Concomitant Opioid and Benzodiazepine Tapering Strategies of Prescribers

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Purpose: Opioids and benzodiazepines have Central Nervous System and respiratory depressant adverse effects, which are compounded when these medications are taken concurrently. Tapering one or both of these agents is frequently undertaken by prescribers. Unfortunately, there are no standardized clinical practice guidelines regarding taper methods for patients on concomitant therapy. The primary purpose of this study is to describe commonalities in concomitant opioid and benzodiazepine tapering strategies among clinicians.

Methods: This study was conducted as a descriptive, non-experimental, web-based survey. Pharmacists, physicians, physician's assistants, advanced practice nurses, and psychiatrists were invited to complete the survey anonymously via Qualtrics. Recruiting for the survey included sending out email invites to providers who have either presented or researched the topic of opioid and benzodiazepine tapering or had experience with patients on opioids and benzodiazepines. Completing and submitting the survey served as consent. The survey was developed consisting of 27 questions to identify clinicians experience with concomitant opioid and benzodiazepine patients and their preferred tapering strategies, including goals, location, taper schedule, and follow-up. Question types included both structured and unstructured responses. The survey was pilot tested prior to distribution by two clinical pharmacists for wording, clarity, and content. The survey was approved as exempt by the Southern Illinois University Edwardsville Institutional Review Board. Data collected from the survey was evaluated using descriptive statistics to summarize responses, with percentages calculated for categorical variables.

Results: A total of 58 respondents initiated the survey, while 47 respondents completed the survey. The majority, 70.7%, of respondents were pharmacists. More than half of the respondents, (62.1%), listed pain management as their primary discipline. For respondents that provided care for patients on concurrent opioids and benzodiazepines, only 15.4% stated they never attempt to taper therapy, while 57.7% attempt to taper therapy either half the time, most of the time, or always. Approximately 35% of respondents listed hospice as a reason they would not attempt to taper therapy. Other listed reasons for not attempting to taper included: previous taper failure, benefits outweigh risks, patient refusal, or patient stable on low doses. When attempting to taper therapy, 84% listed shared decision making/patient preference as the best reflection of their taper strategy. The respondents' goal of taper varied, with 48% citing overall dose reduction and 34% citing complete cessation of either the opioid or benzodiazepine. The majority of respondents utilize a slower taper (over months) in the outpatient setting for both opioid and benzodiazepine tapers (56.9% and 70.8% respectively). In prescribing medications to mitigate withdrawal symptoms, 34% answered definitely yes to opioid tapers, while 39.6% answered maybe to benzodiazepine tapers.

Conclusion: There are several clinical practice commonalities in opioid and benzodiazepine taper strategies. When attempting to taper therapy, respondents overwhelmingly listed shared decision making/patient preference as the best reflection of their taper strategy. Therefore, patient buy-in is key to success when it comes to tapering concomitant opioids and benzodiazepines. Slower tapers that occur over months are preferred for both opioids and benzodiazepines. The next step is to expand this survey to capture more clinicians' responses, with the results potentially evolving into clinical practice guidelines that will assist clinicians in their approach to concomitant opioid and benzodiazepine tapers.