Tapering Opioids

How to Explore and Pursue the Option for Patients Who Stand to Benefit

CHRONIC PAIN/OPIOIDS Part 2 SPRING 2018

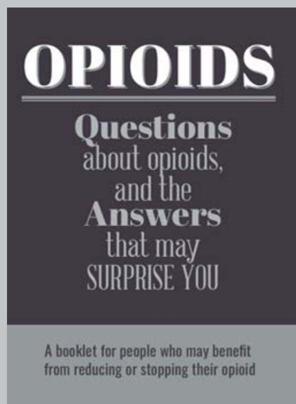
Evidence for pain and function outcomes with opioid tapering[1]

Frank et al 2017

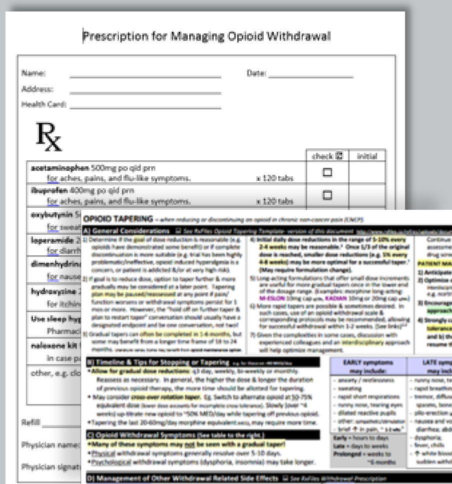
Fair Quality Studies:

Pain	8/8 improved
Function	5/5 improved
Quality of Life	3/3 improved

TOOLS FOR PATIENT DISCUSSION!



CHARTS & TEMPLATES FOR PLANNING AND MANAGING AN OPIOID TAPER


Prescription for Managing Opioid Withdrawal

Name: Date:
Address:
Health Card:

OPIOID TAPERING

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I remember the first time I saw someone with chronic non-cancer pain (CNCP) see improvement after coming off their opioid. The person was in a multidisciplinary program and pursuing rehabilitation following a previous major injury. They were in a lot of pain. One of the team members suggested that the opioid may be doing more harm than good. Given the severity of this person's pain, I was not easily convinced that reducing/stopping the opioid would be the right thing for this patient. After discussion with both the patient and the team-member, I agreed to help find the support needed to pursue a trial of this option. There were obstacles to overcome, but several weeks later, they were off the opioid, progressing well and on the road to getting their life back.

- Loren Regier

The need for information on opioid tapering has grown along with evolving pain guidelines and concerns about the opioid crisis. It is an important and challenging area. We have wrestled with the challenges and put together several documents that discuss rationale, evidence, challenges and strategies to consider.

RATIONALE

- Patients, in whom the opioid is doing more to them than for them, stand to benefit from a reassessment of therapy & consideration of opioid tapering
  - Benefits from an opioid are only seen in a minority of CNCP patients
  - Harms and dose-dependent risks should be avoided or minimized

EVIDENCE

- Available evidence supports that patients with CNCP will often find that their pain and function will usually be no worse and often improved following a taper. (Limited evidence applicable to voluntary patients.) [Frank et al 2017]

CHALLENGES

- Patients are often fearful of opioid withdrawal and worsening pain if they taper their opioid. They may be worried about a lack of alternatives for pain relief. Addressing patient reluctance or resistance is difficult, but may be the key to improved safety and long term improvement.

STRATEGIES

- Use of motivational interviewing techniques & brief interventions may help in creating and exploring ambivalence about considering an opioid taper
  - E.g. What are the upsides & downsides from your perspective?
- Utilizing resources for patients to provide information, deal with myths, and support discussions about opioid tapering
  - E.g. RxFiles Patient Q&A: Opioids...Answers that May Surprise You
- An individualized tapering plan will help in the pursuit of a successful taper
  - E.g. RxFiles Tapering Template, Opioid Withdrawal Prescription
- Switching to an alternate opioid at ≤50-75% of the equivalent dose may be helpful
- Employing any available patient supports & multidisciplinary team members can encourage the patient and increase the chances of success

Tapering Background & Strategies Pg 2
Withdrawal Management/Template Pg 4
Withdrawal Prescription Pg 8
SOWs Form (Opiate Withdrawal Scale) Pg 9
Motivational Interviewing Approaches Pg 10
Opioid Tapering - Info for Patients Pg 14

Evidence-Based Guidelines: Summary of Recommendations Found[1]

- Individualized treatment plans[2,3,4] Offer of frequent follow up
- When initiating an opioid trial, also consider & discuss an "exit" strategy
- If switching/rotating opioids as part of a taper strategy, reduce new opioid by 50% of previous MED & titrate until analgesia achieved.
- Offer option of additional treatment(s) e.g. for pain, withdrawal
- A taper of ~5-10% q2-4 weeks recommended for community setting[5]
- Adjuvant therapies that should be considered[6]
  - Psychological treatment & CBT (helpful for most)
  - Pain specialist, multidisciplinary program or addiction medicine specialists (for more challenging patients)

CNCP Patient Perspectives Regarding Opioid Tapering[7]

BARRIERS

- **Pain in present** may trump opioid risks in the future
- **Pessimism with non-opioid options** if previous unsatisfactory experience in managing without opioids
- **Fear / anxiety over opioid withdrawal** if previous negative experience

FACILITATORS

- **Social support**
  - To identify problematic symptoms and side effects such as opioid use causing poor self-care
  - To encourage sticking with the plan for tapering (a check against bad judgment decisions)
  - Support group for empathy, encouragement & camaraderie (paper doesn't cut it!)
  - Patients who can share success stories of living better after a taper
- **Availability of a Trusted Health Care Provider**
  - Often key to willingness to initiate & sustain opioid tapering!
  - Someone who is supportive, nonjudgmental, flexible, & accessible
- **Noting benefit of improved quality of life after tapering**
  - Noted that pain level after tapering largely unchanged
  - Long term, life was better for having gone through the taper

Patient-Provider Communication: Four Themes[8]

1) **Explaining**- Patients needed to understand individualized reasons for tapering, beyond general, population-level concerns such as addiction potential
2) **Negotiating**- Patients needed to have input, even if it was simply the rate of tapering
3) **Managing difficult conversations**- When patients and providers did not reach a shared understanding, difficulties and misunderstandings arose
4) **Non-abandonment**- Patients needed to know that their providers would not abandon them throughout the tapering process

Approaches to Opioid Tapering

1. **Gradual taper** of current opioid over several weeks or months
   See RxFiles Opioid Tapering Template Pg 5
   http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf
2. **Rapid taper** of current opioid over 1-2 weeks
   See opioid withdrawal scales (e.g. COWS) & corresponding protocols[9]
3. **Switch/rotate opioid to lower dose of alternate opioid** & take advantage of a potential 25-50% dose reduction due to lack of cross-tolerance
4. **Gradual cross-over rotation/switch to lower dose** of alternate opioid over ~4 weeks. Allows potential to take advantage of a 25-50% dose reduction due to lack of cross-tolerance. Decreases the risk of a major adverse event (over- or under-dosing) due to the wide variation in potential equivalent dose for a given patient. However, this approach would require being on 2 opioids for a short period of time (e.g. ~4 weeks), increasing the risk of confusion & the need for weekly dispensing intervals & follow-up.
5. **Opioid Agonist Therapy (OAT) with SUBOXONE or Methadone** is useful for patients with Opioid Use Disorder (OUD) [10] or those on long-term opioids (e.g. ≥ 5-7-10 yrs) or psych comorbidities (especially depression). Prescribing regulations have softened [Health Canada].
   a. **Buprenorphine-naloxone SUBOXONE**: for maintenance; preferred over abstinence only; if withdrawal, opioid use or cravings persistent, switch to methadone
   b. **Methadone Maintenance**: preferred over abstinence only
   c. **Adjunct Naltrexone:** may consider oral naltrexone for use as adjunct treatment after patient discontinues opioid.
6. **Always optimize non-pharmacological/non-opioid supports** (e.g. exercise/activity, psycho-social, determination of taper start date, etc.)

Opioids and Withdrawal Pain [11] Adapted from Dr. P Squire, Family Physician & Pain Specialist BC

- *It is common to mistake the pain of withdrawal for usual pain*
- *Taking an opioid dose that was missed will seem to improve a patients pain, even when often it is just relieving the pain of opioid withdrawal*
- *Almost everyone who takes opioids for a few weeks will have withdrawal symptoms when stopping or significantly cutting the dose of their opioid.*
- *It is important to counsel a patient that one of the early symptoms of opioid withdrawal is increased pain. This pain can be similar to the pain being treated but may also include total body, joint and muscle pains.*
- *Based on both evidence and experience, it is quite likely that pain and function will be no worse, and sometimes better after a few days of an initial flare. By the second week after lowering the opioid dose, pain will often return to where it was.*

References available online

CHRONIC PAIN & OPIOIDS: Strategies for patients who may benefit from tapering

M LeBras PharmD © www.RxFiles.ca April 2018

Where Does My Patient Fit?	What is the Evidence for Tapering?	Potential Management / Tips
❶ **Motivated to taper opioid** • Patient has requested (e.g. taper is necessary for return to work, prescriber is retiring) • Patient has significant adverse events (e.g. sedation, falls, constipation, hypogonadism) • Patient does not meet goals of therapy (i.e. no improvement in function &/or persistent problematic pain) • Pain has resolved (e.g. received surgery)	**Bottom line**: limited evidence, but suggests patient may benefit. Most showed pain/function/QOL stayed the same or improved. • **Evidence**: systematic review (N=40 studies of which N=5 RCTs)[Frank'17] • Pain (N=36 studies): improved (N=29); no change (N=4); worsened (N=3) • Function (N=17 studies): improved (N=13); no change (N=2); ↓ (N=2) • QOL (N=12): improved (N=7); no change (N=4); worsened (N=1 study) • Withdrawal Symptoms (N=18 studies): rate ranged from 0-100% • **What is the best way to taper**? Unknown, therefore *Individualize!* • Strategies typically compared to standard care, were multidisciplinary, & emphasized non-pharm, non-opioid, & self-management. Longer taper (>6mos) may be required if long-term use (≥ 5-7-10yrs) or comorbid psych. • **Caution**: pregnancy (premature labour, abortion with severe withdrawal); ACS (recent); severe/unstable psych; DM (sick day management); ↓cognitive fnx	Initiate taper (see Opioid Tapering Template ± Chart) • Discuss pre-taper plan: start date, self-management, activity, exercise, withdrawal management (see Withdrawal Rx Pg 8). • *Individualize* taper strategy & taper rate • Typically, may reduce opioid by 5-10% every 2-4 weeks • Once at ~1/3 of the original dose may slow rate of taper (e.g. every 4-8 weeks) • Encourage lifesaving naloxone (injectable or intranasal) use as tolerance to higher opioid dose may be lost after 1-2 wks (some mortality has been reported anecdotally and in studies) • Other: opioid switch/rotation, cross-over switch/rotation, methadone or **SUBOXONE** (may consider if pregnant, opioid use ≥ 5-7-10 yrs, comorbid psych especially depression)
❷ **Ambivalent, or even resistant, to taper opioid** • Patient prefers not to taper, or thinks that they would not be able to, including inherited or future legacy patients • Patient has no documented dx requiring opioids (i.e. fibromyalgia)	**Bottom line**: not studied; only voluntary patients included in trials. • Patients may be living with lack of benefit and/or unrealized harms. For example, **opioid-induced-hyperalgesia**, which presents as increased pain with increased opioid dose. Absolute risk is unknown due to challenges in diagnosing. Improvement in pain and function with opioid dose reduction. • Consider prioritizing patients at greatest risk, for example, those in whom potential harm exceeds benefit (e.g. unsafe use, high dose opioid, ≥90MED/d) • Temporarily park the opioid taper; address other problematic/sedating drugs	Maintain dose. Reassess function (*"tell me what you do in a day"*). Also, may reassess readiness to change periodically using (see motivational interviewing support tool Pg 10). Ensure: • Safeguards are in place (e.g. safe storage, disposal, naloxone) • ALL non-opioid & non-pharm options are optimized • Consider providing patient with: • RxFiles Patient Booklet regarding Opioid Tapering • CDN Guidelines, "Opioid Tapering - Info for Patients" Pg 14 • Consider screening tools (BPI, PDI) to create ambivalence
❸ **Taper may be mandated due to safety concerns** • Patient displays characteristics of OUD or aberrancy; has experienced or at ↑ risk of AE/ overdose (eg BZD, COPD, sleep apnea,↓ renal/hepatic fnx)	**Bottom line**: not studied; only voluntary patients included in trials. • **SUBOXONE** or methadone therapy may be used during tapering protocols or as maintenance therapy for opioid use disorder. Treatment paradigm may shift from CNCP treatment to OUD/harm reduction. • **SUBOXONE** or methadone preferred over abstinence only in OUD • **Caution**: some patients may seek other illicit sources of opioids and be a higher risk of overdose/death (BC experience)	• Consider referral to addictions or psychiatry as appropriate • Consider switching/rotating opioid (including methadone or **SUBOXONE** see CPSS resources, BC Centre on Substance Use webinar) • May still initiate taper in the face of resistance. If rapid taper required, consider detox/direct observance and use an opioid withdrawal scale (e.g. COWS) • Encourage lifesaving naloxone (injectable or intranasal) use as tolerance to higher opioid dose may be lost after 1-2 wks

How to Taper a Patient on Transdermal Fentanyl Patch(es)?

Option 1: Taper using patch (↓ dose q2-4wks, then q4-8wks when at ~1/3 of original dose) i.e. 100mcg/h → 87 mcg/h (75+12) → 75mcg/h → 62 mcg/h (50+12) etc until at 12mcg/h, then:

- Discontinue or
- Convert to po opioid (12mcg/h ~50MED*), ↓po dose by ≥25-50% (incomplete cross tolerance) & taper or
- Give limited supply of an IR opioid then stop
- {Limiting matrix patch area in contact with skin (e.g. tape) done anecdotally, but NOT usually recommended. See online extras}

Option 2: Switch/rotate fentanyl patch to oral opioid* (usually taper to ≤100mcg/h with available patch strengths first prior to switch/rotate)

- Fentanyl 100mcg/h ~equivalent to 400 MED
- Decrease by ~50% (allow for incomplete cross tolerance & switch*) ~200mg MED
- IF BID dosing (i.e. morphine SR 100mg po BID): give 50% of dose (50mg) 12h after patch removal, then 100% of dose (100mg) 24h after patch removal, then continue regular dosing. IF once daily dosing (i.e. **KADIAN** 200mg po daily): give 50% of new dose (100mg) 12h after patch removal, then 100% of new dose (200mg) 24h after patch removal , then continue regular dosing. Follow-up with tolerance checks in 24-72hrs to reassess dose.

Opioid (oral dose)	Equivalent dose, approximate (mg)	Conversion to MED
Morphine	30 mg	1
Codeine	200 mg	0.15
Oxycodone	20 mg	1.5
Hydromorphone	6 mg	5

Fentanyl (Transdermal)*	
60-135 mg morphine/day = 25mcg/h	Oral conversion amounts used for *cautious* switch/rotate to fentanyl patch; may be *aggressive* in switch/rotate from fentanyl
135-179 mg morphine/day = 37mcg/h	
180-224 mg morphine/day = 50mcg/h	
225-269 mg morphine/day = 62mcg/h	
270-314 mg morphine/day = 75mcg/h	
315-359 mg morphine/day = 87mcg/h	
360-404 mg morphine/day = 100mcg/h	

* Switching/rotating from fentanyl patch to po opioid is usually not recommended due to unreliable MED conversion. Listed MED are unilateral from po opioid to fentanyl patch. **Be conservative**! **MED**=morphine equivalent dose; **OUD**= opioid use disorder **PDI**=physical disability index

A) General Considerations

See RxFiles Opioid Tapering Template- version of this document http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf

1) Determine if the goal of dose reduction is reasonable (e.g. opioids have demonstrated some benefit) or if complete discontinuation is more suitable (e.g. trial has been highly problematic/ineffective, opioid induced hyperalgesia is a concern, or patient is addicted &/or at very high risk).

2) If goal is to reduce dose, option to taper further & more gradually may be considered at a later point. Tapering plan may be paused/reassessed at any point if pain/ function worsens or withdrawal symptoms persist for 1 mos or more. However, the "hold off on further taper & plan to restart taper" conversation should usually have a designated endpoint and be one conversation, not two!

3) Gradual tapers can often be completed in 1-6 months; some may benefit from a longer time frame of 12-24 mons. Literature varies. Some may benefit from **opioid agonist therapy.**

4) **Set a start date! Initial daily dose reductions in the range of 5-10% every 2-4 weeks may be reasonable.[1] Once 1/3 of the original dose is reached, smaller dose reductions (e.g. 5% every 4-8 weeks) may be more optimal for a successful taper.[1] (May require formulation change).**

5) Long-acting formulations that offer small dose increments are useful for more gradual tapers once in the lower end of the dosage range. {Examples: morphine long-acting: **M-ESLON** 10mg cap q12h, **KADIAN** 10mg or 20mg cap q24h}

6) More rapid tapers are possible & sometimes desired. In such cases, use of an opioid withdrawal scale & corresponding protocols may be recommended, allowing for successful withdrawal within 1-2 weeks. (See links)[2,3]

7) Given the complexities in some cases, discussion with experienced colleagues and an interdisciplinary approach will help optimize management. Continue to use "best practice" tools (e.g. functional assessment, *Opioid Manager* from Canadian guidelines, urine drug screens, etc).

PATIENT MANAGEMENT

1) Anticipate withdrawal & have a plan to manage (see Rx).

2) Optimize other pain management (e.g. non-drug e.g. CBT, interdisciplinary team; add co-analgesics for neuropathic pain e.g. nortriptyline, duloxetine, gabapentin or pregabalin).

3) Encourage functional goal setting.

4) Optimize non-drug tx for insomnia, anxiety & depression.[9]

5) Strongly caution patients that a) they have lost their tolerance to opioids after as little as 1-2 weeks of taper, and b) they are at high risk for overdose if they relapse/ resume their pre-taper dose. Rx Naloxone Kit OTC ✗ ▼ **!**

B) Timeline & Tips for Stopping or Tapering

- **Allow for gradual dose reductions**: e.g. q3 day, weekly, bi-weekly or monthly. Reassess as necessary. In general, the higher the dose & longer the duration of previous opioid therapy, the more time should be allotted for tapering.
- Consider ***switching to 50-75%*** of the MED of an alternate opioid +/- further taper
- May consider ***cross-over switch/rotation taper***: e.g. switch to alternate opioid at 50-75% equivalent dose (lower dose accounts for **incomplete cross tolerance**). Slowly (over ~4 wks) up-titrate new opioid to ~50% MED/d while tapering off previous opioid.
- Tapering the last 20-60mg/day morphine equivalent (MED), may require more time.

C) Opioid Withdrawal Symptoms (See table to the right.)

- **Many of these symptoms may not be seen with a gradual taper!**
- Physical withdrawal symptoms generally resolve over 5-10 days.
- Psychological withdrawal symptoms (dysphoria, insomnia) may take longer.

EARLY symptoms may include:	LATE symptoms may include:	PROLONGED symptoms may include:
- anxiety / restlessness - sweating - rapid short respirations - runny nose, tearing eyes - dilated reactive pupils - other: sympathetic/stimulation - brief ↑ in pain (usually few days but up to 2-4wks)	- runny nose, tearing eyes - rapid breathing, yawning - tremor, diffuse muscle spasms, bone/joint aches - pilo-erection (gooseflesh skin) - nausea and vomiting; diarrhea; abdom. pain - dysphoria; - fever, chills - ↑ white blood cells (if sudden withdrawal)	- irritability, fatigue, malaise, psychological/wellbeing (dysphoria, coping, craving) - bradycardia - decreased body temperature
Early = hours to days **Late** = days to weeks **Prolonged** = wks to ~6mos		◆ Some people with chronic pain will find that fatigue, function & general well-being improve over time with opioid tapering.[4,5] In such cases, gradual, incremental gains in function will be possible & should be explored.

D) Management of Other Withdrawal Related Side Effects

See RxFiles Withdrawal Prescription

Aches/Pains/Myalgia:

⇨ **NSAID** (e.g. naproxen 375-500mg twice daily or ibuprofen 400-600mg four times daily)**: useful for pain & withdrawal. (Give regularly initially.)**

⇨ **Acetaminophen** (650-1000mg q6h as needed) for *aches, pains, flu-like symptoms*

Bowel Function (Constipation / Diarrhea): ensure adequate hydration

⇨ **Laxative** - continue initially to prevent constipation; with time, reduce, hold & eventually stop laxative (See RxFiles Opioid Induced Constipation, page 61)

⇨ **Loperamide** - used if necessary for *diarrhea*; may not need with gradual taper.

Nausea/Vomiting: ensure adequate hydration

⇨ **Dimenhydrinate** 50-100mg q6h PRN [others: **haloperidol** 0.5-1mg po q8-12h; **prochlorperazine** 5-10mg po q6-8h; **nabilone** 0.25-0.5mg HS up to 0.5-1mg TID].

Sweating: ⇨ **Oxybutynin** 2.5-5mg po BID PRN (**short-term**); ensure adequate hydration!

Anxiety, Itchiness, Lacrimation, Cramps, Rhinorrhea, Diaphoresis, Insomnia:

⇨ **hydroxyzine** 25-50mg po TID PRN, or sometimes just needed at HS (**short-term**)

Insomnia: encourage sleep hygiene (e.g. limit stimulation near bedtime: caffeine, alcohol, TV)

⇨ **Employ non-drug & sleep hygiene measures** (e.g. CBT, regular bedtime & wake-time; sleep restriction).[6,7,8] If short-term pharmacologic tx necessary, options: **trazodone** 25mg po HS ($12) up to 100mg; **amitriptyline** 10mg po HS ($13), **doxepine** SILENOR 3-6mg po HS ($30-50)

Pain/Insomnia/Anxiety: *(nabilone ☎: tx of N/anorexia AIDs ; ✆: N/V cancer, palliative)*

⇨ **gabapentin** 300mg HS, **pregabalin**✆ 75mg HS; **nabilone** 0.25✗ -0.5mg HS up to 0.5-1mg TID☎,✆

Physical Withdrawal Sxs (e.g. agitation) – by ↓ sympathetic activity (α_2-adrenergic agonist)**:**

⇨ **Clonidine 0.1mg BID PRN** (some patients may need up 4 doses/day). Some patients may not require if gradual taper. May use SOWS (patient administered scale) for monitoring (e.g. score 10-20 take clonidine) see Pg 9. Caution: if SBP <100, orthostasis, HR <60. Duration (Cochrane): typical use for 7-14 days up to 30 days;[9] however, some may need longer tx (e.g. high dose, ≥ 5 yrs of use, fentanyl). If used regularly, taper, over ~7-10 days, to stop. Some evidence that it may ↑ duration of abstinence decoupling stress from craving.[10] {Tizanidine ZANAFLEX ☎ ✆: 2mg po HS, may ↑ by 2-4mg/d to max ~ 8mg q8h. Taper gradually!}

Opioid Tapering Template

For use when a decision is made to reduce or discontinue an opioid in chronic non-cancer pain (CNCP).

General approach considerations:

1. In discussion with the patient, set a reasonable start date for the taper.
2. Gradual tapers can often be completed in the range **of 1 to 6 months**. However, some may benefit from a longer time frame of 12-24 months. Initial daily dose reductions in the range of 5-10% every 2-4 weeks are reasonable.[1] Once a dose of approximately 1/3 of the original dose is reached, smaller dose reductions (e.g. 5% every 4-8 weeks) may be more suitable for some & more likely to result in a successful taper.[1] More rapid tapers are possible and sometimes desired. In such cases, use of an opioid withdrawal scale (e.g. COWS) & corresponding withdrawal protocols may be recommended, allowing for successful withdrawal within 1-2 weeks. (See links [2-4])
3. Long-acting formulations that offer smaller dose increments are useful for more gradual tapers once in the lower end of the dosage range. {Examples: morphine long-acting: **M-ESLON** 10mg cap $_{q12h}$, **KADIAN** 10mg cap $_{q24h}$.}
4. Consider daily dispensing of opioids or blister packs for those at high risk of overdose or aberrancy use.
5. Determine if the goal of dose reduction is reasonable (e.g. opioids have offered some benefit) or if complete discontinuation is more suitable (e.g. opioid trial has been highly problematic/non-helpful or there is a concern regarding opioid induced hyperalgesia).
6. If goal is to reduce dose, option to taper further & more gradually may be entertained at a later point. Tapering plan may be held/reassessed at any point if pain/function deteriorate or withdrawal symptoms persist for 1 month or more. However, the "hold off on further taper & plan to reassess/restart taper" conversation should have a designated endpoint & be one conversation, not two!
7. Encourage functional goal setting & efforts to enhance non-drug approaches in management plan.
8. Optimize other pain management (e.g. Is something needed for neuropathic pain such as nortriptyline, gabapentin or pregabalin).
9. Anticipate likely and possible withdrawal effects & have a management plan in place. (See Pg 2 & Withdrawal Rx)
10. Given the complexities in some cases, discussion with experienced colleagues and an **interdisciplinary approach** will help optimize management. Continue to use "best practice" tools (e.g. Opioid Manager, UDS).
11. Strongly caution patients that a) they have lost their tolerance to opioids after as little as a week or two of abstinence, & b) they are at risk for overdose if they relapse/resume their original dose.
Consider a Take Home Naloxone Kit OTC ✗ ▼ !

Timeline for discontinuation or reaching a taper "target dose"

Current dose ____

Proposed target dose ____

Timeline (in weeks or months) ____________________________ ☐weeks ☐months

⇨ Allow for gradual q3 day, weekly, bi-weekly or monthly dose reductions. Reassess as necessary.

⇨ In general, the longer the duration of previous opioid therapy, the more time should be allotted for tapering. Rate of tapering should often be even more gradual as total daily dose reaches lower end of range (e.g. ≤120 mg Morphine/day)

See page 2 for customizable Tapering Template, or go online for customizable Opioid Withdrawal Prescription.

Name: ______________________________ **Date:** ______________

Address: ____

(May switch/rotate to 50-75% equivalent morphine dose of an alternate opioid.)
Reduced dose accounts for incomplete cross tolerance. See Opioid Manager Switching Tool.

A) Tapering Schedule*: Drug ______________________

	Dates	(# wks)	AM Dose**	PM Dose	Total Dose/Day	*Quantities Needed*
0.	*Start Date!*		mg	mg	mg	
1.		x wk	mg	mg	mg	
2.		x wk	mg	mg	mg	
3.		x wk	mg	mg	mg	
4.		x wk	mg	mg	mg	
5.		x wk	mg	mg	mg	
6.		x wk	mg	mg	mg	
7.		x wk	mg	mg	mg	
8.		x wk	mg	mg	mg	
9.		x wk	mg	mg	mg	
10.		x wk	mg	mg	mg	
11.		x wk	mg	mg	mg	
12.		x wk	mg	mg	mg	

*template may be adjusted based on patient's progress; decisions on further tapering, etc. Last 20-30 mg may require more time.
if once daily formulation (i.e. **KADIAN or **JURNISTA**) record dose in respective AM or PM column.

B) Opioid withdrawal symptoms:

- **Many of these symptoms may not be seen with a gradual taper!**
- Physical withdrawal symptoms generally resolve by 5-10 days following opioid dose reduction/cessation.
- Psychological withdrawal symptoms (dysphoria, insomnia), if seen, may take longer (months) to resolve.

Early symptoms may include:	**Late symptoms may include:**	**Prolonged symptoms may include:**
- anxiety and restlessness - sweating - rapid short respirations - runny nose, tearing eyes (minor) - dilated reactive pupils - brief ↑ in pain (usually few days)	- runny nose, tearing eyes - rapid breathing, yawning - tremor, diffuse muscle spasms/aches - pilo-erection (goose bumps) - nausea and vomiting; diarrhea - abdominal pain - fever, chills - ↑ white blood cells (if sudden withdrawal)	- irritability, fatigue; hormonal related △ - bradycardia (slower heart rate) - decreased body temperature
Early = hours to days **Late** = days to weeks **Prolonged** = weeks to ~6 months		◆ Some people with chronic pain will find that symptoms such as fatigue & general well-being are improved over time with tapering of the opioid. In such cases, gradual gains in function will be possible & should be explored.

☐ **C) NSAID** (e.g. naproxen 250-375mg twice daily or ibuprofen 400-600mg four times daily)**:** useful for pain & withdrawal aches/pains.

☐ **D) Laxative:** continue initially; with time, or if diarrhea emerges, reduce, hold & eventually stop laxative (See Q&A) [5]

☐ **E) Management of other side effects:**

1. **Clonidine** 0.1mg twice daily PRN (up to 4 times daily) may be prescribed for *general relief/prevention of physical withdrawal sxs*. (Caution if SBP <100, orthostasis, or HR <60); Some patients may not require if gradual taper. May use SOWS (patient administered scale) for monitoring (e.g. score 10-20 take clonidine) see Pg 9. [Cochrane review documented use for 7-14 days up to 30 days,[6] but some may need longer]. If used regularly, taper, over ~7-10d, to stop.
2. ☐ **Acetaminophen** (650-1000mg every 6 hours as needed) may be used for *aches, pains, flu-like symptoms.*
3. ☐ **Loperamide** may be used as necessary for *diarrhea*; however, may not need with gradual taper.
4. ☐ **Non-drug & "sleep hygiene"** measures should be employed (e.g. U of R pain course www.onlinetherapyuser.ca/pain; regular bedtime/wake-time; sleep restriction).[7-9] If additional tx required, short-term **trazodone** 25-50-100mg HS is an option.
5. ☐ **Dimenhydrinate** 50-100mg every 6 hours as needed for *nausea/vomiting* [Alternatives: prochlorperazine 5-10mg q6h, haloperidol 0.5-1mg q12h]
6. ☐ **Other**
7. Remember **tolerance to previous dose of opioid is lost after 1-2 weeks**!
   Consider *Naloxone Kit* OTC ✗ ▼ for risk of overdose!

Physician: ______________________

A) Sample Slow Tapering Schedule*: Drug _____Morphine long acting_(MS CONTIN)

	Dates	(# wks)	AM Dose**	PM Dose	Total Dose/Day	*Quantities Needed*
0.	Current	-	245mg	245mg	490 mg	
1.		X2 wk	230 mg	230 mg	460 mg	*(4x100mg) + (2x30mg) x14d*
2.		X2 wk	215 mg	215 mg	430 mg	
3.		X2 wk	200 mg	200 mg	400 mg	
4.		X2 wk	190 mg	190 mg	380 mg	
5.		X4 wk	175 mg	175 mg	350 mg	
6.		X4 wk	160 mg	160 mg	320 mg	
7.		X4 wk	145 mg	145 mg	290 mg	
8.		X4 wk	130 mg	130 mg	260 mg	
9.		X4 wk	115 mg	115 mg	230 mg	
10.		X8 wk	100 mg	100 mg	200 mg	
11.		X8 wk	90 mg	90 mg	180 mg	
12.		X8 wk	80 mg	80 mg	160 mg	*Switch to* **M-ESLON**, *or once daily* **KADIAN** *for smaller titrations*
13.		X8 wk	140 mg	0 mg	140 mg	
14.		X12 wk	120 mg	0 mg	120 mg	
15.						
16.						

*this template may be adjusted based on patient's progress; decisions on further tapering, etc.

if once daily formulation (i.e. **KADIAN or **JURNISTA**) record dose in respective AM or PM column and "0" in other.

Additional information:

[1]2017 Canadian Guideline for Opioids for Chronic Pain (May 2017) - Links

- **Link to Guideline Site**: http://nationalpaincentre.mcmaster.ca/guidelines.html
- **Opioid Tapering- Information for Patients – English:** http://nationalpaincentre.mcmaster.ca/documents/Opioid%20Tapering%20Patient%20Information%20(english).pdf
- **Opioid Tapering- Information for Patients – French:**
  Sevrage des opioïdes : informations à l'intention des patients.
  http://nationalpaincentre.mcmaster.ca/documents/Opioid%20Tapering%20Patient%20information%20FRENCH.pdf

Other

- **CAMH: Video discussion of issues around how to taper.** http://knowledgex.camh.net/videos/Pages/tapering_presopioids_selby2013.aspx
- **RxFiles: Opioid Taper Template & related materials at**: www.RxFiles.ca
  - Pain/Opioid Resource Links: http://www.rxfiles.ca/rxfiles/uploads/documents/RxFiles-Pain-and-Opioid-Resource-Links.pdf
  - RxFiles Pain/Opioid Newsletter Part 1 – Fall 2017: http://www.rxfiles.ca/rxfiles/uploads/documents/Opioids-Pain-2017-Newsletter.pdf
- **TheWell (Centre for Effective Practice):**
  - **Opioid Tapering Template (2018) at**: https://thewellhealth.ca/opioidtaperingtool
  - **Opioid Manager tool to support the Canadian Opioids in CNCP guideline:** https://thewellhealth.ca/pain
- **CDC - POCKET GUIDE: Tapering Opioids For Chronic Pain**: https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

[2] Clinical Opiate Withdrawal Scale (**COWS**). https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

[3] Subjective Opiate Withdrawal Scale (**SOWS**). http://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf

[4] Butt P, McLeod M. Opioid withdrawal protocol, Saskatchewan.

[5] Opioid Induced Constipation Q&A: http://www.rxfiles.ca/rxfiles/uploads/documents/members/Opioid-Induced-Constipation-QandA.pdf

[6] Gowing L, Farrell MF, Ali R, White JM. Alpha2-adrenergic agonists for the management of opioid withdrawal. Cochrane Database Syst Rev. 2014 Mar 31;3:CD002024.

[7] Merrigan JM, Buysse DJ, Bird JC, Livingston EH. JAMA patient page. Insomnia.JAMA. 2013 Feb 20;309(7):733. Accessed online 21 Oct, 2013 at http://jama.jamanetwork.com/article.aspx?articleid=1653524.

[8] Sedative Patient Information Sheet (RxFiles) http://www.rxfiles.ca/rxfiles/uploads/documents/PSYC-Sedative-PtHdout.pdf

[9] Chronic Insomnia in Older Adults (RxFiles Q&A) http://www.rxfiles.ca/rxfiles/uploads/documents/Insomnia-Older-Adults-QandA.pdf

Prescription for Managing Opioid Withdrawal

Name: ___________________________________ Date: ____________________

Health Card: ___________________________________

℞

	check ☑	initial
acetaminophen 500 mg po qid prn for aches, pains, and flu-like symptoms. x 100 tabs	☐	
ibuprofen 400 mg po qid prn for aches, pains, and flu-like symptoms. x 100 tabs	☐	
cloNIDine 0.1 mg po bid prn for sweating and withdrawal pain. x 30 tabs	☐	
dimenhyDRINATE 50 mg po qid prn for nausea or vomiting. x 30 tabs	☐	
loperamide 2 mg po qid prn for diarrhea. Stop laxatives if loperamide started. x 30 tabs	☐	
Use sleep hygiene for insomnia Pharmacist to please provide education.	☐	
Use meditation, relaxation, and mindfulness Please enroll in the U of R pain course at www.onlinetherapyuser.ca/pain	☐	
***naloxone kit** for injection, 2 vials of 0.4 mg/mL in case patient restarts opioids at high dose. x 1 kit	☐	
other: e.g. oxybutynin (for sweating), melatonin (for sleep), hydrOXYzine (for itchiness or anxiety), traZODone (for sleep), prochlorperazine (for nausea), hyoscine …		

Refill ________ times

Physician name: ________________________________

Physician signature: ________________________________

Sleep Hygiene – some examples

- limiting stimulation near bedtime e.g. caffeine, nicotine, alcohol, TV, late exercise, late heavy dinner
- keep a consistent bedtime and waking time, avoid naps, and only use the bedroom for sleep and sex
- use meditation or relaxation exercises
- avoid clock-watching

***Naloxone Kit**

- Full Rx benefit for NIHB patients.
- In Sask, available for free with training at certain locations to people at risk of, or who may witness an overdose.
- More info at: www.skpharmacists.ca/patients/naloxone

Exercise Prescription (to improve fitness self esteem & sense of wellness)

- Planned exercise or activity is often very helpful! Can be flexible to do more on good days, and less on poor ones. http://www.rxfiles.ca/rxfiles/uploads/documents/Exercise-RxFiles-Rx.pdf

Notes: a) with very gradual opioid tapers, withdrawal symptoms may be minimal and not require treatment
b) this prescription template available in pdf and modifiable MS Word format from www.RxFiles.ca; http://www.rxfiles.ca/rxfiles/uploads/documents/RxFiles-Pain-and-Opioid-Resource-Links.pdf

Assessment of Withdrawal from Opioids: The Subjective Opiate Withdrawal Scale (SOWS)

Name: ______________________________ Date: ______________________________

Health Card: ______________________________

This is a self-administered scale for grading opioid withdrawal symptoms. It contains 16 symptoms whose intensity the patient rates on a scale of 0 (not at all) to 4 (extremely), and takes less than 10 minutes to complete.

Patient Instructions: **please score each of the 16 items below according to how you feel right now. Circle one number only.**

	SYMPTOM	NOT AT ALL	A LITTLE	MODERATELY	QUITE A BIT	EXTREMELY
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goosebumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4

Range 0-64. Handelsman, L., Cochrane, K. J., Aronson, M. J. et al. (1987)
Two New Rating Scales for Opiate Withdrawal, *American Journal of Alcohol Abuse*, 13, 293-308.

Total Score: ________________________

MOTIVATIONAL INTERVIEWING for promoting behavioural change

A Crawley BSP, ACPR © www.RxFiles.ca April 2018

"There is something in human nature that resists being told what to do. Ironically, acknowledging the right and freedom not to change sometimes makes change possible." -Rollnick & Miller
"People are generally better persuaded by the reasons which they have themselves discovered than by those which have come in to the mind of others." -Pascal

Clinical Pearls

- Motivational interviewing is a refined form of guiding. It works by activating a patient's own motivation for change & adherence.
- People tend to believe what they hear themselves say, and tend to be ambivalent towards change. If you are arguing for change, and your patient is arguing against, this only re-enforces the status quo. However, if you elicit Change Talk from your patient, the patient will hear their own desires, abilities, reasons, and needs for change. Change then becomes more likely.
- Motivational interviewing attempts to guide rather than badger, encourage rather than shame, and negotiate rather than dictate.

Important Definitions

Open question: requires more than a yes/no answer.
Reflection: a short summary of what is happening at that moment, said in somewhat different words (i.e. not parroting). May include continuing the paragraph of what the patient is saying (anticipating what is still unsaid).
Confidence: belief in ability to change
Conviction: belief that change is important

Overview

What is Motivational Interviewing? A theory that listening skills and understanding patient motivations can empower a patient. Uses a *guiding* style (see Step 2 below), rather than a prescriptive style. Overall goal is to watch for and encourage Change Talk.
What is Change Talk? See Table 1 - patient statements that indicate a desire, ability, reason, or need for change.
What do I do with Change Talk? Collect it! As the conversation progresses, take note of change talk; reflect it back to the patient. As the conversation closes, present collected Change Talk back to the patient in a summary (see Step 3 below).

Table 1: Change Talk (DARN)
Desire (I *want* to, I would *like* to, I *wish* ...)
Ability (I *could*, I *can*, I *might be able* to ...)
Reasons (It *would be better* if ...)
Need (I *need* to, I *have* to, I really *should* ...)

❶ **Agenda Setting**: raise the subject of behaviour change and ask permission to talk about it.

❷ **Guiding**: guide the patient towards Change Talk through *Listening*, *Asking*, and *Informing*.

Change Talk statements are like flowers in a meadow of conversation, which you pick out with the intention to give back as a bouquet for the patient.

Skill	Why / How / Comments
Listening *true* listening, i.e. without judgment, avoiding road-blocks, and with full attention (silencing even inner chatter)	• **Purpose**: to create an environment amenable to Change Talk. Additionally: to gather high-quality information; to improve your relationship with the patient; to contribute to your own job satisfaction. • **How to do it**: create the environment through eye contact, lack of distraction, and open questions. Use reflection & "continue the paragraph". Patients who feel ambivalent have both sides of the argument within them, and they will often back away from resistance when you reflect nonjudgmentally (i.e. "roll with resistance"). *The urge to correct and direct can be strong, and sometimes appropriate. But in an ambivalent patient, continuing with reflections can lead to the patient making their own arguments for change.* • **Useful tips**: Choosing what to reflect is critical. In particular, reflect back Change Talk (to help patients explore it more) & reflect back resistance in ambivalent patients (rather than arguing against it). Reflections will be confirmed or disconfirmed by the patient; but either way the patient will continue to elaborate (there is no penalty to guessing wrong!). When reflecting, inflect the voice down to end sentences (as in statements) rather than up (as in questions). See **Tapering Opioids Using Motivational Interviewing** for examples of reflection in action. • **Where it goes wrong**: Roadblocks to good listening include agreeing, disagreeing, instructing, questioning, warning, sympathizing, suggesting, analyzing, persuading, shaming, and arguing. To truly listen, your full attention is given to hearing and understanding the patient. (Gives new meaning to the expression 'attending physician'!)
Asking in the service of guiding, with the intent to elicit Change Talk	• **Purpose**: to create an invitation for the patient to weigh his or her choices; to elicit Change Talk. • **How to do it**: see Table 2 for examples of open questions that encourage Change Talk. • **Useful tips**: Assess confidence and conviction towards change (e.g. on a scale of 1 to 10). Can be useful to ask *why* a patient scored themselves a certain way (*Why did you put your confidence at 6, and not 1? What would it take to get you to 8?*). For patients less ready for change, hypotheticals can be less threatening ("*Suppose ...*"). • **Where it goes wrong**: multiple questions in a row can promote resistance - use listening (reflections) in between. As well, avoid asking patients why they don't change (*why can't you, why don't you, why haven't you ...*) as this will only elicit defense of the status quo.
Informing only after asking permission, and not in the style of a lecture	• **Purpose**: to provide information, but only as a guide, NOT as a director. • **How to do it**: *Elicit-Provide-Elicit*. First ask for *permission* to provide information (Elicit). Then, Provide. Last, follow-up to determine the patient's *response* to the info (Elicit again). • **Useful tips**: When providing information on options available, provide several options at once. This way, the patient has choices, but is less likely to "shoot down" each choice in turn. • **Where it goes wrong**: when used to argue, badger, or instruct patients on what they must do. The prescription "*You have to make these changes*" is an empty one, for of course patients don't have to do what they're told.

Table 2: Questions to Promote Change Talk
How confident are you in your ability to change? [Confidence]
How important is it to you to make this change? [Conviction]
Why might you want to make this change?
If you did decide to make this change, how would you do it?
What are some benefits you see in making this change?
Suppose you decided to change. How would life be different?
Suppose you continued without changes. What may happen in 5 years?

Eliciting Permission	Eliciting Response
May I make a suggestion?	*How does that feel to you?*
You can tell me what you think of this idea ...	*What more would you like to know?*
What would you like to know about this?	*What do you think about that?*
What do you already know about this?	*What approach makes sense to you?*

❸ **Summarizing**: Here you will present your collected Change Talk. This is a very important step - the patient will hear their own accumulated arguments for change collected together, perhaps for the first time. *"Let me see if I understand you correctly, and do let me know if I've missed anything."*

❹ **"What Next" Questions**: These test for a patient's level of commitment. If the patient is ready (don't push!) see if they are able to express their behaviour change with specific what, when, and how intentions. "*What would be a first step?*", "*What are you going to do?*", "*How will you do it?*".

❺ **Follow-up**: If a low level of commitment is detected, a further exploration of Change Talk is needed (perhaps at next visit). Planting a seed is valuable too. Patients who have high commitment also need follow-up ... to see what steps they took, how it worked, and to ensure their motivation stays high.

MI can seem both comfortingly familiar and difficult to integrate. Think of it as a refined version of your normal approach. With regular practice, using MI can become second nature.

Potential Conversation Starters

- *How do you think the opioid is helping?*
- *What concerns do you have about the opioid?*
- *What concerns do you have about tapering?*
- *How concerned are you about driving?*

Lets assess your pain & function
& see whether the opioid has been helping at all.

You need to know that
we're not going to pull the rug out from under you!

Motivational Interviewing Alignment

1) Ask:
- What would be the upsides & downsides from your perspective?
- How is your life now, compared to before the opioid started?

2) Reflect:
- So opioids just take the edge off, but you're worried about what they are doing to you
- Sounds like you don't want to be on, but you're afraid to come off
- You think nothing else will work
- It sounds like your pain medicine isn't helping you do what you want.

3) Listen carefully, then link pros and cons (if any):
- So on the one hand, you aren't getting much benefit & you're worried about all the risks. You're also scared about withdrawal & not having something for your pain.

4) Ask permission to provide information:
- Review benefits and harms (sleep apnea, hormonal, mood, hyperalgesia, overdose)
- Tapering strategies – what it might look like, and the support you will provide
- Tell some stories about what other patients have found

Adapted, in part, from Laura Murphy 2017

Motivational Interviewing – Sample Script to Explore Opioid Tapering

Doctor: Hi Mrs. Johnson. It's very good to see you again today. When I saw you a few months ago we talked a little about your chronic low back pain. I'm wondering, how are things going with that?	*Agenda setting.* *Open-ended question.*
Mrs. Johnson: Um, not that well actually - I was hoping to talk to you about that today too.	
Doctor: Can you remind me what you're taking for pain?	*Open-ended question.*
Mrs. Johnson: Right now I take my long-acting morphine twice a day. And I take my short-acting morphine four times a day - usually around each meal and before I go to bed. And I take Tylenol at the same time as my morphine.	
Doctor: And it's not going as well as you'd like.	*Reflective listening.*
Mrs. Johnson: That's an understatement. Doctor, the pain is so terrible. I wake up, I feel like crap. Most days I can hardly get out of bed. It doesn't really get better throughout the day. So I can't do any of things I want.	
Doctor: You'd like to do a lot of things, but you just can't.	*Reflective listening.*
Mrs. Johnson: If I could just move normally! I want to play with my kids - and keep up with chores around the house - but it's impossible!	*Signs of change talk - desire.*
Doctor: Your pain drugs just aren't helping you do what you want.	*Reflecting back change talk.*
Mrs. Johnson: Exactly. Doctor, I would do anything to get rid of the pain. Which is why I came to ask you if we could go up on the dose again.	*Signs of change talk - desire.*
Doctor: In the past, when we increased the dose you were able to play with your kids and keep up with chores.	*Reflective listening.*
Mrs. Johnson: Welllll, not exactly. But I definitely felt better.	
Doctor: The higher dose of morphine made you feel better.	*Roll with resistance.*
Mrs. Johnson: Right. I felt like I could forget about the pain. And it's not like I'm on a high dose or anything.	
Doctor: You haven't really noticed any problems with your dose of morphine.	*Still rolling with resistance.*
Mrs. Johnson: Well, I wouldn't quite say that. I do feel just a little out of it sometimes. Like my kids have to repeat things to me sometimes.	
Doctor: And that bugs you a bit.	*Reflective listening.*
Mrs. Johnson: Yeah, I think, "I'm only 43! And I feel like I'm 90!"	*Change talk - reasons.*
Doctor: It doesn't feel good to feel that way. You're wondering if it's the morphine that's making you feel that way.	*Reflecting change talk.*

Mrs. Johnson: Oh, it's definitely the morphine. But what am I supposed to do? I can't go without it.	
Doctor: May I make an observation?	*Eliciting permission.*
Mrs. Johnson: Yes.	
Doctor: This may surprise you. It sure surprised me when I first heard about it. But for some people out there, when we go higher on their narcotic dose, their pain actually gets worse. And so this may seem hard to believe, but for these folks when we give them less morphine they actually have less pain.	*Providing information.*
Mrs. Johnson: Well, that can't be me.	*Defensive.*
Doctor: That doesn't quite ring true to you.	*Reflective listening to diffuse defensiveness.*
Mrs. Johnson: I know it's not true for me. How can it be? When I'm late in taking my morphine, I notice it right away. The pain comes back right away. So the morphine is definitely doing something.	
Doctor: You feel the morphine is helping, because you have pain when you don't take it.	*Reflective listening.*
Mrs. Johnson: Exactly.	
Doctor: May I make another observation?	*Eliciting permission.*
Mrs. Johnson: Of course.	*Reflective listening has helped diffuse her defensiveness.*
Doctor: What you just said doesn't really surprise me. We know that with opioids, the body gets used to having them there. And so when they're gone, even for a short period of time, the body feels pain from withdrawal. It's kind of like people who have a lot of salt in their diet - they need to keep putting lots of salt on their food to even taste the salt. If they start using less salt, everything tastes bland for a while. But after a few weeks, their taste buds adapt, and they find they don't really miss the salt any more. In fact, if they have a bowl of canned soup, it will taste too salty for them.	*Providing information.*
Mrs. Johnson: Hmm.	
Doctor: What do you think about that?	*Eliciting response.*
Mrs. Johnson: I'll be honest: I'm skeptical. You remember the reason we started the morphine in the first place was we had tried other stuff and nothing had really helped. And so we wanted to try something stronger. And now you're telling me that even the strong stuff isn't going to work. And so what's left? I remember how bad the pain was before we started morphine. So now I have to go back to that?	
Doctor: You're worried that without morphine things will be miserable for you.	*Reflective listening.*
Mrs. Johnson: Yes.	
Doctor: I promise that we'll work together on this. I hope it will make you feel better to hear that I'm not going to abandon you, or suddenly stop your morphine. I also took a look back through your chart before you got here, and I know we tried quite a few things before the morphine, but I actually see a few things that we either didn't try or perhaps didn't give enough of a chance. If I told you that with or without the morphine, we will still aggressively try to get your pain down, how would you feel about that?	*Reassurance.* *Providing information.* *Reassurance.* *Eliciting response.*
Mrs. Johnson: Well, it makes me feel better to know you aren't going to suddenly stop the morphine.	
Doctor: Good! Can I summarize a few things we've discussed? You've told me that the pain is very bad, and that you would do nearly anything to get rid of it. In fact, some days you can hardly get out of bed. What's really important to you is to be able to play with your kids, move around, and do chores around the house. You've been using morphine, at a fairly high dose, but it hasn't really been helping you to do the things you want to do. It also seems like it's making you feel a bit doped up. You're a little nervous about backing down on the morphine dose, but you might be willing to give that a shot as long as we are trying other stuff to control your pain. Is that a fair summary?	*Presenting collected change talk.*
Mrs. Johnson: Yeah, all of that's right. Doctor, I really do want to get this pain under control.	*Change talk - desire.*
Doctor: Well, we are on the same page there. I want your pain to get better too. I have a few suggestions we might consider, if you want to hear them.	*Finding common ground.* *Eliciting permission.*
Mrs. Johnson: Fire away.	
Doctor: OK! The first is that the University of Regina has an online pain management course that I think you might find helpful. They teach some mental skills that can help control your pain symptoms. I've seen a lot of success with this course. The second is that I notice that you tried yoga for your back pain a couple years ago, but felt it didn't help that much. It seems like you did it for a couple weeks or so, is that right?	www.onlinetherapyuser.ca/pain *Presenting numerous options at once prevents the patient from shooting each option down individually.*
Mrs. Johnson: Right.	
Doctor: One thing about yoga for low back pain that a lot of folks don't realize, is that you actually	Tilbrook HE, Cox H, Hewitt CE, et al. *Yoga*

need to do it daily for about 3 months before it starts making a difference. So we could consider giving that a shot again. The third thing I was going to mention is that there's a drug we haven't tried yet for low back pain. It's called duloxetine, and while it doesn't help everybody, it's certainly worth a shot. It works to help numb some of the nerve endings, so that they don't send so many pain signals to the brain. From what I can see, you haven't tried that medication yet. And the fourth thing, of course, is that I'd like to see what happens if we give you a little less morphine. I know it seems counter-intuitive, but you might actually have less pain if you were on a lower dose. Right now you are taking a relatively large long-acting dose and a relatively small short-acting dose. So what I'm thinking about doing is continuing with the same long-acting dose, but holding off on the short-acting dose for now. I'd like to see how that goes. Of all those things I just mentioned, what makes sense to you?	*for chronic low back pain: a randomized trial.* AnnInternMed. 2011;155:569–578 Skljarevski V, Zhang S, Desaiah D, Alaka KJ, Palacios S, Miazgowski T, Patrick K. *Duloxetine versus placebo in patients with chronic low back pain: a 12-week,fixed-dose, randomized, double-blind trial.* J Pain. 2010 Dec;11(12):1282-90.
Mrs. Johnson: Well. I can't imagine starting to do yoga while at the same time getting off morphine. I'd be in way too much pain to even think about yoga.	
Doctor: But other than that, the idea of yoga does appeal to you?	*Reflective listening.*
Mrs. Johnson: Yeah, a little.	
Doctor: What are some of the benefits you see in starting to do yoga?	*Asking - to promote change talk.*
Mrs. Johnson: I know some friends that do it, and they seem to get a lot of benefit. Just in terms of overall fitness. I really should exercise more, I know that. Maybe yoga could help.	*Change talk - need.*
Doctor: You want to exercise more. It's important to you.	*Reflecting back change talk.*
Mrs. Johnson: Right.	
Doctor: And yoga or pilates might be one way for you to do that.	*Reflective listening.*
Mrs. Johnson: Definitely. But again, I think I'm in too much pain to even start.	
Doctor: So doing yoga would be valuable, but you're just not confident in your ability to do it. May I ask, what would give you a bit more confidence?	*Reflective listening.* *Asking - to promote change talk.*
Mrs. Johnson: Well, if I just had a little less pain, I could probably do the yoga. Finding the time isn't the issue. It's just so hard to do something when you know it's going to hurt so bad.	*Change talk - ability.*
Doctor: How about this. What if I gave you 30 short-acting morphine tablets each month, which you would take half an hour prior to doing yoga each day? Is that a fair compromise?	
Mrs. Johnson: Yes ... I bet I could do that. And we'd leave the long-acting morphine alone?	*Change talk - ability.*
Doctor: Correct. Sounds like this is something you'd be willing to try, as long as we did it gradually. Do you want a recommendation from me on a good yoga website or studio?	*Reflecting back change talk.*
Mrs. Johnson: That would be helpful, yes.	www.doyogawithme.com/content/yoga-for-lower-back
Doctor: OK. Now, I want to warn you, that usually with these morphine dose decreases, at first the pain will be worse.	
Mrs. Johnson: Oh, great.	
Doctor: I agree, that's going to be a challenge. But what we tend to find is that the increase in pain is only temporary. So what I'm hoping is that if you can stick it out, your pain should actually go down in the long run. Especially if you stay committed to the yoga. What do you think about that?	*Reflective listening.* *Providing information.* Frank JW, et al. *Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review.* Ann Intern Med. 2017 Aug 1;167(3):181-191.
Mrs. Johnson: I guess, if you think it's going to help my pain, we could give it a try.	*Change talk - ability.*
Doctor: OK! Let me just summarize things again. I know your pain is very bad. We talked a bit about how it's possible the morphine you're on is making it worse, not better. You really want the pain to get better, so we'll try a very small decrease in the dose of morphine and see if that helps. You want to exercise more, so you'll start doing yoga daily, and I'll give you some short-acting morphine that you can take before each yoga session. I'm also going to give you an Exercise Prescription to help remind you how much yoga you should be doing. Maybe try starting the yoga a week from now, to give your body some time to get used to being on a little less morphine. Just as a heads up, I'm going to give your pharmacist a ring and tell her the plan too, so that we're all on the same page. That's a lot that we've talked about today. A minute ago you said that you were willing to give it all a try. Is that still the case?	*Presenting collected change talk.* www.rxfiles.ca/rxfiles/uploads/documents/ Exercise-RxFiles-Rx.pdf *Asking for commitment.*
Mrs. Johnson: I think it's going to be hard. But I'm going to do it. This pain has to get better.	
Doctor: Excellent. I'd like to see you in a month or so to see how things are going. You seem motivated and I hope that keeps up! Remember, I'm here for you.	

Opioid Tapering- Information for Patients

Why should I taper or decrease my opioid medication?

Taking high doses of opioids may not provide good pain relief over a long period of time. The amount of pain relief from opioids can become less at higher doses because of tolerance. Sometimes, opioids can actually cause your pain to get worse. This is called "opioid induced hyperalgesia".

The many side effects of opioids increase with higher doses. Sometimes people using opioids do not connect certain side effects to the medication. That is why many people who try a gradual taper to lower doses, report less pain, and better mood, function and overall quality of life. Sometimes, it is only after such a taper that patients appreciate how opioids were not helping as much as they thought.

What are the side effects of opioid therapy over the long term?

Some of the adverse effects of opioid therapy over the long term include:

- *Tolerance*- The medication becomes less effective over time with patients needing higher doses of opioid to achieve the same level of pain control. By itself, this does not mean patients are addicted, although in some patients it is part of addiction.
- *Physical dependence* –If you abruptly stop or decrease your opioid dose by a large amount, you may experience unpleasant symptoms called withdrawal. This is an expected response to regular opioid therapy that is not the same as addiction. *One of the early symptoms of withdrawal is an increase in pain, which is temporarily improved by taking more opioid*. *Many people on long-term opioids believe that this proves that the opioid is working, rather than being a symptom of withdrawal that will lessen with time.*
- *Constipation*- leading to nausea and poor appetite and less commonly, bowel blockage.
- *Drowsiness causing falls, broken bones, and motor vehicle accidents*
- *Fatigue, low energy, depression* -This can significantly affect your function and ability to work or do day-to-day activities.
- *Sleep apnea or impaired breathing while sleeping* – This can contribute to daytime fatigue and poor thinking ability. It increases your risk for many health conditions and also increases your risk of having a car accident.
- *Low testosterone hormone levels in men* – This can lead to low sex drive, low energy, depressed mood, slower recovery from muscle injuries and decreased bone density (thinning of the bones).
- *Low estrogen and progesterone hormones in women*- leading to decreased bone density and low energy.
- *Pain can get worse in some people, especially at higher doses (opioid-induced hyperalgesia)*

What can I expect when tapering or decreasing my opioid medication?

1. *Pain*- One of the first symptoms of opioid withdrawal is increased pain. This pain may be the same pain that you are being treated for, as well as total body joint and muscle aches. Some people will complain of a recurrence of pain at the site of an old healed injury, such as a broken bone. Taking a dose of opioid reduces all of the above pains – but only temporarily. The pain associated with withdrawal generally passes in most people within 1-2 weeks, and is lessened by tapering doses very slowly. Many people report that the pain that the opioid was originally being taken for does not worsen when opioids are reduced.

   In order to manage any withdrawal mediated pain, prior to reducing your opioids, you and your doctor should develop a plan to deal with this pain. This can include non-drug strategies such distraction, activity, stretching, meditation, and heat or the use of some non-opioid medications. Treating withdrawal pain with opioids delays the taper process.

2. *Withdrawal symptoms* - Opioid withdrawal symptoms can be very unpleasant but are generally not life threatening. However, they sometimes cause people to seek opioids from non-medical sources, which can be very dangerous. Therefore, it is advisable to talk with your doctor regarding a safe approach to gradual tapering. Withdrawal symptoms are similar to a flu-like illness and can begin 6-36 hours after your last dose of opioid. If you stop most opioids quickly or suddenly, withdrawal is most severe 24-72 hours after the last dose, and will diminish over 3-7 days. Some people will feel generally tired and unwell for several weeks and may feel "down" or not quite themselves for several months, particularly if they have been taking very high doses of opioids. If you choose to decrease your dose slowly (over several weeks or months), withdrawal symptoms are usually much less severe. Your doctor may prescribe some non-opioid medications (such as clonidine and others) to help reduce the severity of withdrawal symptoms. You may experience some or all of the following during withdrawal:
    - Sweats, chills, goose flesh
    - Headache, muscle aches, joint pain
    - Abdominal cramps, nausea, vomiting, diarrhea
    - Fatigue, anxiety, trouble sleeping

   These withdrawal symptoms usually resolve with time. A severe increase in your pain that results in a decrease in your daily function that does not reduce over 3-4 weeks is less likely to be due to withdrawal and should be re-evaluated by your doctor.

How do I taper?

Preparation

1. Enlist support from family, friends and all your healthcare team.
2. Make a plan to manage any withdrawal related pain.
3. Make a plan to manage any withdrawal symptoms including anxiety and trouble sleeping.
4. Learn and practice non-drug pain management strategies.
5. There may be times when the withdrawal symptoms have been really severe, and you are not ready to take the next step. Formulate a plan with your doctor and pharmacist for when you may need to pause or slow down a taper. It is OK to take a break, but the key point is to try to move forward with the taper after the pause.
6. Remember that the long term goal is improved pain control and quality of life while reducing potential harms of treatment.

Reductions in opioids can be carried out in many ways

1. Fast – Simply stopping your opioids immediately, or reducing rapidly over a few days or weeks will result in more severe withdrawal symptoms, but the worst will be over in a relatively short period of time. This method is best carried out in a medically supervised withdrawal center. Ask your doctor if such a center exists in your community.
2. Slow – Gradual dose reductions of 5 to 10% of the dose every 2-4 weeks with frequent follow-up with your doctor is the preferred method for most people. If you are taking any short- acting opioids it may be preferable to switch your total dose to long acting opioids taken on a regular schedule. This may make it easier for you to stick to the withdrawal plan. A pharmacist can help lay out a schedule of dose reductions.
3. Methadone or buprenorphine-naloxone – Another strategy that may result in less severe withdrawal is a switch to methadone or buprenorphine-naloxone and then gradually tapering off. This requires a doctor trained to use these medications but can be an alternative to the "Slow" method noted above.

Additional Materials to Support Patient Safety and Discussions Around Opioids

OPIOIDS

Questions about opioids, and the Answers that may SURPRISE YOU

A booklet for people who may benefit from reducing or stopping their opioid

This 12 page patient booklet addresses:

- common patient questions and concerns about opioids and opioid tapering
- two opioid tapering success stories from patients *in their own words*
- insights on the complex interplay between chronic pain, opioids and why they sometimes do more harm than good

See www.RxFiles.ca/PainLinks to access this and other patient resources for pain management.

Take Home Naloxone:

- Injectable and intranasal formulations available
- potentially life-saving for those at risk of opioid overdose
- now available without a prescription
- in many cases, patients may be able to obtain a kit at no charge (in SK Take Home Naloxone is available to those who may witness an opioid overdose and who successfully complete an overdose prevention program)

For more information on Take Home Naloxone in SK:
http://publications.gov.sk.ca/documents/13/99221-Program%20Kits-Community%20Resources-Jan-29-2018.pdf

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