MINNESOTA

# Tapering and discontinuing opioid use

The goal of opioid tapering is to improve the risk benefit profile for patients on chronic opioid analgesic therapy. Changes in co-occurring conditions, diagnoses, medications, functional status and the duration of opioid therapy affect the risk benefit analysis.

Patient readiness is also a factor in the risk benefit analysis. Pay careful attention to the patient's fears about tapering their opioid dose, and encourage patients to identify ways in which the clinic can provide support. When the risk benefit analysis indicates that a taper will improve the patient's safety profile, open communication throughout the process is important for success. Forced tapers are not recommended, and are not supported by evidence. For a taper to be successful, the provider and patient should approach the process as a long-term project to be worked on together.

## Clinical Recommendations

1. Discuss tapering and discontinuing use in advance of initiating chronic opioid analgesic therapy and with each dose increase. Providers and patients should identify situations in which a taper is indicated and document those situations in the treatment plan or agreement.
2. Routinely discuss tapering or discontinuing chronic opioid analgesic therapy with patients, regardless of their risk of harm. Tapering should be addressed at least every three months.
3. Taper opioid therapy to a reduced dose or taper to discontinuation when the risks of continued opioid therapy outweigh benefits. Tapering high-risk patients to less than 50 MME/day is a reasonable initial goal. The taper protocol must be individualized to the patient's circumstances and address all of the biopsychosocial factors that may impact the taper process.
4. Offer non-opioid and non-pharmacological therapies to treat any pain that may re-emerge during the opioid taper and to treat any withdrawal symptoms that occur during the taper. Patients will likely benefit from cognitive behavioral therapy during the taper process.

## Discussion

Tapering chronic opioid analgesic therapy to a reduced dosage or to discontinuation is challenging for both the clinician and the patient. Preparing a patient for a taper is challenging and takes considerable time. For this reason it is recommended to routinely discuss tapering with patients at every face-to-face visit, including when chronic opioid analgesic therapy is initiated. Clearly communicate about the following issues before initiating a taper and throughout the taper process, while monitoring for signs of Opioid Use Disorder:

- Reasons for tapering opioids
- Taper process
- Pain management during the taper
- Management of withdrawal symptoms

It is the consensus of the Opioid Prescribing Work Group that opioid tapering should be offered and discussed at every face-to-face visit or at least every three months. Discussing tapering early and often may assist with setting the expectation that chronic opioid analgesic therapy should not be continued indefinitely.

## Indications for non-rapid taper or discontinuation

- Patient expresses desire to reduce opioid dosage or discontinue opioid therapy
- Resolution or healing of a painful condition
- Decreasing analgesic effect for pain condition
- The condition being treated is contraindicated for opioid therapy, e.g., migraine or fibromyalgia
- Prescribed dose is higher than the maximum recommended dose of 50 MME/day
- Patient is nonadherent to the treatment plan or noncompliant with the patient-provider agreement
- Treatment goals are not being met
- Adverse effects of opioid therapy are not tolerated or are unmanageable.

Patients receiving a low, daily dose of opioids, e.g., <30 MME/day, are less likely to experience severe withdrawal symptoms during a rapid taper. However, some patients may benefit from the structure and support provided by a taper regimen. Develop a brief taper plan with patients on low daily MME doses who exhibit distress about discontinuing opioid therapy.

## Indications for rapid taper or discontinuation

A rapid taper or an abrupt discontinuation of opioids is generally not recommended, however it may be appropriate in the following circumstances:

- Patient has a severe adverse reaction or an allergic reaction to opioid formulations
- Patient has already discontinued opioids and gone through withdrawal
- Confirmed diversion of prescription opioids
- Patient preference
- Patient with a history of nonfatal opioid overdose

A 2015 cohort study of nonfatal opioid overdoses found that 91 percent of patients are maintained on opioids after surviving an overdose. Continuing opioids after surviving an opioid overdose confers risk of repeated overdose and death (*LaRochelle, 2016*). If it is not possible or inappropriate to abruptly discontinue opioids following a nonfatal overdose, clinicians should significantly increase visit frequency, monitoring and harm-reduction strategies.

**Immediately assess patients who experience a nonfatal overdose or for whom diversion is confirmed for a substance use disorder and provide follow-up care as appropriate.**

Circumstances in which a taper may not be appropriate and ongoing therapy is determined to be the safer treatment option:

- Patients with Opioid Use Disorder or other substance use disorders. See referral.
- Patients in an active mental health crisis.
- Patients with cognitive impairments who are on very low daily doses, e.g., patient receives 30 MME/day in a controlled environment.

## Assessment

Complete a biopsychosocial assessment (/dhs/opip/opioid-guidelines/factors-in-treatment/biopsychosocial-assessment.jsp) of the patient before initiating an opioid taper, including evaluation of medical, psychiatric and any substance use conditions. Discuss current living arrangements and social support networks with the patient in order to assess the stability of the patient's environment during the taper. Clinicians should pay careful attention to the factors that may predict difficulties tapering, including depressive symptoms, anxiety related to the taper, high pain scores, past failed tapers and high opioid doses. Patients with depressive symptoms at initiation of an opioid taper are more likely to drop out of the taper and return to opioid use *(Berna, 2015)*.

Maximize mental health conditions before initiating a taper. Patients with depression or elevated anxiety should be receiving treatment for those conditions before initiating the taper. It is expected that all patients on chronic opioid analgesic therapy have a multidisciplinary treatment plan, appropriate to their risk level and access to services. If a patient does not have a multidisciplinary treatment plan, the treating clinicians should refer the patient to the appropriate level of psychiatric care.

Reassess the patient's medical and psychological conditions — as well as support network and living conditions — throughout the taper. Frequency of assessment and evaluation should be determined by the patient's risk level. In general, follow up with the patient within one week to one month after any opioid dosage change.

## Taper process and treatment

The optimal timing and approach to tapering depends on a number of patient factors, including: opioid dose; duration of therapy; type of opioid formulation; concomitant medication use; and the patient's medical, psychiatric and social conditions. In addition, the patient's risk of harm for continued opioid use is a key factor in determining the taper strategy.

When the risk of harm is not imminent, the taper should be slow enough to minimize symptoms and signs of opioid withdrawal. A decrease of 10 percent of the original dose per week is a reasonable starting point when developing the taper strategy *(CDC, 2016a)*. Patients in need of a more rapid taper may tolerate dose reductions up to 20 percent per week. Patients in need of a more gradual taper over months — or even years — may reduce doses by 5-20 percent every four weeks *(Berna, 2015; CDC, 2016a)*.

Educate patients about expected withdrawal symptoms and pain outcomes before initiating the taper and throughout the process. Consider assessing the patient's withdrawal symptoms with a brief, validated screening such as the patient self-rated Subjective Opiate Withdrawal Scale or the practitioner assessment Clinical Opiate Withdrawal Scale (Handelsman, 1987; Wesson, 2003). Optimize non-opioid and non-pharmacologic treatment modalities for pain and withdrawal symptoms during the taper process.

Clinicians should consider the following when developing a taper strategy with a patient:

- Patients may tolerate larger dose reductions in the beginning of the taper and then require smaller dose reductions as daily MME is decreased.
- Providing patients with the option to pause the taper may reduce the risk of a failed taper.
- Tapers should be considered to be successful as long as the patient is making progress at reducing opioid dosage.
- Consider tapering daily dose to less than 50 MME for patients who do not concomitantly use benzodiazepines or other sedative-hypnotics. This may be considered a successful taper, because it has reduced the daily dose to a level where known harms from the medication are reduced. Patients may be able to reduce dosage more easily than discontinue opioids, as an initial step.

A multidisciplinary approach to the taper process may be required, based on the patient's needs. Consider involving the following providers in the taper plan and process:

- Primary care providers
- Mental health providers
- Pharmacists
- Physical therapy
- Addiction specialists

Trust and open communication between the clinician and provider are key to a successful taper process.

Additional resources:

- Oregon tapering guidance (https://www.oregonpainguidance.org/guideline/tapering/)

- Veterans Administration Opioid Decision Taper Tool (https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/52_Pain_Opioid_Taper_Tool_IB_10_939

## Concomitant chronic opioid analgesic therapy and benzodiazepines

Consider sequential tapers for patients concomitantly on chronic opioid analgesic therapy and sedative hypnotics. There is a paucity of evidence related to which medication should be tapered first, therefore the approach should be individualized. The 2016 CDC Chronic Pain Prescribing Guidelines suggest tapering the opioid first, given the greater risks of benzodiazepine withdrawal relative to opioid withdrawal and the possibility of increased anxiety related to the opioid taper *(CDC, 2016a).* However, concurrent use of benzodiazepines and opioids multiplies the risk of opioid-related harm. Given that benzodiazepines are risk multipliers, tapering the benzodiazepines first may be appropriate. Patients receiving high daily MME and intermittent benzodiazepines may be able to successfully taper benzodiazepines first. For patients who receive therapies from two different clinicians, care must be coordinated between the prescribers.

## Referral

During the course of an opioid taper, symptoms of an Opioid Use Disorder or other mental health conditions requiring treatment may be revealed or exacerbated. Clinicians must remain vigilant for signs and symptoms of Opioid Use Disorder during the taper process. If there is concern about Opioid Use Disorder or another substance use disorder, treat the patient for Opioid Use Disorder using an evidence-based treatment approach or refer the patient to an evidence-based treatment provider. Patients on chronic opioid analgesic therapy with untreated Opioid Use Disorder who are tapered off opioids are at risk for harm unless referred to treatment *(Compton, 2016; Nagar, 2015)*. Refer patients with exacerbated or emerging mental health conditions to the appropriate mental health care provider. All patients undergoing a taper are likely to benefit from enhanced mental health care and support.

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