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Patient-Centered Reduction or Discontinuation of Long-term Opioid Analgesics:

The HHS Guide for Clinicians

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Prescription opioid use continues to contribute to significant morbidity and mortality in the United States.[1-4] In 2017, 17029 of the 47600 opioid-related overdose deaths involved prescription opioids.[5] Nearly 2 million individuals in the United States have a prescription opioid use disorder.[1] At the same time, approximately 11% of US adults report daily pain,[1] and an estimated 3% to 4% use opioids long-term to help manage chronic pain.[1] Although limiting opioid analgesic prescribing to situations for which benefits outweigh risks can improve individual and population health, rapidly decreasing or abruptly discontinuing long-term opioid analgesics can significantly increase the risk of adverse consequences, including opioid-related hospitalizations and emergency department visits.[3]

Nonopioid strategies may provide equally or more effective pain relief and lower risks than opioids for most patients with chronic pain and for many with acute conditions.[1] In addition, because the benefits of long-term opioid therapy often diminish over time while the risks do not, the 2016 Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain recommends that clinicians and patients regularly reevaluate benefits and risks of continuing opioid therapy, particularly at higher dosages.[1] Yet, patients may find the

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idea of reducing or discontinuing opioid therapy anxiety-provoking.[1] Determining when and how to taper opioids can be challenging for clinicians.[6] There is a need for clear guidance to support clinicians in negotiating challenges with changes in opioid prescribing for patients receiving opioid therapy.

There are concerning reports of patients having opioid therapy discontinued abruptly[3] and of clinicians being unwilling to accept new patients who are receiving opioids for chronic pain,[4] which may leave patients at risk for abrupt discontinuation and withdrawal symptoms. Payer and health system policies that misinterpret cautionary dosage thresholds as mandates for dose reduction may result in rapid tapers or abrupt discontinuation of opioids.[7] While evidence on the effectiveness and safety of different strategies to reduce opioid dosage is limited,[6] emerging data suggest that when there is a decision to reduce opioid dosage, certain practices, including integration of nonpharmacologic pain management, behavioral support, and slower tapers, may improve outcomes.[6]

To help clinicians reduce risks and improve outcomes related to opioid dose reduction and discontinuation among patients prescribed opioids to manage pain (particularly chronic pain), the US Department of Health and Human Services (HHS) developed the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics.[8] A working group composed of experts from HHS agencies considered systematic reviews on opioid tapering and national guidelines on opioid prescribing published after 2014 to identify and summarize evidence-based clinical practices and guidance relevant to opioid dosage reduction or discontinuation. Six experts external to HHS reviewed the working group's summary and provided input. Guidance is provided to assist clinicians in 8 areas: (1) criteria for considering reducing or discontinuing opioid therapy, (2) considerations prior to deciding to taper opioids, (3) steps to ensure patient safety prior to initiating a taper, (4) shared decision-making with patients, (5) the rate of opioid taper, (6) opioid withdrawal management, (7) behavioral health support, and (8) challenges to tapering.[8] The HHS guide emphasizes the importance of shared decision-making with patients, individualized and slow tapers, and integration of pain management and behavioral support.[8]

Involving patients in decisions regarding continuation or discontinuation of opioid analgesics may improve outcomes. Among studies rated by a systematic review as "good" or "fair" quality, when opioids were tapered following discussion with patients who agreed to taper, pain, function, and quality of life improved after opioid dose reduction.[6] The HHS guide encourages collaborating with patients whenever possible in making decisions about whether to taper opioids and outlines additional opportunities to share decision-making with patients.[8] For example, clinicians can include patients in decisions such as which medication will be decreased first and how quickly tapering will occur.[8]

If there is a decision to taper opioids, integrating behavioral and nonopioid pain therapies before and during a taper can help manage pain and strengthen the therapeutic relationship.[8] Worsening of pain is a frequent symptom of opioid withdrawal that may be prolonged but tends to diminish over time.[8] It can be helpful to counsel patients regarding the transient nature of this effect.[8]

Mental health comorbidities and opioid use disorder are common in patients receiving long-term opioid therapy for chronic pain.[1,8] Symptoms of depression predict taper dropout, and managing comorbid mental health disorders can improve the likelihood of opioid tapering success.[8] The HHS guide and current guidelines recommend that patients who exhibit signs and symptoms of opioid misuse be assessed for opioid use disorder using *Diagnostic and Statistical Manual of Mental Disorders* (*Fifth Edition*) criteria and offered medication treatment if criteria are met, especially if the patient has moderate or severe opioid use disorder.[1,8,9]

The HHS guide and current guidelines emphasize that tapering should be individualized and should ideally proceed slowly enough to minimize opioid withdrawal symptoms and signs.[1,8,9] Physical dependence occurs as early as a few days after consistent opioid use,[1] and when opioids have been prescribed continuously for longer than a few days, sudden discontinuation may precipitate significant opioid withdrawal.[3] Rapid tapering or sudden discontinuation of opioids in physically dependent patients can also increase risks of psychological distress and opioid-related emergency department visits and hospitalizations, supporting the importance of slow tapering.[3] One study involving 494 patients found that each additional week of tapering time before opioid discontinuation was associated with a 7% relative reduction in the risk of opioid-related emergency department visits or hospitalizations.[3] Although relatively faster tapers (eg, 10% per week) may be successful for some patients who have taken opioids for shorter time periods (eg, weeks to months), slower tapers (eg, ≤10% per month) are often better tolerated when patients have been taking opioids continuously for chronic pain, especially following opioid use for more than a year.[1,8] Slower tapers may require several months to years depending on the opioid dosage.[8] Significant opioid withdrawal symptoms may indicate a need to further slow the taper rate.[8]

Some patients with unanticipated challenges to tapering, such as inability to make progress in tapering despite opioid-related harm, may have undiagnosed opioid use disorder. Thus, it is recommended to assess patients experiencing these challenges for opioid use disorder using *Diagnostic and Statistical Manual of Mental Disorders* (*Fifth Edition*) criteria and offer or arrange for medication treatment if criteria for opioid use disorder are met, especially if it is moderate or severe.[1] Furthermore, patients who do not meet criteria for opioid use disorder but who have an unfavorable risk/benefit profile for continued high-dose opioid use might benefit from transition to buprenorphine (Supplement).[2,8] Buprenorphine is an opioid partial agonist that can be used to manage pain as well as opioid use disorder,[2] and has other properties that may be helpful in the context of long-term opioid therapy,[9] including less respiratory depression and overdose risk than other opioids.[2] The HHS guide provides additional details on transitioning from full agonist opioids to buprenorphine, including attention to timing of the initial buprenorphine dose to avoid precipitating withdrawal from full agonist opioids, dosing for analgesia, and resources available from the Substance Abuse and Mental Health Services Administration, including training, technical assistance, and mentors for clinicians who need to taper opioids and have additional questions.[8]

While safe and effective opioid use and discontinuation can be challenging, the Centers for Disease Control and Prevention guideline and the HHS guide emphasize that clinicians have

a responsibility to provide care for or arrange for management of patients' pain and should not abandon patients.[1,8] For patients who are unable or unwilling to taper and who continue receiving high-dose or otherwise high-risk opioid regimens (eg, opioids prescribed concurrently with benzodiazepines), close monitoring and mitigation of overdose risk are recommended.[1,8]

More research is critically needed to define optimal strategies for opioid tapering. Many of the available studies on opioid tapering used uncontrolled designs and are rated low in quality by systematic reviews.[6] One systematic review of patient outcomes after opioid tapering found that of 67 studies identified (11 randomized trials and 56 observational studies), only 3 studies were "good" quality and 13 were "fair" quality.[6] Of note, among the limited set of studies with at least fair-quality evidence, opioid tapering was associated with improved pain, function, and quality of life.[6]

While evidence on the benefits and risks of opioid dose reduction or discontinuation is evolving and evidence on effectiveness of various approaches to tapering is limited,[6] fair- or good-quality studies in which positive outcomes were found following opioid tapering used specific opioid tapering practices[6]; harm has been reported with other practices.[3] Unless there is a life-threatening issue, such as imminent overdose, the benefits of rapidly tapering or abruptly discontinuing opioids are unlikely to outweigh the significant risks of these practices.[3,8] However, following slow, voluntary reduction of long-term opioid dosages, most patients report improvements in function, quality of life, anxiety, and mood without worsening pain or with decreased pain levels.[6]

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

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