Part V. Tapering Opioid Analgesic Therapy

Introduction

A taper is a reduction in daily opioid dosage done in order to improve a patient’s safety profile. A successful taper can result in either a lower daily dose, or discontinuation of opioid therapy, depending on the patient’s goals and risk profile.

Concern about the safety and efficacy of opioid therapy for chronic pain has led to increased numbers of patients being considered for dose reductions. A limited body of evidence indicates that voluntary tapers among patients with chronic pain can result in improved function, sleep, anxiety and mood, without worsening pain (Frank, 2017; AHRQ, 2020). At the same time, changes in chronic opioid analgesic therapy (COAT) regimens have the potential to harm patients if not done carefully in a collaborative, thoughtful and measured manner. The risks of abrupt discontinuation or failed tapers in physically dependent people include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, thoughts of suicide, hospitalizations and termination of care (FDA, 2019). For many patients, the idea of tapering elicits anxiety and fear about uncontrolled pain, loss of control and withdrawal.

The first step in determining whether a taper is appropriate is a thorough risk benefit analysis of continuing opioid therapy at the current dose with the patient. Patient readiness is 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. Changes in co-occurring conditions, diagnoses, medications, functional status and duration of opioid therapy affect the risk benefit analysis. When the risk benefit analysis indicates a taper will improve the patient’s safety profile, open communication throughout the process is important for success. Forced tapers are not recommended, and should only be undertaken when the patient is at immediate risk from the opioids and after careful education of the patient about those risks.

Characteristics of a successful taper:

- Going slowly
- Shared decision making is employed; a strong therapeutic alliance is prioritized
- Mental health is stabilized prior to and during the taper
- Risk analysis focuses on the patient’s individual, medical risks
- Dose reductions are informed by reassessment of pain and function, not a specific target dose
- Non-opioid pain management is offered throughout taper
- Patient has increased access to clinical providers, including more frequent visits during dose reductions
- Patient education is ongoing and tailored to the patient’s progress in the taper
- Provider screens for emergence of opioid use disorder (OUD) during dose reductions
Clinical Recommendations

• Reduce opioid dosage only when it improves the patient’s risk benefit ratio, ideally employing shared decision making with the patient. Providers should not taper a patient for their own convenience or solely to comply with system or state policy.

• **Chronic opioid analgesic therapy should not be abruptly discontinued** unless there is proven opioid diversion. Abrupt discontinuation can cause acute opioid withdrawal and poses a significant risk to the patient. Clinical situations that may warrant a dramatic (~50%) dose reduction include: acute encephalopathy, acute respiratory failure, or a sudden change of medication clearance resulting in build-up of medication. Patients at imminent risk of overdose due to a diagnosed opioid use disorder (OUD) should receive an urgent referral to addiction medicine. These referrals should be “warm hand-offs” including clinician to clinician communication about the case and rapid connection of the patient to the addiction medicine provider.

• **Routinely discuss the benefits and risks of continuing the current dose of opioid therapy with all COAT patients.** These should be routine discussions conducted in a supportive tone. **Refer to patient goals established when COAT was initiated or established with a new patient.** Discuss whether goals are being met, the patient’s current functionality on opioid therapy, and any opioid-related adverse reactions. When discussing opioid-related risks with the patient, focus on the patient’s medical risks related to opioid therapy, rather than societal risks associated with the opioid public health crisis.

  Document the patient’s risk-benefit profile based on routine discussion of the patient’s ability to meet treatment goals and experience of any opioid-related adverse events.

• **Use motivational interviewing techniques to discuss reducing dosage** when the benefit of continuing opioid therapy at the current dose no longer outweighs the risk. Using motivational interviewing techniques may help the patient identify a willingness to change their opioid treatment regimen. Patient voluntariness and understanding should be the goal for each patient (but not an absolute requirement) prior to initiating a taper.

• Evaluate patients for opioid use disorder and depression or suicidal thoughts prior to initiating a taper, and throughout the tapering process. Treat or refer patients to treatment for substance use disorders or any active mental health crisis at the beginning of the taper and any time throughout the taper process.

• **Use shared decision making to the extent possible to establish a taper plan individualized to the patient’s circumstances.** A plan that focuses on making incremental changes informed by reassessment of pain, function and safety is more likely to be successful than a plan with a predetermined timeline and specific target dose.
• Consider consulting with a pharmacist to understand available medication formulations to optimize increments of dosage change. Changing the formulation of a given opioid (e.g., long-acting to short-acting formulations or strengths of the same formulation) may facilitate the dose reduction process, but also confuse the patient. Do not change or “rotate” types of opioids prior to the taper unless you have expertise doing so, e.g., oxycodone to methadone, or hydromorphone to tramadol. Provide clear communication to the patient on any changes in the medication formulation.

• Increase the frequency of clinic visits or remote visits during dose reductions. Invite the patient to contact the clinic if problems arise during dose reductions.

• Offer non-opioid and non-pharmacological therapies to treat pain that may re-emerge during the taper and to treat any distressing withdrawal symptoms that occur during the taper. Withdrawal symptoms may indicate the need to slow a taper. Patients will likely benefit from Cognitive Behavioral Therapy (CBT) during the taper process.

• Educate patient on the increased risks of overdose when tapering, supply a naloxone prescription, and encourage the patient to ask family and friends to become educated about rescue use. A patient’s friends and family can learn how to use naloxone in a clinic setting, at a pharmacy or through online education.

Discussion

Identifying taper candidates

There are three reasons to taper chronic opioid analgesic therapy:

1) the patient requests a dose reduction or discontinuation of use and a taper is safe;
2) the patient’s medical risks of ongoing opioid therapy at the current dose outweigh the benefit of continued use; and
3) there is a lack of demonstrated benefit of ongoing therapy at the current dose (i.e., patient continues to report high pain scores despite opioid use and there is lack of demonstrated functional gain) and the taper is safe.

A thorough risk-benefit analysis of the patient’s current comorbidities and ability to meet stated treatment goals is necessary to identify whether a patient is a good candidate for a taper. Clear documentation of the patient’s risk profile and subsequent taper plan, when appropriate, may increase the likelihood of a successful taper (Buonora, 2020).

Risk-benefit analysis

Assessment of the patient’s benefit from opioid therapy should focus on his or her ability to meet treatment goals. This includes reassessing goals that are not being met in order to determine if different goals are needed. If a patient does not have clearly identified goals in a treatment plan, then the
provider and patient should establish goals at the next clinic visit. Providers should document whether the patient is able to meet treatment goals over time as part of responsible COAT management.

The **risks associated with COAT** are well documented and range from mild to severe. Opioids increase the risks of constipation, falls, delirium, pneumonia, loss of social function, and opioid use disorder, and complicate the treatment of sleep apnea and chronic obstructive pulmonary disorder (COPD). A limited body of research suggests that patients may be more receptive to discussing risks related to their personal health, rather than population health risks related to the opioid crisis (*Matthias, 2017*). Providers should objectively assess and document risk factors in the patient medical record, while recognizing that risk tolerance will differ by patient.

Providers do not need to use a formal screening tool each time the patient’s risk-benefit ratio is analyzed. The Institute for Clinical Systems Improvement Acute Pain Assessment and Opioid Prescribing Protocol work group developed the ABCDPQRS mnemonic for screening risks and potential contraindications to opioid use (*ICSI, 2019*). Please see Appendix A of the Institute for Clinical Systems Improvement Pain Health Care Guideline (2017) for more detailed information (p. 59).

### The ICSI ABCDPQRS mnemonic is one useful tool that addresses potential risks to opioid use:

- **A** – Alcohol use
- **B** – Benzodiazepines and other drug use
- **C** – Clearance and metabolism of drug
- **D** – Delirium, dementia and falls risk
- **P** – Psychiatric comorbidities
- **Q** – Query the Prescription Drug Monitoring Program
- **R** – Respiratory insufficiency and sleep apnea
- **S** – Safe driving, work, storage and disposal

### Red flags indicating the risk of opioid therapy outweighs the benefit:

- Decreasing analgesic effect for pain conditions;
- Falls at home;
- Recent pneumonia, worsening COPD status, worsening obstructive sleep apnea (OSA);
- Observed or reported somnolence or oversedation;
- Change in renal or liver function;
- Interest in becoming pregnant;
- Episodes of bowel obstruction or constipation;
- Additional new medications (anticholinergics, benzodiazepines) causing interactions with opioids, such as sedation or delirium, in the patient;
- Accidental, non-fatal overdose;
- Diagnosis of opioid use disorder;
- Suicidal intent or action;
- Urine toxicology indicative of other substance use not prescribed to the patient;
- Ongoing use despite resolution or healing of a painful condition;
- The condition being treated is contraindicated for opioid therapy, e.g. migraine or fibromyalgia; or
- Adverse effects of opioid therapy are not tolerated or are unmanageable
Situations when the patient is not currently a good candidate for a taper

Not all patients on COAT are good candidates for an opioid taper. Circumstances in which a taper may not be appropriate in the near term include:

- Patients in an active mental health crisis, without suicidal intent or indications for psychiatric hospitalization;
- Recently inherited patients on legacy opioids;¹
- Patients with cognitive impairments who are on very low daily doses, e.g., patient receives 30 MME/day or less in a controlled environment.

If a patient is not presently a good candidate for a taper, providers should continue to monitor the patient’s risk profile. Avoid insisting on opioid tapering or discontinuation when opioid use may be warranted (e.g., treatment of cancer pain, patients with a terminal illness, pain at the end of life, or other circumstances in which benefits outweigh risks of opioid therapy) (HHS, 2019a).

Situations that may warrant abrupt discontinuation or rapid tapering to a lower dose of opioid therapy

- Proven opioid diversion;
- Acute encephalopathy;
- Acute respiratory failure;
- Sudden change of medication clearance resulting in build-up of medication; and
- Overdose, respiratory suppression, or oversedation on current opioid regimen, posing an ongoing risk if the medications are continued.

Use caution prescribing to and discontinuing opioids for individuals with opioid use disorder (OUD).

OUD is not in itself a contraindication to pain treatment with opioids, but OUD complicates opioid analgesia and greatly increases the risks of adverse outcomes. Patients may overdose from the prescribed opioids or may overdose after an abrupt discontinuation of opioids. Patients in pain with OUD require prompt access to an addiction trained provider, certified to treat addiction with buprenorphine or methadone. Providers are encouraged to attain this training or certification.

Patient Engagement: Plan

Active patient engagement is a key element in successful taper programs. Successful taper programs actively engage the patient from the outset by discussing the patient’s risk profile, developing motivation to change, setting goals, developing priorities, and monitoring the taper progress. Depending on the patient’s readiness for change, providers may spend a significant amount of time developing the patient’s motivation to change, addressing barriers to tapering, or planning the taper.

¹ Reassess patient’s risk benefit profile once care has been established.
Consider the timing of taper discussions in relation to other events in the patient’s life, and the primary purpose of the clinic visit. It may be counter-productive to introduce tapering when a patient is in the clinic for a refill.

Qualitative analyses of patients undergoing tapers provides valuable insights for providers considering recommending a taper. Henry et al identified the following elements to consider when engaging patients in a taper (Henry, 2019):

- Many COAT patients have prior experience with tapering, which may not have been positive. Providers should ask about prior taper efforts, and clarify any confusion about what tapers entail. Patients may equate an opioid taper with a detoxification period or immediate cessation of therapy.
- Patients’ social relationships, emotional state and health status can either facilitate or impede tapering. Due to the dynamic nature of these factors, patients’ pain and perceived need for opioids fluctuate daily. This may be at odds with a regimented taper plan.
- Tapering requires substantial effort, or work, across multiple domains of patients’ everyday lives. For example, patients may have to time when they take their medication based on daily activities, or limit contact with individuals who do not support their taper. Providers should be aware that patients do not often talk about this.

**Motivational Interviewing**

Tapering opioid therapy often elicits significant fear and anxiety for patients as they consider ongoing pain management, ability to function and potential disruptions to their daily life. For patients who are reluctant to taper, the first step may be to initiate a discussion about their understanding and perceived risks and benefits of continued use. Motivational interviewing strategies may be employed to discuss ongoing opioid therapy in a collaborative manner.

Motivational interviewing (MI) is a patient-centered approach shown to elicit behavior change. It is especially effective in working with people who are not yet thinking about making a change or are ambivalent to the change. It elicits and respects patient’s values, wisdom and motivation to change, rather than attempting to convince them to follow a particular prescribed course of action. MI helps address resistance, establish functional goals and achieve behavior change within the constraints of an active clinical practice.

Motivational interviewing is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice in working with people with various health, mental health conditions and substance use disorders.

Motivational Interviewing Framework (CDC, 2016)
• **Ask open ended questions.** This increases the patient’s involvement in the discussion and allows more meaningful discussion.
  o What is your long term goal for your opioid therapy?
  o What is your plan to get to that long term goal?
  o Can you imagine life without opioids? What would that life be like?
  o Do you know how your opioid medications affect your well-being?
  o Do you know what benefits may occur if you reduce your opioid dose?
  o What do you know about tapering opioid medications?

• **Reflect.** Reflective listening helps the patient feel understood and can range from sampling rephrasing the patient’s statements to a summary of the patient’s wants and needs. This can help engage the patient and help him/her arrive at an idea for change.
  o It sounds like you miss being able to play with your grandchildren.
  o I get the sense that you are concerned about the cost of treatment.
  o I understand that you are worried about how bad your pain would be without opioids.

• **Empathy.** Expressing empathy helps the patient develop a sense of trust and feel understood. By “normalizing” and expressing that struggling with chronic pain management is common, patients may feel they aren’t alone in their experience.
  o Many people with chronic pain report feeling like you do. They want to start being more active but find it difficult.
  o A lot of people are concerned about managing their pain if the amount of opioids is decreased.

• **Evoke change talk.** Rather than telling the patient why they should change, ask questions to evoke reasons from patients themselves. Recognize and affirm “change talk” when you hear it, such as “I will” or “I intend to…”
  o What would you like to see different about your life right now?
  o What do you hope will be different if you try the therapy we talked about?

• **Develop discrepancies.** You can help your patient see the difference between their current behavior and goals.
  o You’ve told me that exercise helps you have more energy and reduces stiffness. Why do you think it’s been hard for you to get more active?
  o I know you’d like to get back to work, and therapy can be very beneficial. What will help you schedule sessions more regularly?

• **Roll with resistance and provide personalized feedback.** When patients express resistance and reasons for not achieving goals, help them find ways to succeed.
  o I know it can be hard to find the time to exercise. Do you think you could take the stairs when you go into work each day?
  o It sounds like feeling exhausted at the end of the day is getting in the way of your goal to spend more time with your friends. Could you make plans to meet in the morning for coffee instead?
• **Support self-efficacy.** Boost confidence that change is possible. Identify the patient’s past successes to help motivate future change.
  - I’ve noticed your determination in other aspects of your life, and I’m confident that you have the willpower to stick to this plan. Let’s talk about your goals again at our next follow-up appointment.
  - I am happy to see that your ability to walk is improving, and I can see you’re committed to your treatment plan. How do you feel about your progress?

• **Set specific, short-term goals and provide affirmation.** Take joy in patient successes and show your joy. Recognize patient strengths, efforts and successful behavior change. Affirmative statements provide encouragement and helps the patient feel supported.
  - I am glad to see your endurance is improving with physical therapy. Keep it up!
  - It’s great to hear you went on a walk with your husband last week. The more regularly you walk, the stronger your knees will get.

**Evaluating comorbidities and barriers to a successful taper**

Medical and psychiatric comorbidities

Medical factors that may predict difficulties with tapering include: depressive symptoms; anxiety related to the taper; high pain scores; past failed taper; and high opioid dose. 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). Therefore, it is important to improve mental health to the extent possible or ensure adequate treatment of underlying mental health conditions prior to initiating a taper. Patients with depression or anxiety should be receiving treatment for those conditions prior to initiating a taper.

All patients on COAT should have a multi-disciplinary treatment plan, appropriate to their risk level and access to services. If a patient does not have a multi-disciplinary treatment plan, the treating clinicians should refer the patient to the appropriate level of psychiatric or psychological care.

Social and emotional factors

Tapering requires substantial effort across multiple aspects of a patient’s everyday life; however, patients discuss this superficially, if at all, with clinicians. Henry at al., found that two of the most...
common dynamics impacting tapering were: 1) the patient’s ability to fulfill their roles; and 2) responsibilities related to work and family (Henry, 2019). Discuss living arrangements, daily responsibilities, and social support networks with the patient. Providers should recognize that social and emotional factors are dynamic, and may influence the patient’s pain and perceived need for pain relief on a daily basis. Providers can support patient’s efforts to taper by acknowledging the patient’s roles and responsibilities, and incorporating strategies to fulfill those roles within the taper plan.

Developing a taper plan

*Shared decision making*

Shared decision making about the taper plan should be done to the extent possible. Shared decision making is a process in which clinicians and patients work together to make decisions and select treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values (HealthIT.gov, 2013). Taper plans must be individualized, and patients will have different preferences and goals.

The Agency for Healthcare Research and Quality’s SHARE model identifies the five essential steps of shared decision making (The SHARE Approach, 2018).

**Step 1: Seek your patient’s participation.** Inviting patients to participate lets them know that they have options and that their goals and concerns are part of the decision making process.

**Step 2: Help your patient explore and compare treatment options.** Patients need to know the available options. Provide balanced information based on the best available scientific evidence. Check back with patients to be sure they understand.

**Step 3: Assess your patient’s values and preferences.** Assist patients in evaluating options based on their goals and concerns.

**Step 4: Reach a decision with your patient.** Ask the patient if he or she is ready to make a decision, or needs additional information or tools. Patients may also need time to consider the options or discuss them with family members, friends or caregivers.

**Step 5: Evaluate your patient’s decision.** Make plans to review the decision in the future, and monitor the extent to which the decision is being implemented. If barriers exist, assist the patient with navigating those issues.

Patient education is an important element of the shared decision making process.

- Continue to revisit the goals and process of an opioid taper. Clinicians should provide continued reassurance that they will support the patient through the taper process.
• Educate patients about different approaches to the taper. Discuss different approaches to reducing dosage and the timing of the taper. Providing options around timing and dosage may reduce fear and anxiety by giving the patient control over elements of the process.
• Educate patients about expected withdrawal symptoms and pain outcomes prior to initiating the taper and throughout the process.
• Tell patients that their physical pain may get worse each time the dose is decreased, but that with time the body will adjust to the new lower dose (4 weeks), the pain level will return to baseline. The increased pain patients experience after dosage decrease does not indicate progression of their underlying pain condition. Rather, the pain represents time-limited, opioid withdrawal-mediated pain (Lembke, 2020).
• Discuss the differences between opioid dependence and addiction. Discuss the fact that tapers sometimes reveal an OUD. If an OUD is detected, it is nothing shameful, rather an indication that another type of treatment is needed. Reassure the patient that the OUD will be treated in addition to treating pain, and that you will support them through the process.

Reduce the risk of an overdose during a taper:

• Provide opioid overdose education, and prescribe naloxone to patients when initiating a taper.

• Strongly caution patients that it takes as little as a week to lose their tolerance and that they are at risk of an overdose if they resume their original dose.

• Educate the patient that pharmaceuticals obtained from friends or acquaintances are frequently adulterated with highly potent and lethal doses of fentanyl even if these pills look exactly like the medication they normally took. “Counterfeit” pharmaceuticals have led to many deaths during dosage reductions.

Taper speed

One of the biggest mistakes made with tapering opioid therapy is going too fast. A retrospective analysis of Vermont Medicaid data between 2013 and 2017 found that among long-term opioid recipients undergoing a taper, the median length of time to discontinuation was 1 day. Almost half of patient undergoing a taper had an opioid-related hospitalization or emergency room visit after the stopped treatment (Mark 2019).

Given the dynamic nature of chronic pain, more flexible taper plans focused on sustained, gradual reductions, rather than a predetermined reduction rate, are often more successful. The taper approach should incorporate patient preferences, and be individualized based on the patient’s goals and concerns. Providers should consider the following when developing a taper plan:

• A successful initial decrease is important. The success of the initial dose reduction is more important than achieving a specific dose decrease.
• The interval between dose administration and the dose of each administration are two different variables in a taper. One or both may be adjusted at each dose decrease, depending on patient preference and the opioid dosing availability.

• **Go slowly.** Patients may tolerate larger dose reductions in the beginning of the taper and then require smaller dose reductions as daily MME is decreased.
  - A **slower taper** is a 5-10% dose reduction per month. This rate serves as a starting point, but patients may require a dose reduction rate of less than 5% a month of a 5-10% dose reduction over the course of 2-3 months. Slower tapers are often better tolerated than more rapid tapers, especially following opioid use of more than a year. Slower tapers may take several months to years to complete.
  - A **faster taper** involves a decrease of 10% of the original dose per week or longer. Faster tapers are not preferred, but may be needed for patient safety when the risks of continuing opioid therapy outweigh the risks of a rapid taper or when patients have been on COAT for a short period of time.
  - Sudden large dosage decreases may be necessary if the patient becomes encephalopathic, has a change in renal or pulmonary status or has a new medication that interacts with opioids. When continuing the current opioid dose poses an imminent medical risk, but discontinuation of the opioid is not appropriate (such as a patient with cancer or sickle cell disease who develops renal failure) a dose decrease of 30-50% followed by close monitoring may be appropriate.

• Maintain the same dosing schedule when possible, especially at the beginning the taper. Patients may be accustomed to taking pain medication at a certain time each day, or before certain activities. Discuss whether the proposed schedule aligns with the patient’s daily roles and responsibilities.

• Provide patients with the option to pause the taper and restart again when ready. Pauses give patient time to acquire new skills for management of pain and emotional distress, introduction of other medications, or initiation of other treatments, while allowing for physical adjustment to a new dosage (VA, 2019; VA 2017). This may reduce the risk of a failed taper.

• Tapers should be considered successful as long as the patient is making gentle progress at reducing opioid dosage.

• Providers should be aware that patients will develop strategies for navigating the taper. Some strategies may present a safety risk, such as maintaining an opioid “stash” for emergencies, obtaining opioids for other sources, or using other substances to manage pain (Henry, 2019).

• Consider prescribing smaller day supply (i.e., 2 weeks instead of 4 weeks) to avoid patients overusing medications and running out early.

Providers should document the taper plan in the medical record and in patient materials, including prescription instructions. As the taper progresses or if conditions change, providers should update patient records with any changes to the plan. A case-control study in a large urban primary care setting found that taper plans documented in health records and prescription instructions were associated with an increased likelihood of sustained opioid taper (Sullivan, 2020).

*Concomitant COAT and benzodiazepines*
Consider sequential tapers for patients concomitantly on COAT 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, 2016). However, concurrent use of benzodiazepines and opioids multiplies the risk of opioid-related harm. Given that benzodiazepines are risk multipliers, tapering the benzodiazepine first may be appropriate. Patients receiving high daily MME and intermittent benzodiazepines may be able to successfully taper the benzodiazepine first. For patients who receive therapies from two different clinicians, care must be coordinated between the prescribers.

Supporting the patient during a taper

Reassess the patient’s medical and psychological conditions—as well as support network and living condition—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.

Provide behavioral health support

- All patients undergoing a taper are likely to benefit from enhanced mental health care and support. Ask how you can support the patient during the taper.
- Directly address patient fears about tapering prior to initiation and throughout the opioid taper. Fear is a common emotion among patients considering a taper, and can be a significant barrier. Many patients fear the possibility of worse pain, withdrawal and loss of function (Henry, 2019). Providers should be aware that fears of addiction and overdose may be less common.
- Tell patients “I know you can do this” or “I’ll stick by you through this.” Make yourself or a team member available to the patient to provide support, if needed (VA Opioid Decision Taper Tool, 2019).
- Follow up frequently. Successful tapering studies have used at least weekly follow up (Frank, 2017).
- Monitor patient for signs of anxiety, depression, suicidal ideation, and opioid use disorder throughout the taper. Collaborate with mental health providers and with other specialists as needed to optimize psychosocial support for anxiety related to the taper (Dowell, 2016).
- If available, refer patients with exacerbated or emerging mental health conditions to the appropriate mental health care provider, while continuing to provide pain management and support during the taper.

Provide ongoing pain management support
Ongoing pain management of the underlying conditions is an important part of the taper plan. Optimize non-opioid and non-pharmacologic treatment modalities for pain during the taper process. This includes:

- Pain education
- Good sleep hygiene
- Physical activities, as tolerated
- Good nutrition
- Non-opioid pain medications
- Psychological support. Most patients will benefit from CBT during the opioid taper.

**Address symptoms of opioid withdrawal**

- If tapering is done gradually, withdrawal symptoms should be minimized and manageable.
- Expectation management is an important aspect of counseling patients through withdrawal.
- 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).
- Significant opioid withdrawal symptoms may indicate a need to pause or slow the taper rate.
- Onset of withdrawal symptoms depends on the duration of action of the opioid medication used by the patient. Symptoms can begin as early as a few hours after the last medication dose or as long as a few days, depending on the duration of action (Berna, 2015).
- Early withdrawal symptoms (e.g., anxiety, restlessness, sweating, yawning, muscle aches, diarrhea and cramping) usually resolve after 5-10 days but can take longer (VA Opioid Decision Taper Tool, 2019).
- Some symptoms (e.g., dysphoria, insomnia, irritability) can take weeks to months to resolve (VA Opioid Decision Taper Tool, 2019).
- Consider using non-addictive medications to help mitigate withdrawal symptoms. If the taper is slow enough, withdrawal symptoms should be minimal and tolerated.
  - Short-term oral medications can help manage withdrawal symptoms, especially when prescribing faster tapers (VA Opioid Decision Taper Tool, 2019). These include alpha-2 agonists for the management of autonomic signs and symptoms (sweating, tachycardia), and symptomatic medications for muscle aches, insomnia, nausea, abdominal cramping, or diarrhea

**Screening and treatment of opioid use disorders**

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 OUD during the taper process. If there is concern about OUD, treat the patient for OUD using an evidence-based treatment approach or refer the patient to a provider who offers medication for opioid use disorder, such as methadone or buprenorphine. Patients on COAT with untreated OUD who are tapered off opioids are at risk for harm unless referred to treatment. 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.

References


FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering. Available at https://www.fda.gov/Drugs/DrugSafety/ucm635038.htm (accessed April 13, 2019)


