Opioid Medication Tapering Guide for Healthcare Providers Caring for Injured Workers with Chronic Pain

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Introduction

This document provides information to help healthcare providers achieve success in working with their injured worker patients to achieve safer and more effective pain control, decrease opioid risks, and reduce their dependence on long-term, high dose opioid medications. It represents a public health perspective, drawing on recommendations from the medical and public health literature, state workers' compensation statutes, and public health agency guidelines. The goal of a taper is to improve the patient's physical and mental wellbeing by reducing physical and psychological dependence on opioids and giving them care, confidence, and skills to better manage pain.

Providers should never abandon patients or withdraw a prescription for opioids without a plan, even if the provider suspects that the patient is misusing or abusing the medication. The rapid physical withdrawal accompanying a loss of a prescription can have potentially lethal consequences. This guide aims to help you keep your patient safe and on the road to better health.

This guide covers when to taper opioid medications, patient engagement and pre-assessment, assessment, how to taper, harm reduction, pain and symptom management during tapering, and risks of tapering/discontinuation and patient protections. It is informed by the framework recommended by the CDC (see **Appendix A - 24 Points of CDC Tapering Recommendation**). Resource links that provide more information for clinicians and patients are at the beginning of each section.

When to Taper

Healthcare providers must decide with their patients when to discontinue or reduce opioid medications. The Centers for Disease Control and Prevention recommends opioid tapering for when the criteria below apply.

Resources: CDC Tapering Guideline, HHS Guide, MME calculator

According to the CDC Clinical Practice Guideline, opioid tapering should be considered when any of the following apply:

- The patient requests dose reduction or discontinuation
- Pain improves and might indicate resolution of an underlying cause
- Opioid therapy has not meaningfully reduced pain or improved function
- The patient has been treated with opioids for a prolonged period (e.g., years) and the benefit-risk balance is unclear (e.g., decreased positive effects because of tolerance and symptoms such as reduced focus or memory that might be due to opioids)
- The patient is receiving higher opioid dosages without evidence of benefitting from the higher dosage
- The patient experiences side effects that diminish quality of life or impair function
- Evidence of opioid misuse[1]
- The patient experiences an overdose or other serious event (e.g., an event leading to hospitalization or injury) or has warning signs for an impending event (e.g., confusion, sedation, or slurred speech)

[1] Misuse is a pre-clinical problematic pattern of opioid use including using others' prescriptions, hoarding, taking at higher doses, using for a reason other than prescribed, or using in any way that can cause harm to self or others. Opioid use disorder (OUD) is diagnosis detailed in the DSM-5. It is based upon the patient reporting certain behaviors, such as compulsive drug seeking and interference with relationships and work, etc. Patients with prescriptions are less likely to report aberrant behaviors and far less likely to be diagnosed with OUD.

- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., sleep apnea, pulmonary disease, liver disease, kidney disease, fall risk, or mental health conditions) that increase risk for adverse outcomes

Patient Engagement and Pre-Assessment:

Patients who meet one or more of the "when to taper" criteria above may or may not be favorably disposed toward a taper. For patients who are wary of a reduction in opioid medications, either because they fear withdrawal symptoms or uncontrolled pain or both, the challenge becomes how to engage the patient in the process and secure an affirmative agreement for tapering. A forced taper has limited chance of success. Thus, this section includes strategies for broaching the subject of tapering, eliciting, and understanding the patient's point of view, and promoting tapering as an option for the patient. This may be the most challenging aspect of tapering, particularly for patients who are physically and/or psychologically dependent upon opioids and who have experience with withdrawal symptoms, hyperalgesia, or tolerance.

Resources: Understanding motivational interviewing, SAMHSA motivational interviewing, Pain catastrophizing scale, Transtheoretical model of behavior change, Patient handout on opioid risks and benefits, Shared decision making, The art of difficult conversations, My Opioid Manager, Emotional Regulation Toolkit

Core Strategies for Patient Engagement

The first step in this process is to engage the patient in an exploratory conversation about tapering. Success is more likely when the patient is in agreement with the need for tapering, discontinuation, or medication-assisted treatment. The patient may have considerable anxiety, negative attitudes, and bad experiences that will profoundly influence this discussion. Always demonstrate concern and respect for the patient's lived experiences and knowledge base (Crawley et al., 2018).

Initiate a conversation about **the goals of care and set realistic expectations** for what a taper intends to achieve, such as:

- The patient will be able to do more activities with less pain.
- While the patient may not be completely pain-free, they will be able to better manage their pain.
- Tapering opioids reduces side effects and risk of overdose.

It may be helpful to **ask patients to visual themselves in the future** with better controlled pain, fewer side effects, and greater function and ability to do things they want to do. If possible, **provide testimonials** from individuals who have successfully gone through tapering (Furlan, personal communication, October 3, 2022). Helping them envision a future healthy state can i**ncrease your patient's confidence** in their ability to be successful and to have better health.

Assess your patient's baseline knowledge related to:

- How opioids modify the brain, tolerance, withdrawal, and hyperalgesia
- Opioid side effects and risks
- Clinical guidelines discouraging use of opioids for chronic non-cancer pain/lack of evidence of effectiveness
- Over-prescription of opioids by the medical community (Faculty of Pain Medicine of the Royal College of Anaesthetists, n.d.).

- Pain as a mind-body response
- Alternative pain management

Based on the patient's knowledge, provide **education** to complete their understanding. **Engage and educate the patient's family**, household, and others in their network on whom they rely for social support. These individuals should also be told what to expect during the taper and informed as to how they can be supportive throughout the process, such as by reminding the patient of potential positive outcomes. **Talk to all other providers** involved in the patient's care and ensure that they are providing clear, accurate, and consistent information about opioids and tapering.

When discussing why the patient should consider tapering, **give reasons that are specific and relevant to the patient**. For example, you can suggest that patient should consider tapering because they have a comorbid heart condition that increases risk, or they have said that they want to be able to do more activities with their grandchildren. A **personalized rationale** will be more effective than population-level concerns such as "too many people are getting addicted and overdosing" (Matthias et al., 2017).

Address patient concerns about "pain, abandonment, stigma, and safety" (Bree Collaborative, 2020). **Highlight the non-opioid pain management** that you and other providers will offer to the patient. For patients who have been on these medications for a long time, the fear of pain caused by tapering or discontinuing maybe more significant than the fear of overdose. This fear of pain may be *pain catastrophizing*, a phenomenon where chronic pain patients feel helpless in the face of their pain, think often about their pain, and fear that their pain will intensify (Leung, 2012). These **feelings should be validated** compassionately while also reminding the patient that one goal of tapering is to reduce these feelings through better pain management and less dependence on opioids.

Additional Strategies for Patient Engagement

Motivational interviewing can enhance patient readiness by strengthening motivation for and commitment to behavior change (Crawley et al., 2018). Allow the patient to express their perspective, including any resistance to change. When the patient speaks, listen for change talk, phrases like "I want," "I could," or "it would be better if," which indicate goals that may motivate them to make a change. Ask questions to create an opportunity for exploration of these motivations.

The **elicit-provide-elicit** technique can be used to build upon the patient's curiosity about a taper. First, ask the patient if they want to know more about something specific. If the patient agrees, give them the information. Then, ask the patient for their thoughts about or their response to that information. Throughout the conversation help the patient identify their motivations to change, summarize the conversation, and repeat the patient's motivations to reinforce them.

Shared decision-making is a framework to empower patients' involvement in their own care. This involves giving the patient information about the decision-making process, including the risks and benefits of continuing at the patient's current dosage of opioids and the risks and benefits of tapering opioids. Make your expectations and limitations clear: Will you continue to prescribe the same dosage of opioids if the patient is not ready to taper? What support will you provide through continuing or tapering the prescription? Review alternative pain treatment and management strategies with the patient and develop the taper plan together.

The BRAVO protocol (Lembke, 2018) the protocol is divided into five steps, with each letter standing for one step.

- *Broaching the subject*. Acknowledge, identify, and normalize patient anxiety. Communicate that a taper is not a punishment but has been carefully considered for the benefit of the patient's health.

- *Risk-benefit calculation*. Discusses the patient's current pain and function, and the risks and benefits of continuation versus tapering.
- *Addiction happens*. Reassure the patient that addiction and opioid dependance are normal and treatable.
- *Velocity and validation*. Prepare the patient for withdrawal, validate their experiences, and prescribe medications to help mitigate withdrawal symptoms. Make sure not to taper too fast and to never reverse a taper.
- *Offering strategies* for coping with pain, including non-opioid medications and pain therapies, mindfulness, and skills for emotional regulation.

Not all patients will be immediately ready to begin a taper. Assess the patient's readiness level and respond with an appropriate intervention (Cigna, 2019). **If the patient is open** to the idea of specialist referral and/or care coordination to address their pain and behavioral needs, you can proceed with referral. **If the patient is ambivalent** about specialist referral and/or care coordination, educate them about the specialized care that can be provided to them, the risks of long-term opioid use, and the potential benefits of tapering. This type of patient may also agree to meet with a specialist or care coordinator with you to become more comfortable with the idea of seeing them. **If the patient is resistant to referral or any change in opioid use, continue to work with the patient, provide information, and encourage referral again at a later date.** Reassure the patient that no changes need to take place now and schedule the next visit to continue the preassessment and engagement, ideally within a month's time. Educate the patient and their family about **overdose prevention** and should prescribe, recommend, and/or **provide naloxone**.

Assessment

This section discusses what to do once a **patient has agreed to tapering.** This includes assessing comorbidities that may make continued opioid use more dangerous and/or may make tapering more difficult. It may be impossible, difficult, or dangerous to engage in tapering without addressing these comorbidities, biopsychosocial conditions, contextual factors such as previous failed tapers, and other red flags. You may also need to assess the patients' other resources/insurance that may play a role in setting them up for a successful taper.

Resources: ACE questionnaire, PHQ-9 depression questionnaire, PC-PTSD-5 screen, Fact sheets about opioids during pregnancy and breastfeeding, SUD assessment, STOP BANG assessment for respiratory depression, Sample biopsychosocial assessment criteria, Opioid risk tool (ORT), PEG scale of pain intensity and interference

The most important component in assessment is **developing a treatment plan that addresses the taper as well as pain, function, and comorbidities**. Comorbid conditions that can complicate pain management include depression, anxiety, sleep disorders, suicidality, PTSD, adverse childhood experiences (ACE), alcohol misuse, and substance use disorder (Bree Collaborative, 2020; Veterans Health Administration, 2016). Respiratory, liver, and kidney conditions can increase the risk of continued opioid use (Veterans Health Administration, 2016). If patient is pregnant, consider postponing the taper and ensure the patient will deliver at a facility equipped for the treatment of neonatal opioid withdrawal syndrome (Centers for Disease Control and Prevention, 2021)

The plan should include **treatment for opioid side effects** and treatment for pain in coordination with any relevant providers. **Consider the specialists** who should be engaged based on the patient's needs, e.g., social workers, psychologists, and/or rehabilitation specialists.

Consider **prescribing naloxone** and instructing the patient and their family in overdose prevention, especially when the patient Is on a high dose of opioids, uses medications that increase risk, or has comorbidities.

The patient's **current non-opioid pain management practices** should also be assessed. Medications that can increase the risk of opioid use include benzodiazepines, gabapentin, and z-drugs. If a patient is using both opioids and benzodiazepines and would like to taper off of both, the patient should begin by tapering the opioid, then benzodiazepines (Agency Medical Directors' Group, 2015). **Discuss the effectiveness of the patient's current strategies**, reinforce effective strategies, suggest modifications or replacements for ineffective strategies, and encourage the development of pain management skills.

If the patient has **previously attempted a taper** or discontinuation, discuss the reasoning behind the attempt and why the taper was unsuccessful or impermanent. Barriers identified to previous attempts should be discussed to determine how to best overcome them in this taper.

Self-efficacy is a person's belief in their own ability to perform specific behaviors and reach specific goals (Sharma & Romas, 2012). There are multiple strategies that a provider can use to help a patient improve their self-efficacy:

- **break down patient goals into small, practical steps**, like starting on a slow taper and teaching them one new pain self-management technique
- reference a **credible role model**. You may be able to connect the patient with someone else who has successfully tapered from long-term high-dose opioids and is willing to discuss their experience.
- reassure the patient that you **believe in their ability to succeed** and talk through the support that will be provided and, if applicable, **how they will address challenges** that occurred during a previous taper event.
- **reduce the stress** associated with making changes. Teach relaxation techniques as part the treatment of plan and reassure the patient that they will not be going through this taper alone.

Patients should also be **assessed for problematic opioid use** and tapering challenges. These include biopsychosocial risk factors (see assessment questionnaire linked above). A patient's physical and psychological health should be understood to be connected with their social environment. Other challenges may be substance use disorder, misuse, aberrant behaviors, risk of respiratory depression, and previous overdose (Bree Collaborative, 2020).

Determine if the patient is using opioids in a way that is not consistent with their prescription by talking to the patient and consulting their prescription drug monitoring program. Questions to answer are: Does the patient have multiple prescribers? Does the patient often refill early? Does the patient have a history of lost or stolen medication? Does the patient have a history of diversion? Does the patient have a history of non-prescription opioid use?

You may determine that you would like a patient to have **urine drug screening** as a condition for future opioid medication prescriptions. Inform the patient of the reason for testing, the frequency of testing, what results are expected, and what will happen if the test shows an unexpected result (Agency Medical Directors' Group, 2015). However, be aware that drug screening can be humiliating, erode patient-provider trust, and may not be effective in reducing opioid misuse (Collen, 2009; Starrels et al., 2010).

If red flags are identified related to the patient's use of opioid medications, explain to the patient that they are at increased risk from continued opioid use and they may need to be evaluated for **opioid use disorder.** Follow the diagnostic criteria of the DSM-5 and, if appropriate, refer the patient for substance use disorder treatment. If a patient has used non-prescription injected opioids, test the patient for hepatitis B and C and HIV and provide appropriate treatment. Again, it is essential that you **not abandon the patient** - work with them to achieve less opioid dependence and reduction in problematic use. This may include a transition to medication-assisted treatment for opioid use disorder.

How to Taper

This section details the rate at which opioids should be decreased during a taper as well as potential taper risks. There is a lack of consensus regarding taper rates, frequency of dose reductions, and taper durations. A taper plan should be developed that best supports the patient's pain and function and minimizes their health risks and withdrawal symptoms. Treatment "contracts" are also discussed.

Resources: VHA opioid taper decision tool, Cigna patient-centered safe opioid tapering resource guide, Alberta opioid tapering for chronic pain patients, HHS guide for clinicians on the appropriate dosage reduction or discontinuation of long-term opioid analgesics, NHS West Suffolk fentanyl patches tapering guidance

Taper Rate and Process

Dose reduction guidelines vary, but many recommend **reductions of 5-10% every 1-4 weeks.** Slower tapers may reduce by MME by 2% and/or make reductions every 2 months. Consider slow tapers for patients with high levels of anxiety, psychological dependence, comorbid cardiorespiratory conditions, or if they are elderly (Alberta Health Services, 2019). Patients who are very anxious about the taper may benefit from starting on a slower schedule, then increasing to a more typical rate. Patients on higher doses who have been on opioids for a longer time will have a longer taper and likely need a more gradual taper. You may consider a faster taper for patients using nonprescription opioids, in cases of diversion, or if the harms of continued opioid use greatly outweigh the benefits. Never use an ultrarapid taper.

Allow a patient to pause or slow the taper to promote reinforcement of non-opioid management strategies. The taper should also be slowed once ½ or ¼ of the original dose is reached. However, be aware that dose variability is associated with an increase in overdose risk. A **taper should rarely be reversed**; carefully discuss the risks and benefits with the patient and proceed with caution.

When switching medications, especially from fentanyl patches, the initial opioid dose should be reduced by 25-50% to account for variation in cross-tolerance (Intermountain Healthcare, 2020). For patients tapering from fentanyl patches, one suggestion is to taper by 12-25 µg/hour every 2-4 weeks. When the dose is 12 µg/hour, switch to morphine sulfate (NHS West Suffolk, 2018). It may be easier to switch the patient to an oral opioid for tapering.

When reducing the dose, the patient should **continue to take their daily doses at the same time** they normally would. Once the smallest available medication dose is reached, the time between doses should be extended (Oregon Health Authority, 2020). When the patient is taking only one pill per day of this smallest dose, the next reduction can be to no opioids (Fishbain et al., 1993).

To maintain the taper, **schedule visits at least once per week** to assess the patient's functional and pain status and provide continued reassurance and encouragement. Survey the patient on progress toward **personal health and function goals established at the onset**, and revisit and revise these goals each visit. Also, relay any strategies that have been of use to their other patients.

If the patient resists the taper, consider slowing or pausing the taper, increasing multidisciplinary support, and/or referring the patient to opioid use disorder treatment. Develop, with patient involvement, **a longitudinal care plan** after the taper is completed (Oregon Health Authority, 2020).

Taper Impacts, Risks, and Considerations

Inform patients of the potential **impacts of tapering** and discontinuation and take steps to manage these risks. These include withdrawal symptoms, mental health challenges, and hyperalgesia. **Opioid withdrawal** symptoms include nausea, diarrhea, muscle pain, myoclonus, and insomnia. These symptoms are treatable, although it may be appropriate to slow the taper to address them.

Tapering may unmask or **exacerbate a patient's underlying mental health conditions**. In this case, treat appropriately and involve other specialists and consider slowing the taper. Involve crisis response and/or a behavioral health specialist if the patient expresses suicidality. Involve behavioral health specialist before tapering for patients at risk for aberrant behaviors during taper (Oregon Pain Guidance, 2014) and engage addiction specialists if overdose is imminent or if the patient overdoses (Minnesota, 2021).

For **pregnant patients**, tapering may cause premature labor or spontaneous abortion (Minnesota, 2021). Another risk is **hyperalgesia (opioid-induced pain)**, which can be treated with non-opioid medication and non-pharmacologic strategies. **Acknowledge that this pain is normal but temporary**, and that many people have reduced pain after a completed taper. Consider whether maintaining the patient on a lower dose of opioids is appropriate, rather than tapering off opioids completely.

Tapering may also increase overdose risk. Caution the patient that **tolerance to a previous higher dose is lost in as little time as one week**, meaning that a patient returning to a dose that they were previously used to can result in overdose (Veterans Health Administration, 2016). Tapering could also inspire a patient to seek nonprescription opioids. Educate the patient on the dangers of this and consider opioid use disorder treatment, psychosocial support, and compliance testing.

Pain Management During Tapering

This section discusses non-opioid medications, non-pharmacologic pain treatments, and strategies for pain self-management**.**

Resources: CDC fact sheet on nonopioid treatments for chronic pain, Evidence summary of nonopioid pharmacologic treatments for chronic pain, Pacing activity leaflet, Tampa Scale of Kinesiophobia, Fear-Avoidance Beliefs Questionnaire, Patient PTSD handouts, How to sleep well with pain, Pain Neuroscience Education 101, This Might Hurt (film), DBT Skills: Opposite Action and Emotion Regulation

Non-Opioid Medications

Recommended **non-opioid medications** include treatments for pain, withdrawal symptoms, and side effects of opioid use. Adjunct medications that may be used during weaning include: clonidine (used off-label for withdrawal symptoms); trazodone, diphenhydramine, or hydroxyzine for sleep; acetaminophen, aspirin, or NSAIDs for pain; dicyclomine for abdominal cramps; Pepto-Bismol for diarrhea; and methocarbamol for muscle cramps. (see **Appendix C – Highlighted Medications**). Off label use of antidepressants, especially SNRIs, tricyclic agents and anticonvulsants may also be considered. When these are prescribed, be aware of side effects and drug interactions and share this information with the patient. Also discuss possible contraindications with the patient's general practitioner (Bruneau et al., 2018).

Over-the-counter pain medications, including non-steroidal anti-inflammatory drugs **(NSAIDs), acetaminophen, and topical medications** can provide pain relief and allow increased function for patients with chronic pain as well as for patients experiencing pain due to withdrawal (Dowell et al., 2022; Murphy et al., 2018).

Patients may also benefit from steroid injection therapies, including epidural, sacroiliac joint, or trigger point injections (Zhou et al., 2017).

Gabapentinoids have been widely used as an alternative therapy to opioids, recent research is conclusive that **they lack efficacy and introduce new harms**, especially for patients concurrently using benzodiazepines (Liu et al., 2021). Because benzodiazepines, z-drugs, and gabapentinoids can increase risk, these medications should be used with caution (Liu et al., 2021). In elderly patients, avoid using codeine and methadone (Agency Medical Directors' Group, 2015).

Cannabinoids are widely used for pain relief, and, in many states they are available with and without a prescription. However, there is a lack of consensus on their risks, benefits, and effectiveness, especially in the long term. Cannabinoids should not be the first attempted analgesic to replace opioids. If cannabinoids are being considered, a systematic review recommends that they be used concurrently with other pain-relief medications (Allan et al., 2018). Use of cannabinoids may be detrimental to brain, heart, lung, and mental health (CDC, 2022). Monitor the patient closely for effectiveness and signs of negative side effects, including cannabis use disorder (CUD). The extant DSM-5 criteria for CUD do not all apply for patients using cannabis medically. A proposed alteration is to exclude the "tolerance" and "withdrawal" criteria, as these are expected with medical use, and to only consider the remaining criteria for CUD (Chung et al., 2023).

Non-Pharmacological Pain Management

Best practices in pain management include:

- Comprehensive interdisciplinary pain management programs
- Patient education in pain self-management
- Cognitive Behavioral Therapy and related psychological pain management modalities, and
- Functional restoration through therapeutic coaching, physical activity, and touch therapies**.**

There is a wide variety of **non-pharmacological pain management** that can be used to address pain and help support the patient through and beyond the taper process. **Physical activity** and exercise may entail a home exercise program, graded exercise, yoga, progressive/resistive exercise, household functional tasks, and/or short walks (Hooten, 2020; Massachusetts Department of Industrial Accidents, 2016; Pullen, 2019; Veterans Health Administration, 2016). The goal of exercise is to increase the patient's flexibility, strength, and aerobic capacity (Oregon Pain Guidance, 2014). The best exercise program is one that the patient will adhere to (Furlan, personal communication, October 3, 2022).

The "big five" aspects of **pain self-management** are self-monitoring, relaxation, pacing, self-talk, and communication (Alberta Health Services, 2019). Self-management of pain includes the development of **"opposite action skills"** which enable the patient to do things which are the opposite of how they are feeling. In the context of pain, the patient practices doing activities that they enjoy and can reasonably perform despite some pain, while focusing on the activity rather than the pain (Lembke, 2018). These and other therapies can reduce the patient's tendency to catastrophize, i.e., associating moving and activities with worsening pain and physical harm.

Functional restoration is the acquisition of skills, knowledge, and behavior changes necessary to assume primary responsibility for their physical and emotional wellbeing. It encompasses coordinated care from multiple specialists, including physical or occupational therapists, rehabilitation specialists, and psychologists (Feinberg & Feinberg, 2011).

Pain neuroscience education (PNE) educates the patient on pain perception and hyperalgesia and helps them feel confident that their body is healthy. PNE is combined with exercise and body scans to show the patient that they can move without harm.

Behavioral pain management has the best evidence of effectiveness and should be considered for all patients. There are many types of behavioral therapies that may be beneficial for patients undergoing tapering, including cognitive behavioral therapy, dialectical behavior therapy, biobehavioral therapy, mindfulness, acceptance and commitment therapy, group therapy, and family therapy (Chandwani et al., 2008; Cigna, 2019; Davis et al., 2020; Hooten, 2020; Huffman et al., 2013; Minnesota, 2021; Nilsen et al., 2010; Rich, 2020; Veterans Health Administration, 2016; Wenger et al., 2018). The patient's needs and goals, as well as the specialists available to them, will help determine which type or types to pursue.

As appropriate, **engage specialists for the treatment of the patient's pain**, practicing warm handoffs and evaluating the qualifications and experience of other providers to ensure their suitability. Functional programs, physical therapy, and occupational therapy should all be considered. Additional approaches include **nutrition, hydration, sleep hygiene, deep breathing, mindfulness, acupuncture, massage, and Transcutaneous electrical nerve stimulation (TENS) therapy** (Minnesota, 2021; Oregon Pain Guidance, 2014; Pullen, 2019; Veterans Health Administration, 2016; Wenger et al., 2018).

Pain management approaches need to be tailored to the diagnosis, previous treatments, comorbidities, experiences, and preferences of each patient. Several approaches may need to be tried to determine what combination provides the most relief. The patient may have had negative experiences with non-opioid treatments for their pain and does not want to return to those treatments. Even if the patient is still in pain at their current dosage, they are likely afraid that reducing the dosage will cause the pain to increase. The patient knows what their pain felt like with no treatment, and, if applicable, what their pain is like when attempting a taper or when they have missed a dose of their medication. All of these experiences should be validated rather than dismissed in order to successfully encourage the patient to try alternatives.

Harm Reduction and Patient Protections

This section describes the principles of **harm reduction**, a framework based on respect rather than punishment for people who use drugs. This framework may be applicable to patients on long-term opioid therapy. Be aware that your patients may have probable opioid use disorder and may be unwilling to engage in treatment or opioid reductions. In those cases, it is vitally important that you do not abandon patients, despite their aberrant behaviors. This section focuses on preventing opioid overdose deaths in these patients. Additionally, we address prescribing "contracts" which are often not in the patient's best interests and can put providers in a difficult position. Be aware of patients' rights to confidentiality, informed consent, and participation in decisions about their medical care (see **Appendix B – Patients' Rights (Abridged**).

Resources: Opioid overdose response basics, Naloxone quick facts, Boston Public Health Commission overdose response training

According to the National Harm Reduction Coalition (2020), the principles of harm reduction are to:

- Accept, for better or worse, that licit and illicit drug use is part of our world and choose to work to minimize its harmful effects rather than simply ignore or condemn them
- Understand drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledge that some ways of using drugs are clearly safer than others
- Establish quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies
- Call for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm
- Ensure that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them
- Affirm people who use drugs themselves as the primary agents of reducing the harms of their drug use and seek to empower them to share information and support each other in strategies which meet their actual conditions of use

- Recognize that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm
- Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with drug use

For most patients using long-term opioid therapy, whether they are tapering or not, it is important to provide **naloxone, naloxone education, and overdose education to the patient and their family**. Discuss medication assisted treatment (MAT) with patients with diagnosed OUD. Both you and your patients should understand the extent to which **fear of pain is a highly motivating factor conditioning their drug-seeking behavior** (Frank et al., 2016). It is also important to recognize that the patient was prescribed high doses of opioids for their pain – they did not choose this dose independently. The patient's resistance to non-opioid pain management and independent medical exams, and other OUD behaviors, are both due to their physical dependence on opioids and their knowledge that their prescriber is in control of their access to medication and pain relief.

Opioid Prescribing Contracts and Tapering Agreements

Some guidelines call for a signed contract where the patient agrees to only use opioids in accordance with the taper plan and submit to drug testing. There is a **lack of evidence as to the effectiveness of these contracts** in promoting health and discouraging opioid misuse (Kay et al., 2018; Starrels et al., 2010). A patient may feel coerced into signing an agreement in order to continue their access to pain medication (Helft et al., 2014; Laks et al., 2021; Lieber et al., 2011). Having a patient sign such an agreement can diminish the patient's trust in you and increase the stigma they already feel as a chronic pain patient using opioid medications (Helft et al., 2014; Irwin et al., 2021). There is evidence that these contracts are disproportionately enforced in patients of color (Hausmann et al., 2013). Instead of a contract, **consider, instead, a treatment plan document** that is not signed (Fine, 2010; Ho, 2017).

If you decide to require a contract, the contract or agreement that lists expectations for patient behavior and responsibilities should also include **expectations for provider behavior** and responsibilities (Lieber et al., 2011; Rowe, 2010). The patient must be provided with information and treatments services that allow them to meet the expectations they agree to, within an achievable timeframe (Lieber et al., 2011).

An additional concern is that patients may not have the literacy level to understand treatment contract and may be unable to accurately understand and adhere to their terms (Albrecht et al., 2015; Bahniwal et al., 2018; Irwin et al., 2021). **Ensure that the patient understands the terms of the contract** or aspects of the treatment plan, provide a copy to them, and review it regularly. Inform the patient that **the contract is not a legal document**.

Abandonment must not be a consequence of contract violation. Know what you plan to do if a patient refuses to sign the contract, violates the contract, or, without a contract, does not adhere to the treatment plan or shows signs of opioid misuse, and clearly communicate these to the patient.

Conclusion

This guidance document presents a synthesis of public health and medical literature available as of April 2023. Physicians and other health care providers face difficult challenges when assisting patients on long-term opioid therapy. The guidelines can be used by clinicians to develop clinical policies and protocols to assist patients with safe, responsible pain management. They should be understood as guidelines, not strict rules. Work with each patient to develop a taper plan that works for them and their

goals, and do not be discouraged if patients are not immediately ready to begin tapering or face challenges during the taper. Misguided efforts to "cut-off" medication based on misuse can have tragic unintended consequences for overdose. It is critically important that providers maintain compassionate care even when they suspect medication misuse. Opioids can re-wire the brain and prompt drug-seeking behavior in anyone, including healthcare providers. This guide is meant to convey safe, compassionate, and effective approaches to reducing and/or eliminating dependence on opioid medications for injured workers. Comments and corrections are welcome via email to Cora_Roelofs@uml.edu.

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Appendices

Appendix A: 24 Points of CDC Tapering Recommendation (Centers for Disease Control and Prevention, n.d.; Danielson et al., 2021)

Suggested Instances to Taper

1) When the patient requests a dose reduction
2) When the patient does not have clinically meaningful improvement in pain and function
3) When on dosages ≥ 50 MME per day without benefit
4) When opioids are combined with benzodiazepines
5) When patient shows signs of substance use disorder (e.g. work or family problems related to opioid use, difficulty controlling use)
6) When the patient experiences overdose or other serious adverse event
7) When patient shows early warning signs for overdose risk such as confusion, sedation, or slurred speech

Suggested Ways to Taper

8) Develop an individualized tapering plan with the patient
9) Minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications
10) Taper slowly
11) Decrease of 10% per month if patients have taken opioids for more than a year
12) Decrease of 10% per week if patients have taken opioids for less than a year
13) Discuss the risk of overdose if patients quickly return to a previously prescribed higher dose
14) Use extra caution for pregnant women
15) Use extra caution for patients with an opioid use disorder
16) Offer psychosocial support, such as mental health providers, arrange for treatment of opioid use disorder, or offer naloxone for overdose prevention
17) Watch for signs of anxiety, depression, or opioid use disorder
18) Encourage the patient through the tapering process

Taper Considerations

19) Weigh the benefits and risks of opioids to make a decision about whether to continue, reduce, or discontinue use
20) Caution against abrupt tapering or sudden discontinuation
21) Adjust the rate and duration of the taper according to the patient's response
22) Should not reverse a taper
23) Once the lowest available dose is reached the interval between doses can be extended
24) Be considerate of inherited patients

Appendix B: Patients' Rights (Abridged)

Consumer Bill of Rights and Responsibilities (1997):

- "To fully participate in all decisions related to their health care"
- "To considerate, respectful care from all members of the health care system at all times and under all circumstances"
- "To communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected"

Massachusetts Patients' and Residents' Rights (2009):

- "To confidentiality of all records and communications to the extent provided by law"
- "To have all reasonable requests responded to promptly and adequately within the capacity of the facility"
- "To informed consent to the extent provided by law"
- "Upon request, to obtain an explanation as to the relationship, if any, of the physician to any other health care facility or educational institutions insofar as said relationship relates to his care or treatment, and such explanation shall include said physician's ownership or financial interest, if any, in the facility or other health care facilities insofar as said ownership relates to the care or treatment of said patient or resident"

Appendix C: Highlighted Medications

Symptoms	**Medications**
Withdrawal symptoms	Alpha-2 adrenergic agonists, buprenorphine, clonidine, doxepin, methadone, naltrexone, guanfacine, lofexidine, baclofen
Pain	NSAIDs, acetaminophen, topical medications
Diarrhea	Loperamide, dicyclomine, bismuth subsalicylate
Constipation	Laxatives
Nausea, vomiting	Prochlorperazine, haloperidol, ondansetron, promethazine, metoclopramide
Dyspepsia	Calcium carbonate, milk of magnesia
Anxiety	Hydroxyzine, quetiapine, SSRIs, bupropion, mirtazapine, diphenhydramine
Insomnia	Trazodone
Seizure, neuropathic pain	Topiramate, SNRIs
Muscle pain, myoclonus	Muscle relaxants, cyclobenzaprine, tizanidine, methocarbamol