Massachusetts Consultation Service
MCSTAP
for Treatment of Addiction and Pain

MCSTAP Process Tip Sheet for Tapering Opioids and Benzodiazepines in Patients with SUD and Pain

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Below adopted from BRAVO Protocol (https://www.oregonpainguidance.org/wp-content/uploads/2019/02/BRAVO-updated-2019.pdf?x91687)

	Tip / Clinical Pearl	Notes
☐	B = Broaching the Subject	• Suggesting an opioid taper can trigger anxiety • Identify this feeling for patients, normalize it and express empathy • Make clear that opioid taper was carefully considered, not impulsive and not punitive
☐	R = Risk – Benefit Calculator	• Consider the risks of long-term opioid therapy and weigh against the benefits in this patient • Is MED > 90 mg? Are there medical comorbidities? Are there side effects? Is there a lack of functional improvement? Is there a lack of significant pain relief despite dose increases? • Is there dangerous co-prescribing such as benzodiazepines? If there is, what do you taper first?
☐	A = Addiction Happens	• Misuse of opioids in long term opioid therapy is common and can predict subsequent addiction. • Physical dependence, withdrawal and tolerance by themselves do not define addiction. Addiction refers to behaviors associated with opioid use. Think of the 4 C's: Control, Compulsion, Craving, Continued Use (despite consequences) • Normalize the concept of addiction to medications prescribed for pain and reassure patients that there are effective treatments and link to treatment (i.e., MOUD)
☐	V = Velocity Matters	• Tapering too fast is the most common mistake prescribers make; decreases should be no more than 5-10% at no faster than 1-week intervals (most patients require much longer) • It's ok to take breaks in the taper schedule, but avoid going backward during the taper

		• Validate the patient's experience of opioid withdrawal, which may initially increase body pain. Pain from withdrawal will resolve and doesn't mean any underlying condition is worsening • Use other medications to mitigate some of the symptoms of withdrawal
☐	O = Other Strategies for Coping with Pain	• If not already in place, offer non-opioid pain therapies during the taper

Benzodiazepine taper

APPROACH to Tapering

Taper slowly: slow tapers are more likely to be successful than fast tapers. Use scheduled rather than p.r.n. doses. Halt or reverse taper if severe anxiety or depression occurs.

Schedule follow-up visits q. 1–4 weeks depending on the patient's response to taper. At each visit, ask patient about the benefits of tapering (e.g., increased energy, increased alertness)

Be open to the idea that a full taper may be extremely challenging, and that substantial dose reduction may be an adequate outcome.

PROTOCOL for Outpatient Benzodiazepine Tapering

Initiation

Can taper with a longer-acting agent, e.g., diazepam/clonazepam, or taper with agent that patient is taking. (Diazepam can cause prolonged sedation in elderly and those with liver impairment.) Insufficient evidence to strongly support the use of one particular benzodiazepine for tapering. Convert to equivalent dose in divided doses (see equivalence table below). Adjust initial dose according to symptoms (equivalence table is approximate).

Decreasing the Dose

Taper by no more than 5 mg diazepam equivalent/week. Adjust rate of taper according to symptoms. Slow the pace of the taper once dose is below 20 mg of diazepam equivalent (e.g., 1–2 mg/week). Rx: dispense daily, 2x weekly, or weekly depending on dose and patient reliability.

Another Approach

Taper according to the proportional dose remaining: Taper by 10% of the dose every 1–2 weeks until the dose is at 20% of the original dose; then taper by 5% every 2–4 weeks. Source: Adapted from Kahan 2002

Benzodiazepine Equivalent Table

Source: Adapted from Kalvik 1995; Canadian Pharmacists Association 1999.

Benzodiazepine	Equivalent to 5 mg diazepam (mg) *
Alprazolam (Xanax®)**	0.5
Bromazepam (Lectopam®)	3–6
Chlordiazepoxide (Librium®)	10–25
Clonazepam (Rivotril®)	0.5–1
Clorazepate (Tranxene®)	7.5
Flurazepam (Dalmane®)	15
Lorazepam (Ativan®)	0.5–1
Nitrazepam (Mogadon®)	5–10
Oxazepam (Serax®)	15
Temazepam (Restoril®)	10–15
Triazolam (Halcion®)**	0.25

* Equivalences are approximate. Careful monitoring is required to avoid over-sedation, particularly in older adults and those with impaired hepatic metabolism.

**Equivalency uncertain.

Source: Canadian guidelines - http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b06.html

http://www.cpsa.ca/wp-content/uploads/2017/06/Benzodiazepine-Clinical-Toolkit-Use-and-Taper.pdf

Other Resources:

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/59_PTSD_NCPTSD_Provider_Helping_Patients_Taper_BZD.pdf

Curbside Consultation: Tapering Patients Off of Benzodiazepines Commentary by CHINYERE I. OGBONNA, MD, MPH, Kaiser Permanente San Jose, San Jose, California, and ANNA LEMBKE, MD, Stanford University School of Medicine, Stanford, California https://www.aafp.org/afp/2017/1101/p606.html

OPIOID TAPER: controversial topic! 2016 DEA guide advises considering taper, then 2017 and 2018 rebuttals came out about allowing for more clinician discretion.

Remember to evaluate patients for underlying OUD—studies show that many patients with underlying OUD were not offered buprenorphine or methadone treatment when they would have been candidates. (less than 1% of patients who met criteria for OUD!)

VA resource is detailed, with sample taper schedules VA Taper considerations

The idea of Complex Persistent Dependence: Some patients will not do well with even a slow taper and will spiral out of control.