

Opioid Taper/Discontinuation (The BRAVO Protocol)

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Helping patients to decrease or discontinue long term opioid therapy (30 days or greater) can present a challenging clinical scenario, especially in patients on high doses (greater than 90 MEDs), with moderate to severe chronic pain, and co-occurring mental health disorders (depression, anxiety, PTSD).¹ For this type of complex chronic pain patient, the usual recommendation to decrease opioids by 10% of the starting dose every week,² may not apply. These patients often need slower tapers, on the order of 5-10% decreases or less every *month*.³ Expert consensus suggests the taper speed should be tailored to the individual needs of the patient. Some patients who have been on opioids for years to decades, may require years to taper their dose.

With this complex chronic pain patient in mind, the BRAVO protocol outlines a safe and compassionate strategy to approach opioid tapering, while also maintaining a therapeutic alliance.

BRAVO

B = Broaching the Subject

In this initial conversation, even suggesting an opioid taper can trigger extreme anxiety in some patients, to the point where patients may temporarily lose their ability to attend to the conversation. To mitigate the anxiety, the primary care provider can try identifying this feeling for patients, normalizing it, and expressing empathy.

For example, the provider might say: “Hi Mrs. Smith, I scheduled some extra time for us today because I want to discuss a very important topic with you. I’ve been thinking a lot about your chronic pain and how to help you with that and would like to suggest that we taper you down and maybe even off your opioid medication. Now, I know the very thought of an opioid taper is terrifying for you, and you’re not alone in that ... it’s totally normal to feel afraid about going down on your dose, especially after you’ve been taking opioids for so long. But, please hear me out, and let me tell you the reasons why I think it’s a good plan for you.”

Note here how the provider tells the patient “I’ve been thinking a lot about your chronic pain..” This is an important and multilayered communication. With this phraseology, the provider is communicating to the patient that the opioid taper was carefully considered and not an impulse or some form of retaliation. The provider communicates to the patient that he or she is in the provider’s mind even when the patient is not immediately in front of them; the patient exists for the provider outside of the clinic environment.

As the famous psychoanalyst, Donald Winnicott says, the provider, like the “good enough mother,” creates a “holding environment” for the patient to feel safe.⁴ By arranging for enough time to discuss this delicate topic and anticipating the patient’s strong emotional reaction to the topic, the provider increases the chances of preserving a good therapeutic alliance and hence a more successful taper experience.

B = Broaching the Subject – Summary points

- 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

The risk–benefit calculation is a way to compare the side effects, pain relief, and functional benefits incurred from chronic opioid therapy, to determine if the relative benefits outweigh the risks, and if a decrease in dose or full taper is indicated.⁵ In many cases, the adverse effects of chronic opioid therapy often exceeded its medical utility. Once the primary care provider determines that the adverse effects of the opioids for a given patient outweigh the benefits, the provider should take time to discuss his or her reasoning with the patient.

The provider might say something like: “I think we need to get you off opioids because they’re doing more harm than good. Your pain is no better than before you started on opioids, and may even be worse. More importantly, you’re less functional than you used to be, spending most of the day in bed. Your husband reports you are detached from family life. Opioids can do that, even when we’re not aware of them doing that. For all of those reasons, we’re going to work together to slowly taper you off these medications.”

Invariably, many patients will protest the taper and endorse all the ways the opioids are helping them, even with clear evidence to the contrary. The provider’s job is to remain empathic, yet resolute, and communicate to patients that a careful risk–benefit assessment informed by experience and compassion has led to this treatment plan. Providers should communicate to patients that to continue opioids under these circumstances would be to cause the patient further harm.

It’s important to document the reasons for the taper and the plan in the chart, in addition to explaining it to the patient.

An opioid taper should be considered when any of the following situations occur:

- The medication fails to show significant analgesia despite incremental dose increases.
- The medication fails to show functional improvement over time.
- MED is in excess of 90 mg/d or methadone dose is in excess of 30mg/d.
- Significant physical risk factors are present (sleep apnea, prolonged QT, pulmonary disease, etc.).
- Side effects of medication are interfering with quality of life.
- Patient request.

R = Risk – Benefit Calculator – Summary points

- 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

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V)—an imperfect but nonetheless useful catalog of behaviors the medical profession relies upon to diagnose psychopathology—uses 11 different criteria to diagnose substance use disorders (SUDs).⁶ A

short-hand way to remember these criteria is to think of the “four C’s”: Control, Compulsion, Craving, and Continued use despite consequences.

Control refers to out-of-control use, for example using more than intended.

Compulsion refers mental preoccupation with using and using against a conscious desire to abstain.

Craving refers to physiologic and/or mental states of wanting.

Continued use despite consequences refers to the social, legal, economic, interpersonal, and other problems that arise as a result of use, yet which still do not deter use.

If the patient endorses two to three items on the DSM diagnostic list, then the patient has a mild SUD. Four to five items signifies a moderate SUD, and six or more items indicates a severe SUD. For example, the patient who describes “a persistent desire ... to *control* substance use”(control), “important ... *activities given up because of* substance use” (consequences), “the substance taken in *larger amounts* than was intended” (control) and “tolerance” (needing more of the substance to get the same effect) has a moderate SUD (four criteria met). While tolerance and withdrawal are part of the DSM-V criteria for an SUD, the diagnosis of SUD cannot be based solely on the patient meeting criteria for tolerance and withdrawal. Similarly, tolerance and withdrawal do not need to be present to make a diagnosis of an SUD.

Although physical dependence, withdrawal, and tolerance are part of the DSM-5 diagnostic criteria for SUD, they cannot be the sole criteria for making a diagnosis of an SUD. An individual can be physically dependent on and tolerant to a substance or behavior without being addicted.

For example, someone who takes an opioid pill daily for pain as prescribed by a doctor may be dependent on opioids, need more and more medication to get the same effect (tolerance), and experience opioid withdrawal when cutting back or discontinuing use, but is not addicted to opioids by virtue of taking them as prescribed. This individual would meet criteria for a diagnosis of “opioid dependence, physiologic,” but not “opioid use disorder.”

Likewise, an individual can be addicted to opioid pain pills (i.e., using them in a way that is out of control, compulsive, and leads to consequences) without necessarily being dependent on opioids. For example, someone who binges on opioids to the point of respiratory suppression, risking death, but doesn’t take opioids daily, will not develop the tolerance and withdrawal symptoms (i.e., physical dependence) that arises with daily use. This individual would meet criteria for a diagnosis of “opioid use disorder,” but not “opioid dependence, physiologic.”

Patients who become addicted to prescription opioids may exhibit the following behaviors: taking more of the medication than directed, hoarding the medication and take a lot at once to change the way they feel, taking the medication to improve mood and energy rather than to treat pain, spending a lot of time and effort trying to get more medication, craving the medicine, or getting into trouble at work or in their personal lives owing to use of the medication.

Recent studies suggest that as many as 25% of patients taking daily opioid medications long term will misuse those medications, a harbinger of addiction.⁷ Quite an increase from the 1% risk of addiction doctors were taught in the 1990s.⁸ When talking to patients about addiction to prescription opioids, providers should begin by normalizing the process of becoming addicted

to opioids prescribed for pain and reassuring patients that there is effective treatment for opioid use disorders/addiction, as follows:

“When we [doctors] first started prescribing opioids more liberally for chronic pain in the 1980s, we believed the risk of becoming addicted, as long as we were prescribing them for a medical condition, was very low. Since then, we have learned a lot and now know that even when patients are being prescribed opioids for a legitimate pain condition, and take them as prescribed, they can become addicted to those opioids. So, if in the process of a slow and medically supervised taper, you are unable to come off opioids, it is possible that you too have become addicted. If that’s true for you, you’re not alone. Millions of people have become addicted to prescription opioids through a doctors’ prescription. The good news is there’s treatment for addiction, which may even help your pain.”

By being transparent about the ways in which the health care field has contributed to the opioid epidemic, and discussing treatment for opioid use disorders upfront, providers minimize the shame patients experience in admitting to themselves and others that they have become addicted and provide hope in the form of treatment if the opioid use disorder is a problem. It is also helpful to talk to patients about the difference between “opioid dependence, physiologic” and “opioid use disorder/addiction” and share with patients what their diagnosis is and why the diagnosis is appropriate.

Most importantly, patients who develop an opioid use disorder should be referred for treatment. Multiple randomized controlled trials across decades and continents have demonstrated proven efficacy for a variety of opioid use disorder treatments. The most robust evidence is for opioid agonist therapy in the form of buprenorphine-naloxone or methadone maintenance.⁹

A = Addiction Happens – Summary points

- 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

V = Velocity Matters (And So Does Validation)

The biggest mistake providers make in tapering patients off chronic opioid therapy is tapering too fast. The standard recommendation to decrease by 5% to 10% of the starting dose every 1 to 2 weeks is intolerable for some patients, especially those on high doses long term. Some patients may need to decrease by as little as 5% or less every 2 to 3 months, with even smaller decrements toward the end of the taper. It is not unreasonable to take many months to years to wean some patients off chronic opioid therapy, especially those who have been taking opioids daily for decades. So, go slowly.

It’s also important to keep the same dosing schedule. When it comes to addictive substances, brains are like little alarm clocks that sound whenever they’re used to getting a dose. If the

patient is on a twice-daily or thrice daily regimen, keep him or her on that schedule as they taper, decreasing by increments at a given dose.

Patient involvement, and to some extent autonomy, in the taper process, is vital to success. If the patient is on several different opioids, let the patient decide which medication to taper first unless there is an immediate safety issue, which demands tapering a specific medication first (e.g., concern for overdose with methadone, which because of unpredictable metabolism, has been shown to contribute to overdose in some cases). Involve the patient in the decision of how much to taper and when.

It's okay to take breaks in the taper, waiting at a given dose for some period before continuing. For example, if the patient has an important event coming up (e.g., wedding, family reunion, professional presentation) and doesn't want to be in low-grade withdrawal, it would be reasonable to defer the next decrement in dose until after that event.

Most importantly, never go backward during the taper (i.e., increase the dose), lest the hard work of withdrawal from the last dose reduction is lost. The use of nonaddictive medications to ameliorate the symptoms of withdrawal can be helpful.

The second most common reason opioid tapers fail is because the provider doesn't validate the patient's experience about opioid withdrawal before and during the taper. Most patients on chronic opioid therapy have already experienced varying degrees of opioid withdrawal and are frightened to experience it again, with many misconceptions about withdrawal and what it means for their underlying disease process. Even people without chronic pain have body pain when going through opioid withdrawal. Indeed, patients should be told once opioid withdrawal is over, their pain may improve, due to a resetting of the pain threshold.

Symptoms of Opioid Withdrawal

Early Symptoms

Agitation
Anxiety
Muscle aches
Increased tearing
Insomnia
Runny nose
Sweating
Yawning

Late Symptoms

Abdominal cramping
Diarrhea
Dilated pupils
Goose bumps
Nausea
Vomiting

To prepare patients for opioid withdrawal, the provider should be honest with patients: they will feel worse before they feel better. The "feeling worse" will include all the typical symptoms of opioid withdrawal, as well as softer symptoms of opioid withdrawal, namely: irritability, insomnia, anxiety, and dysphoria (or low mood). Most importantly, many patients on chronic opioid therapy for chronic pain believe the physical pain they experience during withdrawal is evidence of their need for medication.

The provider needs to explain to patients that the opioid is probably no longer treating the underlying pain condition but merely withdrawal from the last dose. Furthermore, the pain during opioid withdrawal is not an indication of progression of their underlying pain condition and not the pain they will have to live with off opioids. It is opioid withdrawal-mediated pain.

Emerging evidence suggests pain improves once patients are off of opioid, or on a lower doses.¹⁰

To validate and reassure patients through this process, the provider may want to consider using a cancer treatment analogy when talking to patients about the process of the opioid taper. For example: “What we’re asking you to do is very difficult, but it’s a little bit like going through chemotherapy for cancer treatment. The treatment can be uncomfortable, and at times unbearable, but when it’s over, there is hope that you will be in a better place and feel better than before the treatment.” Be generous with accolades for patients going through this process.

Consider the following adjuvants as needed:

- Antidepressants to manage irritability, sleep disturbance (e.g., trazodone)
- Hydroxyzine for insomnia and anxiety
- Anti-epileptics for neuropathic pain
- Clonidine for autonomic withdrawal symptoms such as rhinorrhea, diarrhea, sweating, tachycardia, hypertension
- NSAIDs for myalgia (e.g., ibuprofen)
- Anti-diarrheal agents for diarrhea
- Opioid Withdrawal Attenuation Cocktail (Appendix F)

Special considerations for methadone: Methadone withdrawal symptoms take longer to manifest because of the long and unpredictable metabolism of the drug. Patients may be overconfident early in the tapering process only to experience severe withdrawal over time. The same principles of opioid tapering are true for methadone; although, a more drawn-out taper may be necessary. Understanding the unique metabolic characteristics of methadone will be helpful for you and the patient to achieve a successful dosage reduction.

V = Velocity Matters – Summary points

- Tapering too fast is the most common mistake physicians make
- It’s ok to take breaks in the taper schedule, but never go 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

Certain therapies, DBT, CBT and Living Well With Chronic Illness workshops, for example, can be quite helpful to support patients through the tapering process and beyond.

Consider some brief office-based interventions to help patients cope with pain, as an alternative to opioids. The following interventions are adapted from Dialectical Behavioral Therapy.

First, teach patients mindfulness practices. An example would be asking them to acknowledge pain and notice if something in the environment is making it worse at the moment, then remember the top three reasons why they want to stay off opioids (e.g., “my kids, I don’t want to feel dependent on something, my health”).

Second, teach patients opposite action skills: acting opposite to the emotional urge in the service of pursuing values or goals. Many patients with chronic pain become obsessively focused on their pain and let it limit their participation in many activities. By contrast, providers can encourage patients to do the opposite and engage in activities, within reason, despite pain being present. This does not mean asking patients to go bungee jumping. This means asking them to engage in physical and mental activities as tolerated, despite being in pain, instead of spending the day in bed focused on their pain. By engaging in other activities, patients are promoting blood flow and neural engagement in areas of the brain that are unrelated to their chronic pain condition.

In addition to providing a conceptual framework for safely and compassionately tapering the opioid dependent patient down and/or off of opioids, “BRAVO” is also an apt rejoinder to patients and doctors who take on this difficult clinical challenge.

O = Other Strategies for Coping with Pain– Summary points

- Tapering too fast is the most common mistake physicians make
- It’s ok to take breaks in the taper schedule, but never go 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

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