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Controlled Substance Deprescribing: A Patient-Centered Approach

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Learning Objectives

1. Discuss patient-centered principles for deprescribing controlled substances
2. Provide recommendations for tapering opioids and benzodiazepines
3. Review risks of tapering/deprescribing and when to refer to a specialist

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DACS provides support to primary care and specialty prescribers in addressing the needs of their patients with substance use disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions provided by expert addiction medicine specialists
- Education and training opportunities related to substance use disorders and chronic pain management
- Assistance in the identification of substance use and behavioral health resources and referrals that meet the needs of the patients in your community

Funding for DACS is provided by The District of Columbia Government, DC Health, Health Regulation and Licensing Administration (HRLA), Pharmaceutical Control Division (PCD). DACS is administered by the University of Maryland School of Medicine staff and faculty.

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Background

- Many patients prescribed opioids and benzodiazepines (BZDs) for years or even decades – told long-term use was safe
  - Misleading practices by Big Pharma
    - Pain as the “fifth vital sign” (1990s/2000s)

Vintage ad for Serax (oxazepam), a benzodiazepine. Sedatives were commonly marketed towards women.

Source: World Benzodiazepine Awareness Day.
https://worldbenzoday.org/benzohistory/

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Epidemiology: Twin Epidemics

- 4x increase in opioid prescriptions in the 1990s-2000s
  - →2.5 million adults in the U.S. living with OUD
  - →80,000 fatal opioid overdoses/year
- 67% increase in BZD Rx's from 1996-2013
  - →2.2 million w Rx sedative/tranquilizer use d/o
  - →OD death rate increased > 4x

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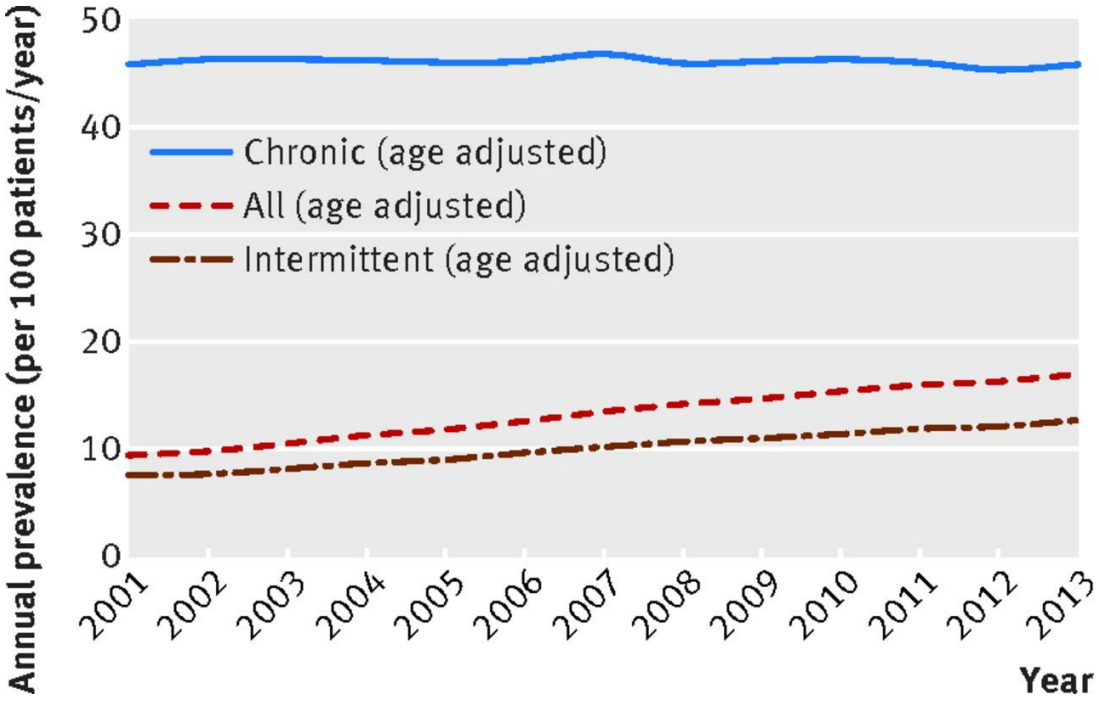
Opioid and BZD Co-Prescribing

- OD risk increases 10x
- Annual age adjusted prevalence of concurrent benzodiazepine/opioid use, 2001-13. Concurrent use was defined as having at least one day of overlap between time covered by prescriptions



Source: *BMJ* 2017; 356 :j760 doi:10.1136/bmj.j760

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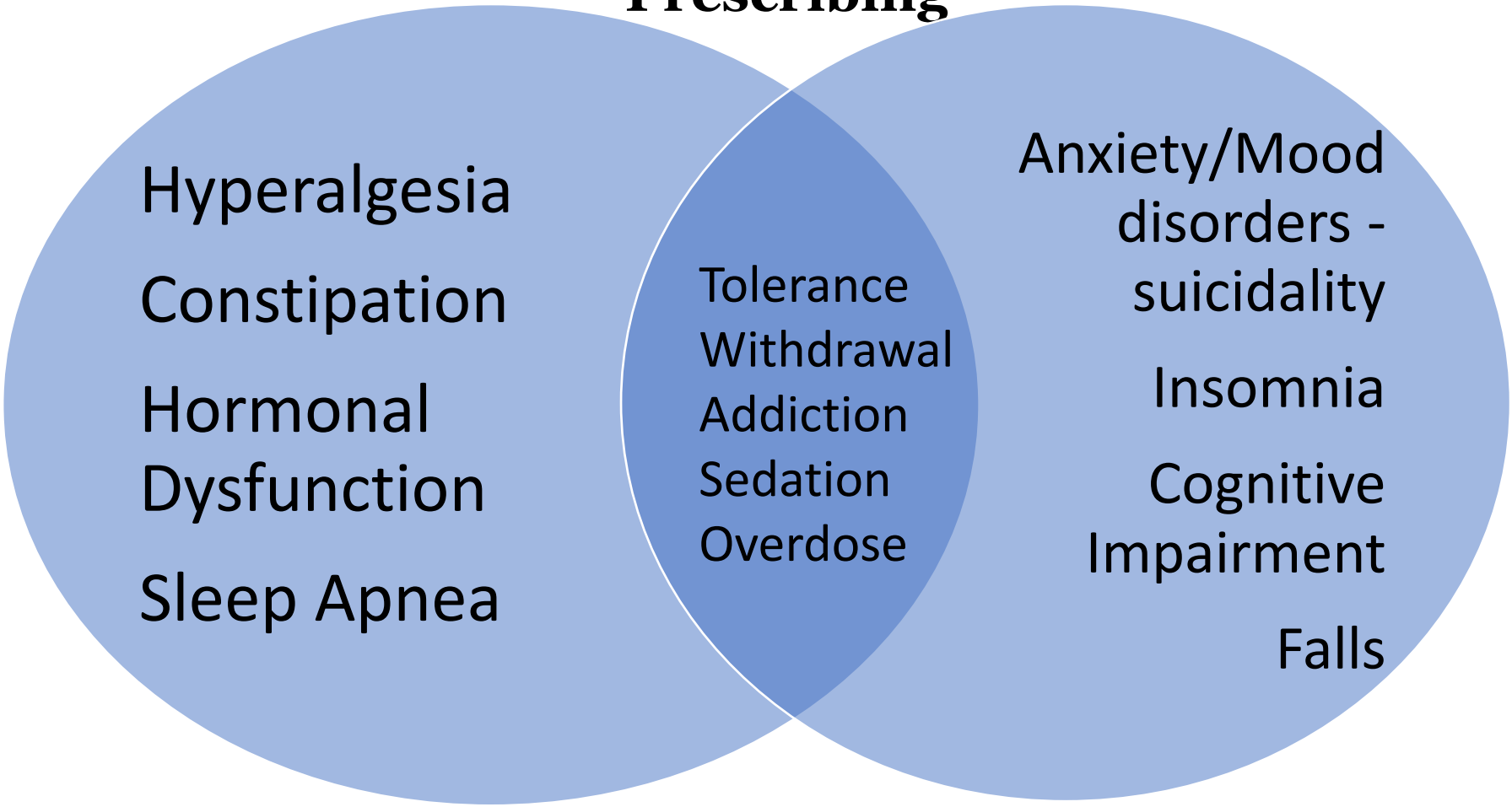
Risks of Long-Term Controlled Substance Prescribing



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Core Patient-Centered Elements

- Curiosity and compassion
- Acknowledge fear, validate experiences
- Build trust through shared decision-making
- Set the pace of the taper together
  - With options to slow down or pause as needed
  - Life events, holidays
- Discuss goals: to reduce/prevent harms and optimize function
  - Come off vs come down to safe level
  - Find tolerable level of pain or anxiety

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Sample Dialogue

- Clinician: Thank you for making the time for a dedicated visit to discuss long term use of your [controlled substance] medication. I understand you have been taking this medication for a long time, and it has helped you. At the same time, there are risks associated with taking it long-term, so we want to optimize control of your [pain/anxiety] while minimizing those risks.

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Sample Dialogue

Patient A: Yes, I read about the risk of addiction, and I don't want that to happen to me, but I am also worried about my [pain or anxiety] if I were to come off the medication.

Patient B: But I've been on this medication for 20 years, and I've never had a problem before – why should I need to come off it now?

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Clinician Response: A

I'm glad you are aware of the potential harms of continuing the same medication indefinitely, and I also hear your concern that it can be uncomfortable, even scary, to stop something that you have taken for a long time.

The good news is that we can taper it slowly. We will work together to create the taper plan and can take breaks if needed. We can also try a substitute which is truly safer.

How does that sound to you?

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Clinician Response: B

It is true that you have not suffered any harms so far, and I am glad for that.

That being said, the way your body processes medication – in other words, your metabolism – changes over time. The medication can build up in your body differently, creating a risk of overdose.

There are also certain risks, such as falling and memory issues, that we worry about more with the passage of time.

Segue into similar language from A

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When to Taper Opioids

- Consider at 50 mg morphine equivalents (50 MME) per day
  - Not a hard cutoff!
  - Consider especially strongly if 90 MME/day
- Adverse effects
  - Especially sedation or overdose event
- Hyperalgesia/Tolerance
- Concomitant use of ETOH, other sedating drugs
- Signs of developing Opioid Use Disorder

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CDC 2022 Opioid Guidelines

AVOID ABRUPT DISCONTINUATION

USE INDIVIDUALIZED TAPERING PLANS

MONITOR AND ADJUST TAPER AS NEEDED

FLEXIBILITY AND CLOSE FOLLOW-UP ARE KEY!

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Pace of Taper

- Patients on daily opioids x over 1 year: 10% of the starting dose/month
  - If on high doses for many years, and/or co-occurring mental health d/o, consider 5%/month or even slower
- Patients on daily opioids x under 1 year: 10% of the starting dose/week
  - Ok to go faster (e.g. 20%/month) if pt prefers
  - Opioid withdrawal is uncomfortable but rarely dangerous

Patients not taking opioid every day:

Cut by 50% - then self-taper

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Sample Opioid Taper

Month	Extended-release morphine dose (mg)	Immediate-release morphine dose (mg)
1	15-30-30	15-15-15-15
2	15-15-30	15-15-15-15
3	15-15-15	15-15-15-15
4	15-15	15-15-15-15
5	15	15-15-15-15
6	None	15-15-15
7	None	15-15
8	None	15
9	None	None

Tapering schedule example for a patients on 90 mg extended-release morphine (30 mg three times daily) and 60 mg immediate-release morphine (15 mg every six hours as needed) for five years. Total daily dose is 150 MME, the target dose reduction is 15 MME per month.

MME; morphine milligram equivalents.

Graphic 129379 Version 1.0

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Another Sample Opioid Taper

Source: Opioid Taper Decision Tool, Veterans Administration

Communicate the opioid taper plan to the Veteran

Example: Veteran is currently taking morphine SR 60 mg, 1 tablet every 8 hours. Goal is to reduce dose of morphine to SR 30 mg every 8 hours using a slow taper. Dose will be reduced by 15 mg every 10 days.

Using **morphine SR 15 mg tablets**, follow the schedule below:

	Morning	Afternoon	Evening
Days 1 to 10	4 tablets = 60 mg	3 tablets = 45 mg	4 tablets = 60 mg
Days 11 to 20	3 tablets = 45 mg	3 tablets = 45 mg	4 tablets = 60 mg
Days 21 to 30	3 tablets = 45 mg	3 tablets = 45 mg	3 tablets = 45 mg

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Taper Tips

- If patient on both long-acting and short-acting formulations, taper the long-acting one first
  - Higher risk of OD with long-acting
  - BUT give pt the option!
- Prescribe lower strength pills
  - Increases pt flexibility
- Alternatives for pain
- Supportive medications for withdrawal
- Co-prescribe naloxone with counseling!

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Taper Tips: Setting Expectations

- Functional goal-setting together with the patient
- Normal to feel worse before feeling better
- Coping with pain
  - Living Well with Chronic Illness workshops
- Involving supportive friends/family/peers
- Opposite action skills

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Adjunct Meds/Strategies

Pain: Multimodal analgesia

- Topical agents
  - Lidocaine
  - Diclofenac
- Acetaminophen
- NSAIDs (if no C/I)
- Gabapentin
  - Caution: euphoria and sedation/fall risk
- Nonpharmacologic modalities
  - Physical Therapy
  - Acupuncture
  - Cognitive Behavioral Therapy

Withdrawal

- Tizanidine (for insomnia and myalgias)
  - 2-4 mg qhs to start; can increase frequency to q 6-8h prn
  - Rx for 1 week
- Clonidine 0.1-0.2 mg 2-4x/day
  - Monitor for hypotension
- Trazodone
- Ondansetron
- Loperamide

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When to Switch to Buprenorphine

- Suspected opioid use disorder
  - Cravings, consequences, loss of control
    - NOT just tolerance, wd
  - Consider also methadone
  - Bup = partial opioid agonist; methadone – full
- Near fatal overdose
- BZD coprescribed
  - 10x OD risk
- Patient highly motivated to come off full agonist opioid
- Concern for opioid-induced hyperalgesia
  - Allodynia

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OUD Diagnostic Criteria

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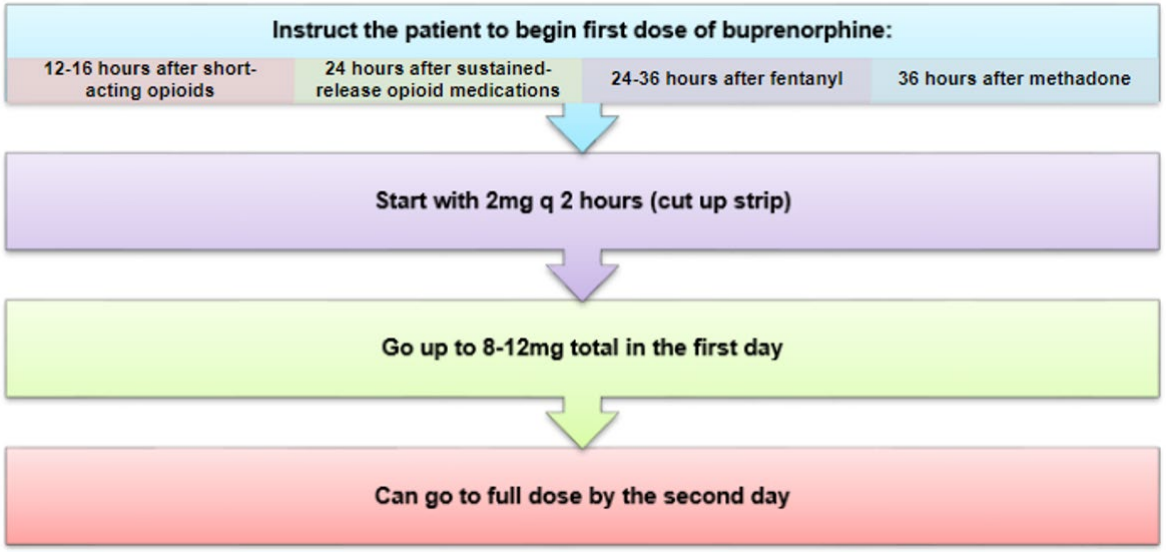
Switching to buprenorphine

- Below refers to buprenorphine-naloxone. If no OUD, can use bup monotherapy, but combination safer
  - Dx code: Uncomplicated opioid dependence (ICD10: F11.20)
- TID-QID dosing (shorter analgesic half-life)



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When to Taper BZDs

- Escalating use over time
  - 15 mg diazepam equivalents (1.5 mg clonazepam / 3 mg lorazepam / 2 mg alprazolam)
  - No hard cutoff!
- Adverse effects
  - Falls
  - Motor vehicle incident, sedation or overdose event
  - Cognitive impairment *especially in elderly
- Concomitant use of ETOH or other sedating drugs
- PTSD (BZDs can interfere with psychotherapy)
- Signs of developing BZD Use Disorder

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Benzodiazepine Tapering: 2025 ASAM Guideline

- Avoid abrupt discontinuation
- Individualized, flexible approach
  - Pauses as needed
- Typical pace: 5–10% every 2–4 weeks
  - In general, do not exceed 25% every 2 weeks
  - Go slower at the beginning and at the very end!
- Switch to longer-acting benzodiazepines
  - Diazepam or clonazepam*
- Lots of anticipatory guidance and close follow up!

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Sample BZD Taper

Benzodiazepine Equivalent Doses and Example Taper

	Approximate Dosage Equivalents	Elimination Half-life
Chlordiazepoxide	10 mg	>100hr
Diazepam	5 mg	>100hr
Clonazepam	0.25-0.5 mg	20-50 hr
Lorazepam	1 mg	10-20 hr
Alprazolam	0.5 mg	12-15 hr
Temazepam	10-20 mg	10-20 hr

Benzodiazepine Taper:

- Switching to a longer acting benzodiazepine may be considered if clinically appropriate. These are suggestions only; high dose alprazolam may not have complete cross tolerance, a gradual switch to diazepam before taper may be appropriate; other treatment modalities (e.g. antidepressants) for anxiety should be considered if clinically appropriate.
- Reduce dose by 50% the first 2-4 weeks then maintain on that dose for 1-2 months then reduce dose by 25% every two weeks.

Milestone Suggestions		Example: Lorazepam 4 mg bid Convert to 40 mg diazepam daily
Week 1		35 mg/day
Week 2	Decrease dose by 25%	30 mg/day (25%)
Week 3		25 mg/day
Week 4	Decrease dose by 25%	20 mg/day (50%)
Week 5-8	Hold dose 1-2 months	Continue at 20 mg/day for 1 month
Week 9-10		15 mg/day
Week 11-12	Decrease dose by 25% at week 11	10 mg/day
Week 13-14	Decrease dose by 25% at week 13	5 mg/day
Week 15		discontinue

Fuller MA, Sajatovic M. (2009). Drug Information Handbook for Psychiatry. 7th ed. Hudson, OH: Lexi-Comp Inc.

Perry PJ, et al. (1997) Psychotropic Drug Handbook, 8th ed. Baltimore, MD: Lippincott Williams & Wilkins.

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

Note: If hepatic impairment, use lorazepam
Not listed: oxazepam. Slow-onset and short-acting BUT fewer drug-drug interactions, may be recommended in future

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Supporting the Taper

- First-line medications for anxiety (SSRIs, SNRIs)
- Supportive medications for insomnia (trazodone, mirtazapine)
- Therapy: CBT, CBT-I, DBT, mindfulness, Acceptance Commitment Therapy
- Healthy sleep behaviors
- Nutrition and exercise
- Social supports
- Counsel patient to avoid ETOH

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BZD Taper: Case

- 83F on lorazepam 1 mg bid x 40 years
  - Recently added 0.5 mg in afternoon due to increased anxiety about health i/s/o recent diagnosis of atrial fibrillation
  - Pt and family aware of risks of long-term BZD dependence and motivated to come off
  - PCP added sertraline + hydroxyzine prn
  - Referred to this provider after inpatient substance use disorder rehab facility determined she did not need their level of care

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Case: Initial Steps

- First step: Mid-day lorazepam dose decreased to 0.25 mg (10% reduction in TDD)
  - Substitute with hydroxyzine 10 mg prn
  - Shortly thereafter increased to 20 mg
- 2 week follow up: No withdrawal, +recurrent anxiety but not rebound
  - Advised after 1 more week, stop pm dose and take 1 mg bid

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Case Continued

- Pt hesitant to switch to different medication
- Over a period of 10 months, tapered to lorazepam 0.5 mg bid as follows: Rx'd 10% fewer pills/month, advised to take 0.5-1 mg bid as needed; substituting the half pill here and there to make supply last until next month
  - Discussed avoiding halving consecutive doses, so as to avoid withdrawal

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Case: Switch to Clonazepam

- Converted from lorazepam 0.5 mg bid to clonazepam 0.25 mg bid
  - Rx'd disintegrating tablets of 0.125 mg to substitute a half dose occasionally (still going at rate of 10%/month – but 10% of previous dose rather than original dose)
  - Pt immediately noted new med "helping me to come off"; experienced it to be longer acting and did not feel the need to take hydroxyzine every afternoon

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Psychosocial stress

- Around 14 months, stress at home: Paused taper
- Increased sertraline to 150 mg
- Revisited non-pharmacologic modalities, in particular Acceptance Commitment Therapy

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Goal Setting and Finale

- Set goal together to come off by her 85th birthday (5 months later)
  - Calculated that this could be achieved by going back to 10%/month decrease within a few weeks
  - Successfully achieved goal
  - Stated, “I feel like I am finally free”
- Added mirtazapine for insomnia; pt noted vivid dreams, c/f weight gain (though normal BMI)
- Switched to trazodone 25 mg qhs with lack of effect; did well with increasing to 50 mg qhs
- Encouraged CBT-i

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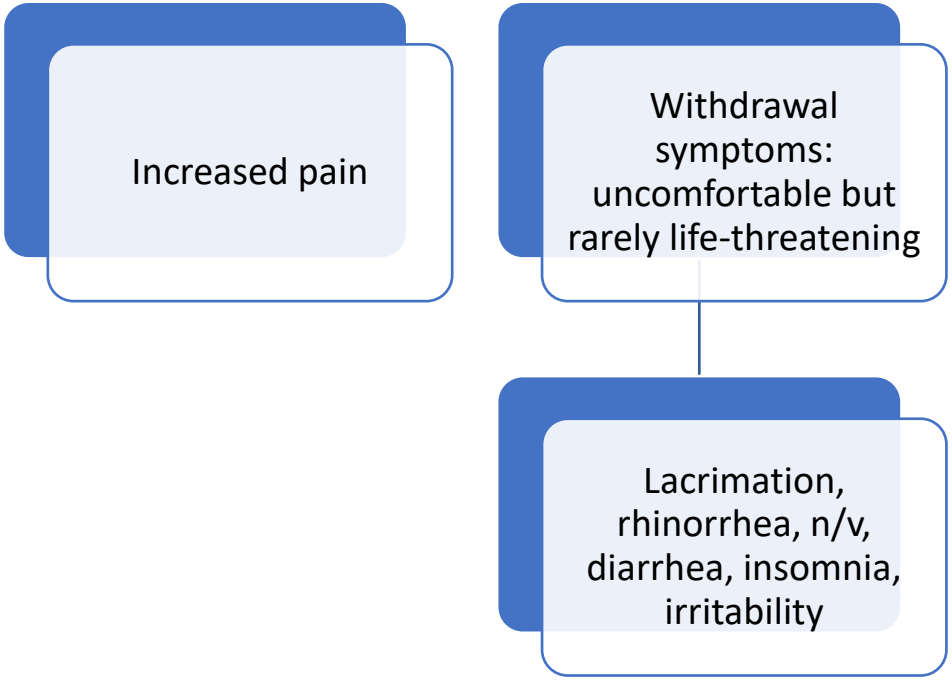
Harms During Opioid Deprescribing



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Harms During BZD Deprescribing

Symptom recurrence	• Return of anxiety
Rebound anxiety	• Worse than baseline
Pseudowithdrawal	• Fear of withdrawal
Withdrawal	• Range of physiologic symptoms (tremors, sweats, n/v) • Includes complicated wd: seizures, delirium tremens • Can be life-threatening

Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar)

Nausea and vomiting	**Headache**
0: No nausea or vomiting	0: Not present
1	1: Very mild
2	2: Mild
3	3: Moderate
4: Intermittent nausea with dry heaves	4: Moderately severe
5	5: Severe
6	6: Very severe
7: Constant nausea, frequent dry heaves and vomiting	7: Extremely severe
Paroxysmal sweats	**Auditory disturbances**
0: No sweats visible	0: Not present
1: Barely perceptible sweating, palms moist	1: Very mild harshness or ability to frighten
2	2: Mild harshness or ability to frighten
3	3: Moderate harshness or ability to frighten
4: Beads of sweat obvious on forehead	4: Moderately severe hallucinations
5	5: Severe hallucinations
6	6: Extremely severe hallucinations
7: Drenching sweats	7: Continuous hallucinations

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Anxiety
0: No anxiety, at ease
1
2
3
4: Moderately anxious, guarded
5
6
7: Acute panic state, consistent with severe delirium or acute schizophrenia
Agitation
0: Normal activity
1: Somewhat more than normal activity
2
3
4: Moderately fidgety and restless
5
6
7: Paces back and forth during most of the interview or constantly thrashes about
Tremor
0: No tremor
1: Not visible, but can be felt at fingertips
2
3
4: Moderate when patient's hands extended
5
6
7: Severe, even with arms not extended

Visual disturbances
0: Not present
1: Very mild photosensitivity
2: Mild photosensitivity
3: Moderate photosensitivity
4: Moderately severe visual hallucinations
5: Severe visual hallucinations
6: Extremely severe visual hallucinations
7: Continuous visual hallucinations
Tactile disturbances
0: None
1: Very mild paresthesias
2: Mild paresthesias
3: Moderate paresthesias
4: Moderately severe hallucinations
5: Severe hallucinations
6: Extremely severe hallucinations
7: Continuous hallucinations
Orientation and clouding of sensorium
0: Oriented and can do serial additions
1: Cannot do serial additions
2: Disoriented for date by no more than 2 calendar days
3: Disoriented for date by more than 2 calendar days
4: Disoriented for place and/or patient
Total score is a simple sum of each item score (maximum score is 67)
Score:
<10: Very mild withdrawal
10 to 15: Mild withdrawal
16 to 20: Modest withdrawal
>20: Severe withdrawal

Adapted from Sullivan JT, Skyora K, Schneiderman J, et al. Br J Addict 1989; 84:1353.

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BZD Withdrawal Risk

Duration of BZD Use	Frequency of BZD Use	Total Daily BZD Dose	Risk for Clinically Significant Withdrawal	Need for taper?
Any	≤3 days per week	Any	Rare	LOW
<1 month	≥4 days per week	Any	Lower risk, but possible	
1–3 months	≥4 days per week	Low‡	Lower risk, but possible	
1–3 months	≥4 days per week	Moderate§ to high**	Yes, with greater risk with increasing dose and duration	
≥3 months	≥4 days per week	Any	Yes, with greater risk with increasing dose and duration	HIGH

‡ A low daily dose is estimated as 10 mg diazepam equivalents or less (e.g., ≤0.5mg clonazepam, ≤2mg lorazepam, ≤1mg alprazolam). See Appendix H for BZD dose equivalents.
§ A moderate daily dose is estimated as 10-15mg diazepam equivalents (e.g., 0.1-1.5mg clonazepam, 2-3mg lorazepam, 1-2mg alprazolam). See Appendix H for BZD dose equivalents.
** A high daily dose is estimated as 15mg diazepam equivalents (e.g., >1.5 mg clonazepam, >3mg lorazepam, >2mg alprazolam). See Appendix H for BZD dose equivalents.

Slide courtesy of Emilly Brunner MD, DFASAM; Chinyere Ogbonna, MD, MPH; and Tricia Wright, MD, MS, FACOG, DFASAM

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Pregnancy and Lactation

- Both opioids/BZDs and discontinuation of these meds carry risks of fetal harm
- Harms of untreated pain, anxiety/mood, sleep disorders
- Weigh risks/benefits
- Extremely close follow up – consider higher level of care

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Discontinuation: Mortality Risks

- Both opioids and BZDs: Risk of pt turning to illicit use → fentanyl exposure
- Opioids: High-risk window for suicide and overdose of up to 100 days
  - Up to 2 years for mental health crises (suicide attempts, depression, anxiety)
- BZDs: Increased risk of suicidal thoughts, attempts, and self-inflicted injury in one study
  - Even at one-year follow-up!

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Risk Management Approaches

- Informed consent before deprescribing
- Monitor closely for withdrawal
- Use slow tapering and breaks

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When to Refer to a Specialist

- Failed tapering attempts
  - Pain Management for uncontrolled pain
- Complex Substance Use Disorder (intense cravings, polysubstance use, need for additional support): Addiction Medicine or Addiction Psychiatry
- Complex psych symptoms: Addiction Psychiatry
- Opioid use disorder with lack of efficacy of buprenorphine
  - Refer to Opioid Treatment Program for methadone

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When to Escalate Level of Care

Withdrawal risk

- Prior history of complicated withdrawal
  - From BZDs or alcohol
- Current s/s of imminent complicated withdrawal
  - CIWA > 15 for benzodiazepines
- History of near fatal overdose
- Nonpharmaceutical BZD use – unable to accurately determine dose

Active psychiatric instability

Pregnancy

Lack of psychosocial support

Refer to inpatient withdrawal management facility

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Take Home Points

- Patient-centered approach is essential
- Evidence-based guidelines allow for a gradual and flexible approach to opioid and benzodiazepine tapering that is generally safe in ambulatory settings
- Be aware of risks and refer to a Specialist or higher level of care in complex cases

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Resources

- Bacchuber et al, Increasing Benzodiazepine Prescriptions and Overdose Mortality in the United States, 1996–2013
- Buresh et al: Treating Perioperative and Acute Pain in Patients on Buprenorphine: Narrative Literature Review and Practice Recommendations
- Brunner E et al: Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations When Risks Outweigh Benefits
- CDC 2022 Opioid Guideline (MMWR 71)
- Duff et al: The Opioid Crisis in the United States: A Brief History
- FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning
- Holt, S and Tetrault, J. Alcohol withdrawal: Ambulatory management. UptoDate
- Lembke A, Opioid Taper/Discontinuation (The BRAVO Protocol)
- Maust et al, Benzodiazepine Discontinuation and Mortality Among Patients Receiving Long-Term Benzodiazepine Therapy
- National Center for PTSD, Benzodiazepine Equivalent Doses and Taper
- NIH, Only 1 in 5 U.S. adults with opioid use disorder received medications to treat it in 2021
- Oliva et al, Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation
- Pisansky et al, Opioid tapering for patients with chronic pain. UpToDate
- SAMHSA, Key Substance Use and Mental Health Indicators in the United States:
- Results from the 2021 National Survey on Drug Use and Health
- SHADAC, The Opioid Epidemic in the United States
- Sun E C et al. Association between concurrent use of prescription opioids and benzodiazepines and overdose: retrospective analysis
- VA Opioid Decision Taper Tool