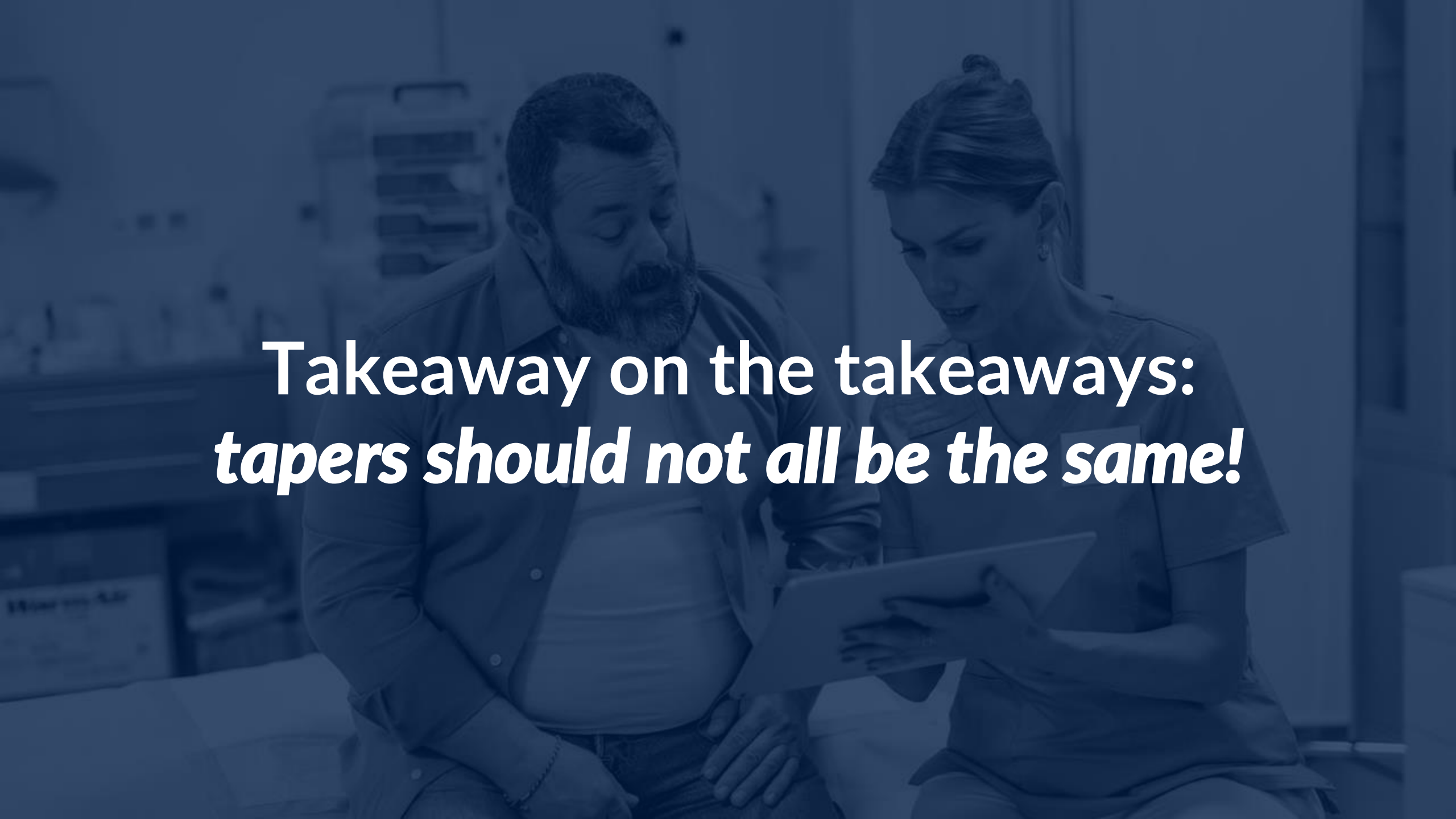

Takeaway on the takeaways:
tapers should not all be the same!

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).

Research Gaps

- No studies were found comparing different tapering strategies
  - Most evaluating adjunctive medications or educational interventions
- Nearly all RCTs evaluated tapering at a rate significantly faster than clinically recommended, with high drop out
- Very few studies evaluated protracted withdrawal
- Highly inconsistent reporting of safety/adverse events

Research Gaps

- VA initiatives to reduce BZD prescribing for PTSD and older adults
  - Nationwide effort began in 2015
- Research demonstrating reduction in new BZD prescriptions and reduction in daily dose for patients with PTSD
- Evaluations also found reduced prescribing rates for older adults but did not assess patient outcomes (eg, sleep or MH outcomes, rates of protracted withdrawal, functionality)

Research Gaps

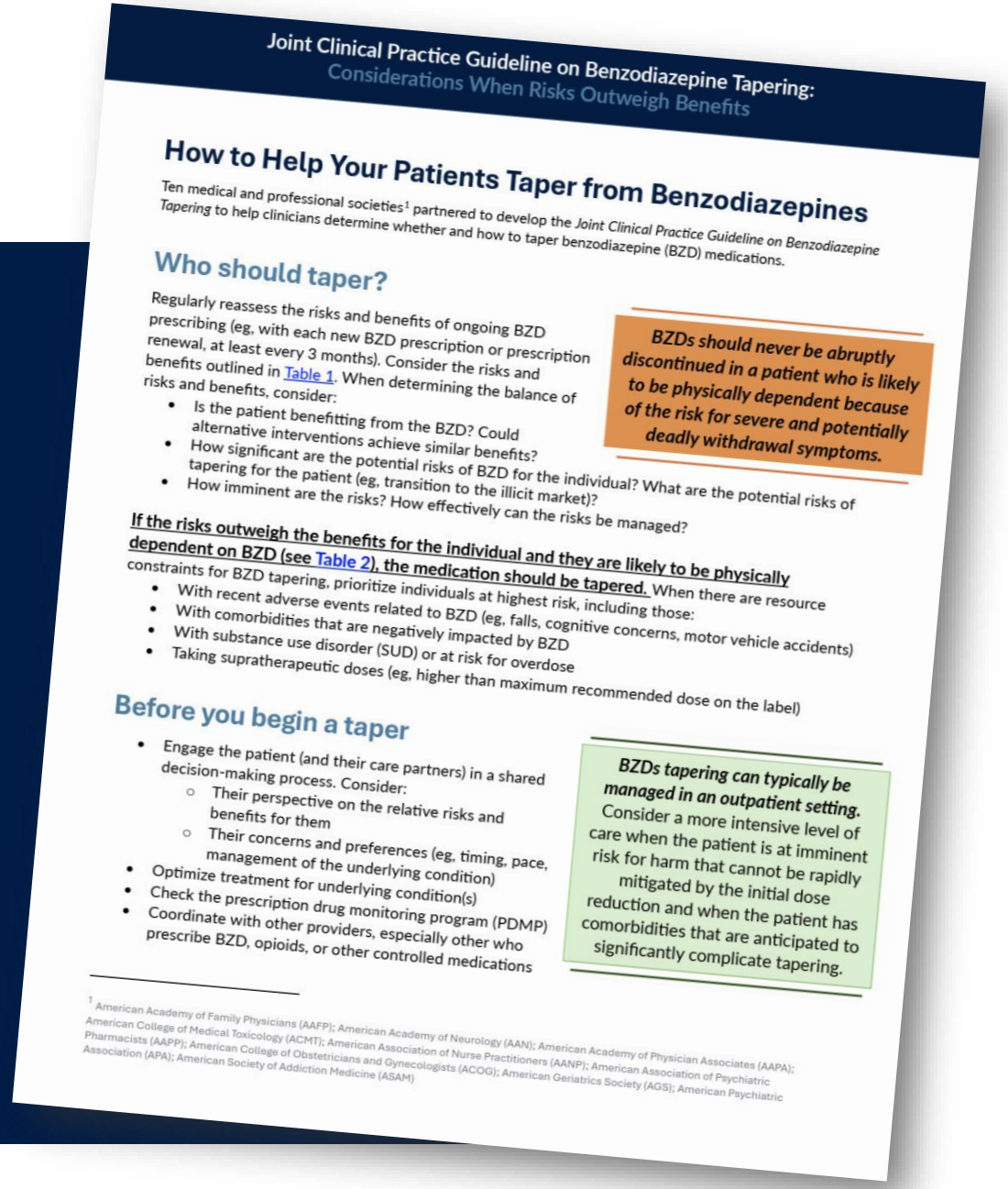
Nearly all recommendations in the guideline are based on clinical consensus.

- As this Guideline is implemented, need for research on its impacts
- Focus on patient-centered outcomes (e.g., adverse events, functionality, mental and physical health outcomes)
- Longer term outcomes including protracted withdrawal
- Patient panel would advocate for research on
  - Existence of BZD induced neurological dysfunction
  - Protracted withdrawal
  - Suicidality
  - Long term impacts of phenobarbital based taper

Resources

- Webinar Series
- 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)

Scan for 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)

Q&A

USE THE CHAT BOX TO ASK YOUR QUESTIONS

Thank You!