Management of Benzodiazepine Use

OVERVIEW

TIMELINE	COMMON PRESENTATIONS
Acute withdrawal Occurs with abrupt cessation after daily use for 4 wks. or more; onset is within 8–96 hrs. of last use. Risk increases with higher doses, longer use, and shorter-acting agents.	**Benzodiazepine overuse** Depression, suicidal ideation, sedation, falls, decreased reaction time, motor incoordination, motor vehicle accidents, respiratory depression, sleep apnea, confusion, worsening cognitive impairments
	Benzodiazepine withdrawal Anxiety, panic, insomnia, emotional lability, abdominal cramping, diarrhea, nausea, decreased appetite, tinnitus, diaphoresis, tremor 50+ mg DE: Tachycardia, hypertension, confusion, disorientation, seizures, delirium, psychosis *Slower onset & predominance of psychological symptoms compared to alcohol withdrawal

ASSESSMENT

- Intake & vital signs
  - Complete substance use history will guide monitoring and treatment
  - Polysubstance use increases OD risk and concurrent withdrawal syndromes may be present
  - Wake clients for assessment during their first 6h of their WMS stay
- Consider closer monitoring of clients with long-term, daily use of fentanyl, due to potential long-term daily exposure to BZD in the unregulated opioid supply
- Care decisions will largely be based on the source of the BZD, the client's risk of harm., the presence of withdrawal, and the presence of BZD use disorder

TREATMENT OF WITHDRAWAL

- BZD withdrawal can be life-threatening; early recognition and treatment is crucial
- If the patient has known BZD use but is not yet showing signs of withdrawal, consider restarting BZD at 50% of their usual dose and titrate/taper as appropriate
- For patients with **any substance use history*** showing signs of BZD withdrawal (e.g., seizures, agitation, severe anxiety despite OAT, psychosis), consider administering lorazepam 2–4 mg SL for stabilization (higher doses may be required for concurrent management of alcohol withdrawal) and send to ED

*Unregulated opioids may be contaminated with BZD; patients who use unregulated opioids are at risk of BZD withdrawal.

MANAGING BENZODIAZEPINE PRESCRIPTIONS

- Low to moderate therapeutic doses not causing harm: Continue prescription
- Imminent risk of BZD toxicity: Immediate dose reduction to reduce risk (e.g., consider lowering dose by 25–50% for patients with concurrent opioid or alcohol use)
- Risk of harm and/or high dosing: Consider long-term outpatient taper (e.g., 30+ mg DE, risk factors such as older age or COPD
- BZD use disorder: Initiate long-term taper with daily dispensing
    - Inpatient management required for abrupt withdrawal of BZD/initial stabilization
    - Referral to outpatient addiction provider highly recommended

GENERAL PRINCIPLES FOR A BENZODIAZEPINE TAPER

The goal of a benzodiazepine taper is not always discontinuation but reaching a safe and effective therapeutic dose. These are general principles only; the taper should be customized to the client.

1) **Address underlying mental health concerns:** Underlying mental health concerns for which BZD may have been originally prescribed (anxiety disorders, mood disorders, post-traumatic stress disorder) should be considered and addressed with psychological therapies and appropriate medications (e.g., SSRIs, SNRIs) throughout a BZD taper.

2) **Convert to a longer-acting BZD:**
    - **a)** Choose the agent: Consider switching from a shorter-acting agent (alprazolam, lorazepam) to a longer-acting agent (diazepam, clonazepam) during BZD taper. This step is not mandatory, but a long-acting agent provides slower onset of withdrawal symptoms, and therefore a smoother taper.
    - **b)** Calculate equivalency: Calculate the client's usual BZD dose equivalency in the chosen long-acting agent (**TIP:** use a table or conversion calculator) and start at 50–75% of this dose, in divided doses, to prevent oversedation. Titrate to the patient's comfort, not exceeding the original dose. Because of differences in potency and drug profiles, consider converting prescription BZD users gradually, substituting one dose at a time.

3) **Plan a taper rate:** There are many approaches for tapering BZD, such as *percentage* (taper 10% q1–2 weeks) and *milligrams* (taper 5–10 mg DE q1–2 weeks). When the dose has reached 20% of the original dose or 20 mg DE, slow the taper to 5% or 1–2 mg q2–4 weeks.

4) **Set a schedule:** Use scheduled doses and avoid PRN dosing. The taper will take longer than the WMS stay. Prescribers should develop and share the taper schedule with the patient's care team.

5) **Determine dispensing:** Use client-centered strategies. Consider daily, every 2–3 days, or weekly dispensing as needed to avoid overuse.

TIPS

Clonazepam is less likely to cause prolonged sedation (consider it in the elderly and those with liver impairment), while diazepam is available in low-dose formulations (e.g., 2 mg) for a smooth taper.

Use a table or conversion calculator to find equivalency.

Conversion and titration can take days or weeks to complete.

Hold the taper for a few weeks if the client experiences negative impacts on function, withdrawal, rebound anxiety, or markedly decreased mood.

A slower taper is required in the elderly.

Use a template or spreadsheet for easy tracking, sharing, or adjusting the taper as needed.

Long-acting BZDs are only required 1–2 times/day. Try to move clients away from frequent dosing when converting from short- to long-acting BZD, e.g., TID to BID.