ALAMEDA ALLIANCE FOR HEALTH

BENZODIAZEPINE TAPER DECISION TOOL – CLINICIAN'S GUIDE

WE ARE HERE TO HELP YOU!

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community, and we appreciate all of your hard work to improve health and wellbeing in our community.

We have created a Benzodiazepine Taper Decision Tool and reference guide to help clinicians determine:

- If a benzodiazepine taper is necessary.
- When to perform the taper.
- When to provide follow-up and support during the taper.

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Benzodiazepine Tapering

Combining both opioids and benzodiazepines can be dangerous because both drugs cause sedation and respiratory depression.[1] Long term use of benzodiazepines could increase risk of cognitive impairment, delirium, falls, fractures and motor vehicle crashes especially in older adults.[2] In 2015, 23% of people who died of an opioid overdose also tested positive for benzodiazepines.[3]

Populations of Who to Taper[4]

- Those with a combination of benzodiazepines, opioids, and/or amphetamines.
- Those who demonstrate an active use or history of substance use disorder.
- Older patients.
- Those with cognitive disorder or traumatic brain injury.

Patients who have been on benzodiazepines for 4-6 weeks should be considered for tapering. Patients who are concurrently taking routine opioids and benzodiazepines can be tapered separately or concurrently.

Specific Tapering Recommendations[4]

Individuals taking higher than recommended doses:

- Consider hospital monitoring to minimize medical risks.
- Consider switching to long-acting benzodiazepines.
- Reduce dose initially by 25-30%.
- Reduce dose by 5-10% daily to weekly.

Individuals taking therapeutic dose-bedtime dosing:

- Reduce by approximately 25% weekly.
- Anticipate and educate on rebound insomnia.
- Educate patient on sleep hygiene.
- Provide alternative options: CBT, non-benzodiazepines (trazadone).

Individuals taking therapeutic doses-daytime dosing (QD to QID):

- Anticipate and educate patient on rebound anxiety and recurrence of initial anxiety symptoms.
- Plan additional psychological support during taper.
- Educate and prepare the last phase of withdrawal, which will be the most difficult.
- Warn that dosing schedule changes (e.g. TID to BID) will be psychologically challenging.

- Initial dose taper between 10-25%.
    - Observe signs of withdrawals.
    - Anticipate and educate withdrawals with short-half life.
    - Individualize subsequent reductions based on individualized response.
- Follow with further reductions of 10-25% as tolerated pharmacologically.
    - Patient may need to taper slowly. Some patients may hold their dose for 1-2 months.

Adjunctive options to support last phase of taper[4, 6, 7]

More research and trials are needed for supportive therapy. Options listed below are studies with highest level of evidence:

- Carbamazepine, paroxetine
    - May reduce symptoms of anxiety
- TCA, paroxetine
    - May help with withdrawals
- TCA
    - Potentially positive effective on benzodiazepine discontinuation

Benzodiazepine Equivalency[2,4, 5]

DRUG	DOSE EQUIVALENCE	ELIMINATION HALF-LIFE (HOURS)	TYPE OF BENZO
Chlorodiazepoxide (Librium)	10 mg	14-95	Long
Diazepam (Valium)	5 mg	100	Long
Flurazepam (Dalmane)	15-30 mg	111-113	Long
Alprazolam (Xanax)	0.5 mg	11.2	Intermediate
Clonazepam (Klonopin)	0.5 mg	17-60	Intermediate
Lorazepam (Ativan)	1 mg	12	Intermediate
Temazepam(Restoril)	10-20 mg	3.5-18.4	Intermediate
Triazolam (Halcion)	0.25-0.5 mg	1.5-5.5	Short

Most studies in primary care have found that successful tapering greater than 10 weeks can lead to achieving long-term abstinence.[2]

Withdrawal symptoms: Agitation, anxiety, tachycardia, dysphoria, insomnia, hallucinations, delusions, delirium.[2]

Tapering Example[4]

Drug: Lorazepam 4 mg bid → Diazepam 40 mg qd

WEEK	DIRECTION	DOSAGE
Week 1		35 mg/day
Week 2	Decrease dose by 25%	30 mg/day (25%)
Week 3		25 mg/day
Week 4	Decrease dose by 25%	20 mg/day (50%)
Week 5-8	Hold dose for 1-2 months	Continue at 20 mg/day for 1 month
Week 9-10		15 mg/day
Week 11-12	Decrease dose by 25% at week 11	10 mg/day
Week 13-14	Decrease dose by 25% at week 13	5 mg/day
Week 15		Discontinue

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Disclaimer

This resource is not a substitute for clinical judgment or medical advice. Adherence to or use of this guide does not guarantee successful treatment. Providers are responsible for assessing the care and needs of the individual patient. Providers must use their professional judgment in making decisions or recommendations that impact the patient's health including use of this resource.

We are here to help!

If you have any questions, please contact:

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