Amid the opioid crisis in the United States, another class of psychoactive medications — benzodiazepines — is often used inappropriately and should be considered for deprescribing. In tapering these medications, safe practices must be adopted and nonpharmacological alternatives should be considered, when appropriate.

In the late 1990s, U.S. health care providers began to prescribe opioid pain relievers in increasing amounts after pharmaceutical companies assured them that patients would not become addicted. These opioid prescribing practices led to widespread misuse of both prescription and nonprescription opioids, and the ensuing realization among the medical community that these medications were indeed addictive. In 2017, the U.S. Department of Health and Human Services (HHS) declared a public health emergency and announced a strategy to combat the opioid epidemic ("What Is the U.S. Opioid Epidemic?" Sept. 4, 2019; http://bit.ly/2uQnlNR).

In October 2019, HHS published guidelines for appropriate dosage reduction or discontinuation of long-term opioid analgesics, which provide advice to clinicians who are considering making a change to a patient’s opioid dosage ("Guide for Clinicians," Oct. 2019; http://bit.ly/2su87gI).

The Comprehensive Addiction and Recovery Act (CARA) of 2016 included provisions that give Medicare Part D plans important new tools to use in 2019 to address opioid overutilization. To execute this law, the Centers for Medicare & Medicaid Services (CMS) passed a
regulation so that Part D plans may create a drug management program. This program limits access to certain controlled substances that have been determined to be “frequently abused drugs” for patients who are considered to be at-risk for prescription drug abuse. Limiting access means that a patient might only be able to obtain these medications from a specified prescriber or pharmacy.

In 2019, CMS identified both opioids and benzodiazepines (BZDs) as frequently abused drugs (MNL Matters, SE18016, Nov. 1, 2018; https://go.cms.gov/35WbBWO). A 2018 study indicated that 12.6% of U.S. adults reported BZD use in the past year, with misuse accounting for 17.2% of overall use. The incidence of BZD use among people aged 65 to 80 has been estimated at 8.7%, and misuse was reported in 0.6% of the 265-year-old population, the lowest of all the age ranges studied (Psychiatr Ser 2019;70:297–106).

In the skilled nursing facility population, it is not uncommon for patients to be admitted who have been taking a BZD for years or even decades. In the United States, more than 10% of women and 6% of men aged 65 to 80 have filled at least one prescription for BZDs in a one-year period; approximately one-third of them have received BZDs for longer than 120 days in a year (JAMA Psychiatry 2015;7:2:136–142).

Development and Effects of Benzodiazepines

The grandfather of all BZDs, chlordiazepoxide (Librium), was identified in 1955 by a chemist at Hoffmann-La Roche pharmaceuticals. The company marketed it and continued to research and develop protocols for enhanced activity, and more new BZDs came on the market. Less than two decades later, BZDs were the most frequently prescribed class of medication in the United States (JAMA 2013;3:25:38–48).

It took 15 years for researchers to discover that BZDs worked by affecting gamma-aminobutyric acid (GABA), which raised concerns about the potential side effects and the risks associated with their use. In the case of long-term use of BZDs, tapering protocols should be discussed. Several pharmacological alternatives and non-pharmacological alternative options are available for treating insomnia and anxiety in older adults. Treatment with BZDs should be avoided for this population when safer alternatives are an option (Mayo Clin Proc 2016;91:1652–1639).

Safety Guidelines

In the “Final Call Letter,” for calendar year 2019 (Apr. 2, 2018; https://go.cms.gov/2FLOKma), CMS announced that new safety edits for opioids and BZDs applied to all Medicare beneficiaries filling prescriptions under the Medicare D benefit, beginning January 1, 2019. These edits adopted by Medicare D Plan sponsors were implemented at the point of sale and included:

- Soft edit for concurrent opioid and BZD use
- Soft edit for duplicative long-acting opioid therapy
- Care coordination edit at 90 morphine milligram equivalents (MME)
- Hard edit at 200 MME or more (optional), and
- Hard edit seven-day supply limit for initial opioid fills (opioid naive)

Soft edits are rejections that can be overridden by the dispensing pharmacist at the point of sale using a series of override codes.

Hard edits require the pharmacist to call the plan’s help desk for an override. These override questions are designed to determine whether the prescription is necessary and safe for the patient to take.

Of note, the first safety edit applies to the concurrent use of an opioid and a BZD. With this opioid-BZD soft edit from CMS — and considering elderly patients may have prolonged use of BZDs — pharmacists and prescribers are questioning how to proceed with patient care. Patients aged 65 and older are sensitive to the side effects of BZDs, but abrupt discontinuation could be harmful or even fatal.

Currently there is no gold standard for a tapering algorithm for BZDs, but an internet search of medical resources can provide several options. The one commonality among all is that this discontinuation must be done gradually.

When to Taper

For elderly nursing home residents, inappropriate or unnecessary BZD use should be identified and a tapering plan developed together with the patient. Tapering can be challenging because some patients may experience both physical and/or psychological withdrawal symptoms. It is important to perform a thorough review of the patient’s history, including the type of BZD prescribed (short or long-acting) and the dose, frequency, and duration of use. An accurate history needs to be obtained to determine whether the patient has ever tried a BZD taper and the details of the attempt.

Chinyere Ogbonna, MD, MPH, of Kaiser Permanente, San Jose, and Anna Lembke, MD, of the Stanford University School of Medicine in California have published specific BZD tapering guidance (An Fam Physician 2014;77:302–314). However, diazepam and the long-acting agents should be avoided for BZD tapering longer than 120 days.

For daytime dosing (one to four times daily), the initial taper should be between 10% and 25% of the total daily dose, with subsequent taps individualized based on the patient’s response. Further reductions of 10% to 25% weekly are well tolerated pharmacologically. Maintaining the patient on a 50% dose for one to two months may be warranted before proceeding further with the taper. For patients on concurrent opioid and BZD therapy, consider tapering one or both medications.

Prolonging the BZD taper longer than six months may worsen long-term outcomes, and patient education about anxiety management and coping is essential for a successful taper. Engage the interdisciplinary health care team to provide support whenever possible.

Non-pharmacological Treatments

Non-pharmacological treatments are key for a successful BZD taper, so they should be included in the patient’s treatment plan. The health care team can assist patients with the challenges they may face when tapering off a BZD (Curr Psychiatry 2019;18:9–10):

- Validate the patient’s concerns.
- Reassure patients that support will be provided throughout the taper.
- Provide additional support resources.
- Educate the patient about the tapering process and symptoms of withdrawal.
- Recommend non-pharmacological therapies such as cognitive-behavioral therapy, motivational interventions, and development of coping skills.
- Involve the patient’s family and friends for support and encouragement.
- Implement supportive and encouraging attitude and be patient. Remember 70% to 90% of patients can be successfully tapered off of a BZD, and several different tapering strategies have been shown to be effective.

Every tapering plan should be tailored to the individual patient. Recurrence or rebound symptoms may occur as early as a few days to one week, but if the care team is educated about monitoring for these symptoms, alternative treatments can be initiated quickly and the process will be successful.