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Deprescription of Benzodiazepine

Oji Gibson
Walden University

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Walden University

College of Nursing

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Oji Gibson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Julibeth Lauren, Committee Chairperson, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Executive Summary: Clinical Practice Guideline

Deprescription of Benzodiazepine

by

Oji Gibson

MS, Walden University, 2023

BS, Saint Elizabeth University, 2011

Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Summary

This Doctor of Nursing Practice (DNP) project involved the development and expert validation of a clinical practice guideline (CPG) aimed at reducing benzodiazepine overprescribing among adults with anxiety disorders in primary care. Overuse and long-term prescribing of benzodiazepines contribute to dependence, cognitive impairment, falls, and overdose risk. The practice-focused question guiding this project was: Based on best practices and evidence in the literature, will the medical providers and expert panel at the DNP project site approve and adopt a standardized clinical practice guideline to reduce benzodiazepine overprescribing? A systematic review of current guidelines, national recommendations, and recent research informed the development of the CPG.

The project process included narrative synthesis, alignment with Appraisal of Guidelines for Research and Evaluation II (AGREE II) domains, and expert panel review using a modified Delphi process to reach consensus on content validity and clarity. Experts demonstrated strong agreement across AGREE II domains, confirming the guideline's rigor, relevance, and applicability in primary care. The findings also confirm the guideline's clarity, feasibility, and readiness for implementation. Implications for nursing practice include advancing evidence-based pharmacologic stewardship, strengthening provider competency, and improving patient safety through standardized prescribing practices. Ultimately, this initiative empowers primary care providers to reduce medication dependence and improve mental health outcomes through safer, evidence-informed care.

Background

The reason for this practice change was the persistent overprescribing of benzodiazepines for adults with anxiety disorders despite well-established guidelines recommending short-term or limited use. Through a data review of the project site organization's medical group, I identified that benzodiazepines were overprescribed in the primary care clinic. For example, one provider in an office of five providers prescribed benzodiazepines to 115 patients, of whom 51 were daily users. The patients' prescriptions varied from one to three times daily, with regular refills. At the DNP project site, providers frequently continued benzodiazepine prescriptions for longer than clinically indicated, often without regular reassessment or documentation of nonpharmacologic alternatives. This gap in practice placed patients at risk for dependence and adverse drug events. It reduced the quality of care, highlighting the urgent need for evidence-based CPGs to support safe prescribing and tapering strategies (Weleff et al., 2023).

The practice-focused question for this project was: "Based on best practices and evidence in the literature, will the medical providers and expert panel at the DNP project site approve and adopt a standardized CPG to reduce benzodiazepine overprescribing?" The purpose of this DNP project was to create, validate, and refine an evidence-based CPG that equips primary care providers with clear, actionable recommendations for safe benzodiazepine prescribing, tapering, and use of alternative therapies. By addressing gaps in harm and practice in this project, I sought to promote safer pharmacologic management of anxiety disorders, reduce medication-related harm, and enhance adherence to national best-practice standards (see Chapoutot et al., 2021).

The evidence that supported this project consistently recommended limiting benzodiazepine use to the short-term management of acute anxiety symptoms due to the well-documented risks of dependence, cognitive impairment, and withdrawal associated with long-term use (Chapoutot et al., 2021). The DNP project preceptor recognized, through evaluation with her colleagues, the challenges they were facing in referring patients to psychiatric mental health providers and the need to manage their anxiety disorders in primary care at the project site. The evidence supporting structured tapering protocols encouraged the use of evidence-based nonpharmacologic therapies (e.g., cognitive-behavioral therapy [CBT]). It stressed the importance of individualized treatment plans and close monitoring to ensure safe prescribing practices (Chen et al., 2020). Telehealth CBT improved anxiety outcomes and enhanced taper success compared to tapering alone. Appropriate alternatives to benzodiazepines, such as CBT, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, and mindfulness-based stress reduction, in addition to gradual benzodiazepine tapering protocols, were suggested to minimize withdrawal symptoms and dependency while transitioning patients to safer alternatives (Chapoutot et al., 2021).

The evidence in the literature supporting this change in practice is based on findings from these studies and reviews, which consistently showed results in several key areas (Garel et al., 2023). There is strong and consistent evidence that long-term benzodiazepine use for anxiety disorders remains common in clinical practice, despite clear guideline recommendations advocating for short-term use (Liu et al., 2023). To support safe discontinuation, multiple strong-quality studies endorsed integrating structured behavioral therapies such as CBT, acceptance and commitment therapy, and

mindfulness-based interventions, which have been shown to improve taper success and address underlying anxiety and insomnia symptoms (Garel et al., 2023). I conducted a comprehensive review of 10 evidence-based articles, utilizing the Johns Hopkins evidence-based practice model to assess the strength of the Evidence. Two articles were Level 1, with strong quality; two were Level 2, with good quality; five articles were Level 3, with good quality; and one was Level 3, with low quality. In summary, the evidence strongly supported the DNP project (see Garel et al., 2023).

CPG Development

The expert panel of reviewers included three interdisciplinary professionals with extensive experience in primary care, mental health, and clinical leadership. The panel consisted of the project site director/preceptor, a family nurse practitioner (FNP), a DNP-prepared clinician, a primary care medical director, a psychiatric-mental health nurse practitioner, and a psychiatrist. Each member was selected based on their advanced clinical expertise, familiarity with evidence-based prescribing practices, and active involvement in the management of patients with anxiety and related disorders.

I purposefully selected panel members to represent a diverse range of perspectives across nursing and medicine, ensuring that the guideline would be both clinically relevant and interdisciplinary in scope. The inclusion of mental health and primary care specialists facilitated a comprehensive review of both pharmacological and nonpharmacological management strategies. Each expert was provided with the draft CPG, the AGREE II appraisal tool, and instructions for independently evaluating the document's scope, clarity, and applicability. Their combined knowledge and professional experience

contributed to a rigorous, comprehensive review process, thereby enhancing the validity and practical utility of the final guideline (Garel et al., 2023).

I used the AGREE II tool to guide the appraisal and validation of the developed CPG in this project. The process for using the AGREE II tool was systematic and structured, involving review of the guideline across six quality domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence. An expert panel of primary care and behavioral health providers independently rated each domain using the AGREE II scoring system, providing both quantitative ratings and qualitative feedback. I analyzed their scores to determine the guideline's overall methodological quality, while their narrative comments informed revisions to strengthen clarity, usability, and alignment with evidence-based recommendations. This structured process ensured that the final guideline met established standards for quality, transparency, and applicability in clinical practice.

Results

The results from this project's expert panel demonstrated strong overall agreement that the developed CPG met high-quality standards across all AGREE II domains. The scope and purpose domain received a perfect score of 100%, reflecting clear articulation of the guideline's objective to develop and seek approval for an evidence-based CPG that supports providers in reducing benzodiazepine overprescribing for anxiety disorders. The panel affirmed that the health questions and target population were well-defined, focusing specifically on adults with anxiety disorders. The stakeholder involvement domain scored 72.2%, with reviewers noting that although target users (i.e., primary care providers across 12 organizational sites) were clearly identified, data on

patient preferences were not collected, which is an area for improvement in future iterations. The rigor of development domain achieved a strong rating of 89.6%, with experts confirming that systematic methods were used to search for and appraise evidence using Population, Intervention, Comparison, Outcome, and Time (PICOT) statements and Medical Subject Headings (MeSH) search strategies.

The criteria for selecting evidence were clearly defined, with an emphasis on peer-reviewed studies published within the last 5 years. Reviewers acknowledged that the body of evidence was limited by the predominance of observational studies, leading to variation in tapering protocols; however, the methods for formulating recommendations were clearly described. The clarity of presentation domain also achieved a perfect score of 100%, with reviewers highlighting the guideline's specific tapering strategies, multiple pharmacologic and nonpharmacologic options, and easily identifiable key recommendations. The applicability domain scored 83.3%, with positive comments on the inclusion of implementation tools, such as patient and provider handouts. However, the absence of auditing criteria was noted as a limitation. Lastly, the editorial independence domain received a score of 83.3%, with reviewers confirming that the recommendations were driven solely by the evidence, and no conflicts of interest were identified. Collectively, these results indicate that the guideline was methodologically sound, clearly presented, and ready for dissemination with minor enhancements recommended for stakeholder engagement and monitoring criteria.

The summary of the review of this proposed CPG indicated strong stakeholder and end-user endorsement, including primary care providers, nurse practitioners, and behavioral health clinicians across the organization. Stakeholders acknowledged that the

guideline addressed a significant gap in clinical practice by offering structured, evidence-based recommendations for managing anxiety disorders and reducing benzodiazepine overprescribing (see Vásquez Cedeño et al., 2023). Their feedback emphasized the guideline's clarity, ease of integration into routine practice, and usefulness in supporting shared decision-making and patient education. Several end users appreciated the inclusion of tapering strategies, nonpharmacological treatment options, and provider handouts to facilitate consistent communication with patients (see Weleff et al., 2023).

The actual/potential impact of adopting this CPG on the project site organization is the promotion of safer, evidence-based prescribing practices that align with national standards for anxiety management (see Caulfield & Stern, 2020). Implementation of the guideline is expected to enhance provider knowledge, confidence, and consistency in prescribing benzodiazepines by providing clear tapering protocols, nonpharmacological alternatives, and structured patient education tools. Organizationally, adoption of this guideline can reduce risks associated with long-term benzodiazepine use, such as dependence, medication errors, and adverse events, thereby enhancing patient safety and quality of care (see Lagha et al., 2021). Additionally, standardizing prescribing practices across all clinical sites supports continuity of care, ensures regulatory compliance, and improves clinical outcomes (see Lagha et al., 2021). Over time, the guidelines may also help reduce healthcare costs by minimizing preventable complications and optimizing the use of resources. The initiative demonstrates the organization's commitment to continuous quality improvement, interprofessional collaboration, and the advancement of nursing leadership in evidence-based practice.

The limitations of this project included the small number of expert reviewers and the absence of direct input from patients or other community stakeholders, which may have limited the diversity of perspectives represented. Additionally, although the AGREE II tool provided a rigorous framework for guideline evaluation, results were based on subjective ratings, which could introduce variability in scoring. The project also lacked implementation and outcome measurement phases, which limited the ability to assess the guideline's actual impact on prescribing behaviors and patient outcomes. Despite these limitations, the review process provided valuable expert validation and established a strong foundation for future implementation and evaluation within the organization.

The importance of this DNP project extends beyond this local site because it has the potential to serve as a model for other healthcare organizations seeking to address benzodiazepine overprescribing through evidence-based, interdisciplinary approaches. The developed CPG can be adapted and implemented in various primary care and behavioral health settings to promote safer prescribing, reduce medication-related harm, and enhance patient outcomes (see Garel et al., 2023). On a broader scale, the project contributes to national efforts to enhance pharmacological stewardship, promote equity in mental health treatment, and strengthen provider accountability in the responsible management of anxiety disorders (see Strawn, 2023).

Conclusion

The impact of this DNP project on the project site organization was significant in promoting evidence-based prescribing practices, enhancing provider awareness, and establishing a structured approach to managing benzodiazepine use among adults with anxiety disorders. Through the development and expert validation of the CPG, the

organization established a standardized framework to guide safe prescribing, support tapering protocols, and promote nonpharmacological treatment alternatives. This initiative strengthened interprofessional collaboration and demonstrated the organization's commitment to quality improvement, patient safety, and regulatory compliance.

My future recommendations for the organization include implementing guidelines across all primary care sites, integrating these recommendations into electronic health record systems, and providing ongoing education to providers on anxiety management and benzodiazepine tapering. Future recommendations for improving this project include conducting a pilot implementation phase with pre- and post-intervention evaluations to assess provider adherence, patient outcomes, and potential barriers to sustainability. Additionally, incorporating patient feedback and health literacy considerations will further enhance the guideline's inclusivity and effectiveness.

The implications of this project on nursing practice include empowering advanced practice nurses to lead evidence-based change initiatives and promote safer pharmacologic management within interprofessional teams. The project highlights the crucial role of nurse practitioners in translating research into practice, enhancing medication safety, and promoting patient-centered care (see Lagha et al., 2021). This project has the potential to advance social change by reducing medication dependence, improving mental health outcomes, and advancing health equity through culturally responsive, accessible anxiety care (see Weleff et al., 2023). The dissemination of this guideline contributes to broader efforts to address the national issue of overprescribing

controlled substances, fostering safer communities and improved public health outcomes (see Wolitzky-Taylor et al., 2023).

The evaluation method used for this project was the AGREE II tool, a validated instrument designed to assess the quality, clarity, and applicability of CPGs. Expert panel members independently evaluated the guideline across six domains using a seven-point Likert scale, and quantitative scores were averaged to determine domain-level results. I also analyzed their qualitative feedback to identify themes and areas for improvement, ensuring methodological rigor and content validity in the final guideline.

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prescription opioids: A pilot randomized controlled trial. *Contemporary Clinical Trials*, 133, 107334. <https://doi.org/10.1016/j.cct.2023.107334>

Appendix: Clinical Practice Guideline

Clinical Practice Guideline

Project Title: Reduction of Benzodiazepine Overprescribing in Primary Care

Version/Date: October 2025

Authors: Oji Gibson, PMHNP-BC, MSN, RN-BC

Sponsoring Organization: N/A

Executive Summary

- Key Recommendations:

General Principles of Benzodiazepine Tapering

1. **Avoid abrupt discontinuation** – especially in long-term or high-dose users, due to risk of seizures, delirium, or severe withdrawal.
2. **Individualize tapering pace** – based on duration of use, dose, patient age, comorbidities, and co-medications.
3. The pharmacokinetics of older/geriatric people may dictate even smaller increments, as Diazepam will accumulate and lead to falls and confusion.
4. **Patient education and support** – clear communication, psychoeducation, and non-pharmacologic interventions (e.g., CBT, mindfulness) improve adherence and success. Provide patient education on risks of long-term benzodiazepine use (cognitive impairment, falls, dependence). Provide shared decision-making and a written tapering plan.
5. **One prescriber, one pharmacy** – consistency reduces risk of errors and misuse.
6. **Tapering** – reduce medication gradually every 1 – 4 weeks, depending on the medication's half-life

Medications & Approaches

1. Switch to a longer-acting benzodiazepine (when appropriate)

- **Diazepam** or **Clonazepam** are commonly used because they provide smoother serum levels and fewer interdose withdrawals.
- Example: Convert alprazolam/lorazepam to diazepam equivalent, then taper gradually.

2. Adjunctive / Supportive Medications (case-dependent, not universal)

- **SSRIs/SNRIs:** treat underlying anxiety/depression to reduce relapse.
- **Buspirone:** non-sedating anxiolytic (may help in GAD) for the elderly population.
- **Gabapentin or Pregabalin:** sometimes used to reduce withdrawal-related anxiety/insomnia (evidence mixed, off-label).
- **Trazodone or Mirtazapine:** may help with insomnia if severe during taper.
- **Melatonin:** safe option for sleep regulation.

3. Medications to Avoid

- **Alcohol** – cross-tolerance, increases CNS depression, worsens withdrawal.
- **Z-drugs (zolpidem, zaleplon, eszopiclone)** – similar risks as benzos, not recommended as substitutes.

- **High-dose antipsychotics** – can worsen sedation, confusion, and interactions without addressing withdrawal.
- **Opioids** – extremely high risk when combined; avoid unless necessary for comorbid pain and carefully managed.

Non-Pharmacologic Strategies

- **Cognitive Behavioral Therapy (CBT)** for anxiety or insomnia – shown to double success rates of benzodiazepine discontinuation.
- **Mindfulness-based stress reduction (MBSR)** and **acceptance-commitment therapy (ACT)** also support coping.
- **Sleep hygiene & relaxation training/education** - help with insomnia rebound.

Red Flags During Taper

- Severe withdrawal (hallucinations, seizures, psychosis) → slow taper further or consider inpatient management. Refer complex patients (e.g., comorbid substance use disorder, severe withdrawal risk) to psychiatry or addiction medicine.
- Relapses of underlying condition → optimize non-benzodiazepine treatment (SSRIs/SNRIs, psychotherapy).

- **Target Population:** Patients diagnosed with anxiety disorder

- **Intended Users:** Outpatient primary care providers

Purpose

The purpose of this clinical practice guideline is to standardize the management of benzodiazepine use among adult patients diagnosed with anxiety disorders, to reduce inappropriate long-term prescribing, prevent adverse outcomes such as dependence and cognitive impairment, and promote the use of evidence-based first-line treatments (SSRIs, SNRIs, CBT).

Scope

This guideline applies to:

- **Population:** Adults (≥ 18 years) are diagnosed with generalized anxiety disorder, panic disorder, or other anxiety disorders, receiving care within their practice.
- **Setting:** Primary care practice.
- **Focus:** Screening for chronic benzodiazepine use, safe prescribing, tapering/discontinuation protocols, patient education, and referral criteria.
- **Exclusions:** This guideline does not address pediatric patients, seizure disorders, status epilepticus management, or short-term procedural sedation.

Background & Rationale

Through a data review of the organization's medical group, it was identified that benzodiazepines are overprescribed in the primary care clinic. For example, one provider

in an office of five providers prescribed benzodiazepines to 115 patients, of whom fifty-one were daily users. The patients' prescriptions varied from one to three times daily, with regular refills. Despite evidence-based guidelines recommending the use of benzodiazepines only for short-term management (typically 2–4 weeks), long-term prescribing is common, particularly in primary care settings. Chronic benzodiazepine use is associated with significant risks, including physical dependence, withdrawal syndromes, cognitive impairment, falls, motor vehicle accidents, and overdose, particularly when combined with opioids or alcohol. **Older adults are disproportionately affected, experiencing higher rates of falls and hospitalizations** (Wolitzky-Taylor et al., 2023). Current practice at the organization exhibits variability in prescribing habits and a lack of standardized tapering protocols. Developing a standardized clinical practice guideline will close this gap by providing evidence-based recommendations for the appropriate prescribing, monitoring, and tapering of benzodiazepines, thereby supporting safer transitions of care and aligning with national patient safety goals and regulatory standards (Wolitzky-Taylor et al., 2023).

Practice Questions / Objectives

“Based on best practices and evidence in the literature, will the medical providers and expert panel at the DNP project site approve and adopt a standardized clinical practice guideline to reduce benzodiazepine overprescribing?”

Identify adult patients with anxiety disorders who are receiving chronic benzodiazepine therapy (>4 weeks).

Develop and implement evidence-based recommendations for safe prescribing, tapering, and monitoring of benzodiazepines in adults with anxiety disorders.

Promote the use of first-line treatments (SSRIs, SNRIs, CBT) as preferred management strategies for chronic anxiety.

Present the standardized tapering protocol to the prescribers.

Improve documentation of benzodiazepine indication, duration, and taper plans in the electronic health record (EHR).

Evaluate outcomes by tracking prescribing rates, taper completion rates, and patient safety metrics (falls, ED visits, withdrawal events) over 6 months.

Methods

• Literature Search Strategy

A comprehensive literature search was conducted to identify current evidence and best practices related to benzodiazepine prescribing, tapering, and management of anxiety disorders.

The following databases were searched: PubMed/MEDLINE, CINAHL Complete, PsycINFO, and Cochrane Library.

Search terms included combinations of controlled vocabulary (MeSH) and keywords:

- “benzodiazepines” OR “benzo tapering” OR “sedative-hypnotics”
- AND “anxiety disorders” OR “generalized anxiety disorder” OR “panic disorder”

- AND “guideline” OR “clinical practice guideline” OR “deprescribing” OR “treatment outcome”

Inclusion criteria:

- Peer-reviewed articles published in English between 2020 and 2025
- Adult population (≥ 18 years) with anxiety disorders
- Systematic reviews, meta-analyses, randomized controlled trials, clinical practice guidelines, or high-quality observational studies
- Studies addressing benzodiazepine prescribing, deprescribing/tapering, or comparative effectiveness with SSRIs/SNRIs/CBT

Exclusion criteria:

- Pediatric-focused studies
- Case reports or single case studies
- Non-peer-reviewed opinion pieces

• **Evidence Grading Approach** – Johns Hopkins Evidence-Based Practice Model for Nursing and Healthcare Professionals (JHEBM)

Expert Panel Composition

- Preceptor – Director of Advanced Practice Clinician - DNP, FNP-C
- Psychiatric Mental Health Nurse Practitioner
- Primary Care, Medical Director

• **Conflict-of-Interest Management** - This guideline was developed independently of commercial or industry influence. All recommendations are based solely on the best available evidence, in alignment with national standards.

Recommendations

Recommendation	Evidence Level	Rationale
Screen all adult patients with anxiety disorders for chronic benzodiazepine use (>4 weeks) at every visit.	Moderate	Early identification of prolonged use supports timely intervention and prevention of dependence.
Use SSRIs, SNRIs, and cognitive behavioral therapy (CBT) as first-line treatment for generalized anxiety disorder instead of long-term benzodiazepines.	High	Robust evidence demonstrates superior long-term efficacy and safety of SSRIs/SNRIs and CBT compared with benzodiazepines.
Initiate a gradual benzodiazepine taper (5–10% dose reduction every 1–2 weeks) for patients on chronic therapy, unless contraindicated. Provide shared decision-making and a written taper plan.	Moderate	Slow tapering reduces the risk of withdrawal symptoms and improves patient adherence to discontinuation.
Monitor for withdrawal symptoms weekly during taper and adjust schedule as needed.	Moderate	Frequent monitoring ensures patient safety and allows for individualized tapering.
Provide patient education on risks of chronic benzodiazepine use (falls, cognitive impairment, overdose risk, dependence).	High	Education increases awareness, supports adherence to taper plans, and aligns with patient-centered care.
Refer patients with complex comorbidities (e.g., substance use disorder, severe withdrawal risk) to psychiatry or addiction medicine for management.	Low	Specialist involvement reduces the risk of adverse outcomes in high-risk populations.
Document indication, taper plan, and follow-up schedule in the electronic health record (EHR) for all benzodiazepine prescriptions.	Moderate	Standardized documentation promotes continuity of care, accountability, and adherence to guidelines.

Implementation Strategies

CPG Presentation

- Conduct mandatory 30-minute provider session reviewing guideline recommendations, risks of long-term benzodiazepine use, and tapering strategies.
- Develop and distribute a pocket card or one-page summary algorithm for use during patient encounters.

Workflow Integration

- Integrate a **benzodiazepine screening question** into the EHR intake template for all patients with anxiety diagnoses.
- Build EHR alerts to flag chronic use (>4 weeks) and recommend a taper plan.
- Create a standardized order set for tapering, including suggested dose-reduction schedules and follow-up visit reminders.

Tools & Resources

- Patient education handout on benzodiazepine risks and tapering expectations.
- Provider quick reference: sample taper schedules by drug type.

Communication & Feedback

- Share baseline prescribing data at staff meetings.
- Provide quarterly reports showing percent reduction in chronic benzodiazepine use and taper completion rates.
- Recognize practice with the highest adherence to the guidelines.

Monitoring & Evaluation

Define key performance indicators, outcome metrics, adherence measures, and plans for periodic review and evaluation.

Key Performance Indicators:

- Percentage of adult patients with anxiety disorders on benzodiazepines >4 weeks.
- Percentage of patients with a documented taper plan in the EHR.
- Rate of adverse outcomes: falls, ED visits related to benzodiazepines, withdrawal-related complications.
- Rate of referral to psychiatry or addiction medicine for complex cases.

Data Collection Methods:

- Monthly audits of the EHR for benzodiazepine prescriptions, taper documentation, and follow-up visits.
- Patient-reported outcomes via brief surveys during office visits.

Responsible Parties:

- Quality Improvement (QI) team: lead audits and compile reports.
- Pharmacy staff: identify patients on chronic benzodiazepines.
- Clinic leadership: review and communicate results to providers.

Evaluation Timeline:

- **Short-term (3 months):** Measure adherence to screening and taper documentation.

- **Long-term (6–12 months):** Evaluate reduction in chronic benzodiazepine use, patient safety outcomes, and successful taper completion rates.

Feedback & Continuous Improvement:

- Quarterly feedback sessions with providers to share data trends.
- Identify barriers and facilitators to guideline adherence.
- Revise tapering protocols and educational tools based on audit findings and staff input.

• Evidence Tables

Author, Year	Study Design	Population	Intervention / Comparison	Key Findings	Evidence Level	Relevance to Recommendation
Caulfield & Stern, 2020	Pilot study	Adults using benzodiazepines with anxiety/mood disorders	High-frequency repetitive transcranial magnetic stimulation (rTMS)	rTMS concurrently improved mood and reduced anxiety symptoms	Moderate	Supports non-pharmacologic adjunct therapies to reduce benzodiazepine use
Chapoutot et al., 2021	Systematic review / Clinical trial	Adults with insomnia or anxiety on long-term benzodiazepines	CBT & Acceptance and Commitment Therapy (ACT) for discontinuation	Both CBT and ACT facilitated benzodiazepine taper and improved anxiety/insomnia outcomes	High	Supports CBT/ACT as evidence-based methods for tapering
Chen et al., 2020	Observational cohort	Adults with anxiety or depressive disorders	Analysis of prolonged/high-dose benzodiazepine use	Identified patient characteristics and risk factors associated with long-term or high-dose use	Moderate	Supports targeted screening and monitoring of high-risk patients
Garel et al., 2023	Pilot intervention	Hemodialysis patients on benzodiazepines	Mindfulness-based intervention for deprescription	Mindfulness intervention aided benzodiazepine taper and reduced anxiety/depression symptoms	Low–Moderate	Supports integrating mindfulness-based approaches into tapering programs
Lagha et al., 2021	Cross-sectional survey	Adults prescribed benzodiazepines for anxiety	Comparison of practice vs guidelines	Found frequent deviations from guideline-recommended prescribing practices	Moderate	Supports need for standardized guideline implementation
Liu et al., 2023	Retrospective study	Outpatients with anxiety disorder	Benzodiazepine-receptor agonist utilization	Reported prescribing patterns and durations in the outpatient setting	Moderate	Supports monitoring and audit of prescribing patterns
Strawn, 2023	Narrative review	Adults with anxiety disorders	Benzodiazepine treatment optimization	Discussed strategies for safe prescribing and tapering	Moderate	Supports recommendations on dose optimization and taper protocols
Vásquez Cedeño et al., 2023	Observational study	Adults >20 years with GAD	Quetiapine as an adjunct to benzodiazepines	Adjunct therapy reduced benzodiazepine dose requirements	Low–Moderate	Supports adjunct pharmacologic strategies when indicated
Weleff et al., 2023	Retrospective analysis	Primary care patients	Benzodiazepine prescribing trends (2019–2020)	Identified high rates of chronic use and deviations from guidelines	Moderate	Supports the need for guideline-based prescribing and monitoring
Wolitzky-Taylor et al., 2023	Pilot RCT	Adults with anxiety using opioids	Telehealth CBT to augment benzodiazepine taper	Telehealth CBT improved taper completion and reduced anxiety	High	Supports telehealth-delivered CBT as an effective tapering adjunct

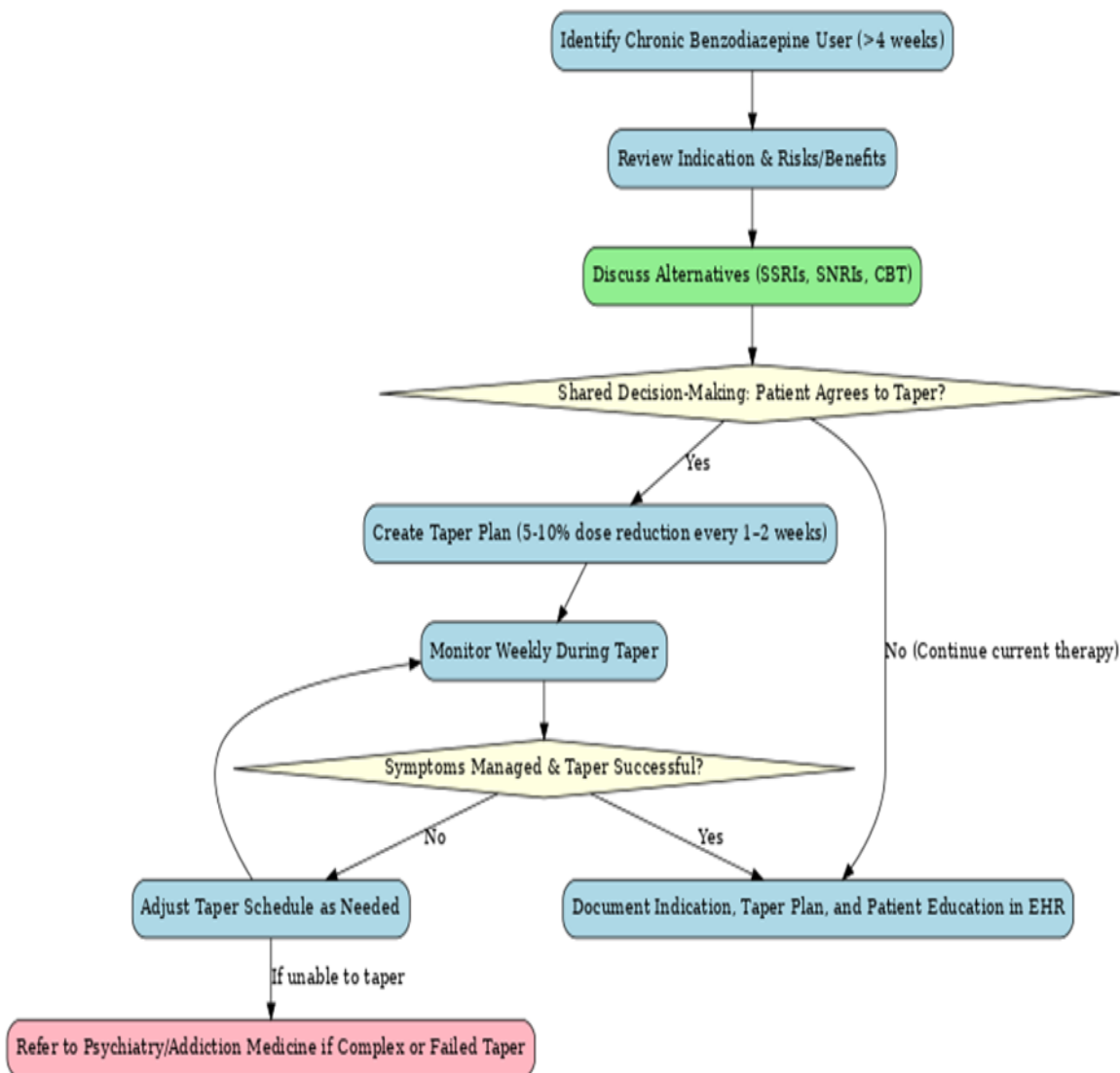
Abbreviations & Definitions

Abbreviation	Meaning
CBT	Cognitive Behavioral Therapy
EHR	Electronic Health Record
GAD	Generalized Anxiety Disorder
RCT	Randomized Controlled Trial
SSRIs	Selective Serotonin Reuptake Inhibitors
SNRIs	Serotonin-Norepinephrine Reuptake Inhibitors
QI	Quality Improvement
Term	Definition
Chronic benzodiazepine use	Use of benzodiazepine medication for more than 4 weeks continuously
Deprescribing / Tapering	Gradual reduction of benzodiazepine dose to minimize withdrawal symptoms and dependence
First-line therapy	Evidence-based initial treatments recommended before benzodiazepines (e.g., SSRIs, SNRIs, CBT)
Adverse events	Any undesirable outcome related to benzodiazepine use (falls, cognitive impairment, overdose)
Shared decision-making	A collaborative process between the patient and the provider to make informed choices about treatment

Flowcharts/Algorithms

Benzodiazepine Tapering Clinical Algorithm

This flowchart provides a step-by-step algorithm for identifying, managing, and tapering chronic benzodiazepine use in adult patients with anxiety disorders.



Benzodiazepine Tapering: Patient Guide

This handout explains why tapering is essential, what to expect, and how to stay safe as you reduce your medication.

Why Taper?

Benzodiazepines (e.g., Xanax, Ativan, Klonopin, Valium) work for short-term anxiety, but long-term use can lead to problems:

- **Dependence** (your body needs medication to feel normal)
- **Memory problems or confusion**
- **Increased risk of falls**
- **Daytime drowsiness or grogginess**

Tapering helps your body adjust slowly and safely.

What to Expect

- Your provider will plan to **reduce your dose gradually every 1–4 weeks**
- Tapering may take **weeks or months**, depending on your situation
- Common withdrawal symptoms (usually mild):
 - Trouble sleeping
 - Anxiety or irritability
 - Headaches or muscle aches
 - Upset stomach

 **Tip: Keep track of your symptoms — share them with your provider at each visit.**

How to Help Yourself

- Take your medication **exactly as prescribed** — do not stop suddenly
- Practice relaxation techniques: deep breathing, meditation, yoga, or walking
- Avoid alcohol and other sedatives
- Build a support network — family, friends, or support groups

When to Call Your Provider


Call right away if you have:


- Severe anxiety or panic attacks
- Hallucinations or confusion
- Thoughts of harming yourself
- Seizures

Remember

Tapering is a **team effort** — slower tapers are safer and easier to manage.

Your provider will adjust the plan to help you succeed

 **Provider Contact:** _____

 **Follow-Up Appointment:** _____

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Provider Survey Monkey link: <https://www.surveymonkey.com/r/ZSDHMKH>

Benzodiazepine Tapering Suggested Guideline for Anxiety Disorders Taper schedule (reduce ~5–25% every 2–4 weeks)

Drugs	Starting Dose	Weeks	Morning	Midday	Evening
Clonazepam (Klonopin)	1 mg BID	1-2	0.75 mg		1 mg
		3-4	0.75 mg		0.75 mg
		5-6	0.5 mg		0.75 mg
		7-8	0.5 mg		0.5 mg
		9-10	0.25 mg		0.5 mg
		11-12	0.25 mg		0.25 mg
		13-14	0.25 mg		
		15-16	STOP		
Lorazepam (Ativan)	1 mg TID	1-2	0.5 mg	1 mg	1 mg
		3-4	0.5 mg	0.5 mg	1 mg
		5-6	0.5 mg		0.5 mg
		7-8	0.5 mg		
		9-10	STOP		
Alprazolam (Xanax)	1 mg TID	Convert to Diazepam 1 mg alprazolam \approx 10 mg diazepam \rightarrow total \approx 30 mg diazepam/day			
Diazepam		1-2	30 mg		
		3-4	25 mg		
		5-6	20 mg		
		7-8	15 mg		
		9-10	10 mg		
		11-12	5 mg		
		13-14	2.5 mg		
	15-16	STOP			

(American Society of Addiction Medicine (ASAM), 2025)

(Ogbonna & Lembke, 2017)

(Sørensen et al., 2022)

Using SSRIs During Benzodiazepine Tapering

- Start the SSRI *before* or at the very beginning of the taper.
 - SSRIs/SNRIs take 4–8 weeks to achieve full therapeutic effect.

- If you taper the benzodiazepine first, patients may experience rebound anxiety before the SSRI has “kicked in.”
- Begin SSRI **2–4 weeks before tapering** if possible (Brunner et al., 2025).
- **If the patient is already motivated to taper, you can start SSRI concurrently with the first taper step; nonetheless, expect to hold the taper longer at the beginning to allow the SSRI effect to build** (American Society of Addiction Medicine (ASAM), 2025).
- Side effects and interactions should also dictate the choice of an SSRI.
 - For example, Escitalopram causes **QTC prolongation**
 - Paroxetine is not suitable for the geriatric population due to its anticholinergic effect.
 - Buspirone is a safer alternative for the elderly.
- **Start low, go slow** to minimize activation side effects (which can worsen anxiety early on).
 - Example: **Escitalopram 5 mg daily → increase to 10 mg after 1–2 weeks.**
 - **Sertraline 25 mg daily → increase to 50 mg after 1 week.**
- **Titrate upward** every 2–4 weeks as tolerated until the therapeutic dose is reached.

Overlap Period

- Maintain benzodiazepine at a **stable dose** while titrating SSRI.
- Once the SSRI is at a therapeutic dose (usually 4–6 weeks in), begin tapering the benzodiazepine.
- This overlap provides a “safety net” against rebound anxiety (Ogbonna & Lembke, 2017)

Taper

Example: Lorazepam 1 mg TID (3 mg/day) → Escitalopram

Week	Benzodiazepine (Lorazepam)	SSRI (Escitalopram)	Clinical Notes
0–2	Hold lorazepam at 1 mg TID	Start escitalopram 5–10 mg daily	Allow SSRI to begin working before taper; monitor tolerability
3–4	Reduce lorazepam to 0.5 mg AM + 1 mg midday + 1 mg PM (2.5 mg/day)	Continue escitalopram 10 mg	First taper step: reassure the patient about mild withdrawal
5–6	Lorazepam 0.5 mg TID (1.5 mg/day)	Increase escitalopram to 15–20 mg if tolerated	SSRI should be reaching a therapeutic effect
7–8	Lorazepam 0.5 mg BID (1 mg/day)	Maintain escitalopram 15–20 mg	An SSRI should cover anxiety; monitor sleep
9–10	Lorazepam 0.5 mg daily (0.5 mg/day)	Continue escitalopram	Withdrawal symptoms are usually mild at this stage
11–12	Stop lorazepam	Continue escitalopram	Reinforce non-drug coping strategies
13+	Off benzodiazepine	Maintain escitalopram	Follow-up at 1 month and 3 months

(American Society of Addiction Medicine (ASAM), 2025)

Best SSRIs for Long-Term Anxiety Management

Escitalopram (Lexapro)

- Strong evidence for GAD and panic disorder
- Well tolerated, fewer drug interactions
- Usual dose: 10–20 mg daily (Brunner et al., 2025)

Sertraline (Zoloft)

- Effective for GAD, panic disorder, and social anxiety disorder
- Flexible dosing, safe in many comorbidities
- Usual dose: 50–200 mg daily

Paroxetine (Paxil)

- Effective for GAD, panic disorder, and social anxiety disorder
- More sedating (can help if insomnia is prominent)

- Higher risk of withdrawal symptoms if doses are missed
- Usual dose: 20–60 mg daily

Fluoxetine (Prozac)

- Long half-life (less withdrawal risk if a dose is missed)
- Useful if adherence is a concern
- Usual dose: 20–60 mg daily (Sørensen et al., 2022)

Buspirone (Buspar)

- Safer option for the elderly due to pharmacokinetics, because diazepam accumulates more, leading to falls and confusion.
- Does not produce significant sedation, dependence, or withdrawal effects.

Best SNRIs for Long-Term Anxiety Management

- **Duloxetine (Cymbalta)**
 - Effective for GAD, also helps with comorbid pain syndromes
 - Usual dose: 60–120 mg daily
- **Venlafaxine XR (Effexor XR)**
 - Strong evidence for GAD, panic disorder, and social anxiety disorder
 - Dose-dependent: lower doses act more like SSRIs, higher doses add norepinephrine effect
 - Usual dose: 75–225 mg daily (Sørensen et al., 2022)

Benzodiazepine Tapering Follow-Up Checklist

1. Medication Adherence

- Review patient's current dose vs. taper schedule
- Pill count or refill history
- Ask about missed doses or extra doses taken
- Confirm patient understands next taper step

2. Withdrawal & Symptom Monitoring

- Ask about common withdrawal symptoms:
 - Anxiety, irritability, insomnia, tremors, sweating
- Screen for severe symptoms:
 - Hallucinations, confusion, seizures (urgent referral if present)
- Use standardized tools if available:
 - CIWA-B (withdrawal), GAD-7 (anxiety), ISI (insomnia)

3. Mental Health & Functioning

- Assess mood, anxiety, and coping strategies
- Ask about daily functioning (work, relationships, sleep quality)
- Screen for depression or suicidal thoughts
- Reinforce use of CBT, relaxation, or mindfulness techniques

4. Safety & Risk Assessment

- Check for concurrent opioid or alcohol use
- Ask about falls, confusion, or sedation (especially in older adults)
- Review driving and work safety concerns

5. Patient Engagement

- Explore patient's confidence in continuing taper

- Address fears or barriers (e.g., “I cannot sleep without it”)
- Reinforce education: risks of long-term benzodiazepine use, benefits of tapering
- Encourage journaling or symptom tracking

Plan Adjustment

- Decide whether to continue tapering, hold, or slow down
- Consider adjunctive support:
 - SSRIs/SNRIs, buspirone (for anxiety)
 - Melatonin, trazodone, low-dose doxepin (for insomnia)
- Document changes and next steps

7. Follow-Up Scheduling

- Next visit in **1–2 weeks** (early taper) or **2–4 weeks** (later taper)
- Provide contact instructions for urgent symptoms
- Plan post-discontinuation follow-up at 1 month and 3 months

Mental Health Follow-Up Amid Provider Shortages

1. Telehealth & Virtual Therapy

- **Video or phone sessions** expand access, especially in rural or underserved areas.
- Many platforms (e.g., Talkspace, BetterHelp, Amwell) connect patients with licensed therapists across state lines.
- **Advantages:** flexible scheduling, reduced travel barriers, and often shorter waiting times.

2. Primary Care Integration

- Primary care providers (PCPs) can **monitor mental health symptoms**, adjust medications, and provide brief counseling.
- **Collaborative Care Models** embed behavioral health specialists into primary care teams, allowing patients to get follow-up without needing a separate therapist.

3. Group Therapy & Peer Support

- **Group CBT or support groups** (in-person or virtual) allow one therapist to reach multiple patients at once (Stringer, 2024).
- **Peer support specialists** (trained individuals with lived experience) can provide ongoing check-ins and accountability (Stringer, 2024).
- Community organizations, NAMI (National Alliance on Mental Illness), and local nonprofits often run free or low-cost groups (Phillips, 2023).

4. Digital Mental Health Tools

- **Evidence-based apps** (e.g., Headspace, Calm, Woebot, MoodMission) provide CBT-based exercises, mindfulness, and symptom tracking.
- **Providers can prescribe digital therapeutics (FDA-cleared programs like reSET or Somryst)** for structured therapy support.
- These tools can **bridge gaps between appointments** or serve as interim support when therapists are unavailable (Phillips, 2023).

6. Crisis & Short-Term Resources

- **988 Suicide & Crisis Lifeline** for immediate support (Vilhauer, 2023).
- **Warm lines** (non-crisis peer support hotlines) for ongoing check-ins.
- **Employee Assistance Programs (EAPs)** often provide short-term counseling sessions at no cost (Stringer, 2024).

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