Changing the Conversation About Opioid Tapering

Research has uncovered potential harms of long-term opioid therapy, particularly at high dosages (1). These findings make it clear that before starting long-term therapy or increasing dosages, clinicians and patients need to carefully weigh the uncertain benefits of opioids for chronic pain against their increasingly clear risks (2, 3). However, little evidence has been available to help weigh the benefits and harms of reducing dosages or discontinuing opioids in patients already receiving long-term therapy or to guide clinicians in how to taper opioids safely and effectively (4). Frank and colleagues' review (5) provides helpful information for clinicians and patients about tapering and discontinuing long-term opioid therapy for chronic pain.

Conclusions should be drawn with caution given the overall very low quality of evidence, as noted by the authors. However, study quality was fair or good for 16 studies (many of which were published recently), and the review focuses on findings from these higher-quality studies. Among the higher-quality studies evaluating pain, function, and quality of life, all found improvements in all outcomes evaluated after opioid dose reduction.

It is important to note how dose reduction was accomplished. Opioids were tapered with buy-in from patients who agreed to decrease the dosage or discontinue therapy. Dosages were reduced relatively slowly (over 22 weeks in 1 study). Patients were provided multidisciplinary care through interdisciplinary pain programs or with behavioral interventions, such as cognitive behavioral therapy or mindfulness meditation, and were followed closely—at least weekly in some studies. Consistent with these practices, the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain (2) recommends providing multimodal care for chronic pain, collaborating with patients, and tapering slowly.

Although evidence does not support the hypothesis that initiatives intended to reduce opioid prescribing increase illicit opioid-related overdose at a population level (6), neither this review nor CDC's guideline (2) provides support for involuntary or precipitous tapering. Such practice could be associated with withdrawal symptoms, damage to the clinician–patient relationship, and patients obtaining opioids from other sources. Clinicians have a responsibility to carefully manage opioid therapy and not abandon patients in chronic pain. Obtaining patient buy-in before tapering is a critical and not insurmountable task. Motivational interviewing techniques can help patients who are not obtaining expected benefits or are experiencing harms from opioids to articulate and act on discrepancies (7) between how they are approaching pain and how they would like to live.

Although most of the reviewed studies were conducted in outpatient settings, only a handful were conducted in primary care, where most opioids are prescribed (5). Optimal dose reduction may be challenging in primary care, but many of the approaches could translate effectively, especially in team-based practices. Most of the higher-quality studies evaluated interdisciplinary pain programs using a biopsychosocial model of chronic pain emphasizing nonpharmacologic and self-management approaches, a framework that has been successfully adopted by primary care–based interdisciplinary teams in the Veterans Health Administration (8). Others evaluated behavioral interventions, including those supported by technology (an interactive voice response intervention) or by different members of the health care team (such as a physician assistant delivering motivational interviewing and pain self-management education).

Slow and steady changes in primary care practice can better align opioid use with circumstances in which benefits outweigh harms. A practical strategy for managing a panel of patients with chronic pain in primary care could include starting long-term opioid therapy in fewer patients initially and avoiding dose escalation in those using opioids in the long term; working with a few interested and motivated patients to slowly taper opioid dosages; and closely monitoring and mitigating overdose risk for patients who continue use of long-term, high-dose opioids (2), using periodic and strategic motivational questions and statements to encourage movement toward therapeutic changes. For example, nonjudgmentally asking what the patient likes and dislikes about opioid therapy can facilitate exploration of ambivalence, and asking patients how they would like things to be different can empower them to imagine change (7). Over time, this strategy should decrease the number of patients who require intensive monitoring while focusing on tapering in a few motivated patients at a time. All patients could receive nonopioid pain management and support through some combination of clinician follow-up, team-based support, and referral. Clinicians can also offer or arrange medication-assisted treatment for patients found to be struggling with opioid use disorder. To support management of patients with chronic pain and tapering of opioid therapy, the CDC offers a tapering pocket guide, a mobile app and online training with motivational interviewing components, and information about nonopioid treatments for pain (9).

Improved payer strategies are also important in supporting greater use of the full range of effective therapies for chronic pain. Payers can improve coverage for evidence-based nonpharmacologic therapies, such as exercise therapy and cognitive behavioral therapy, and can reduce barriers (such as prior authorization) to nonopioid pain medication (and to buprenorphine for patients with opioid use disorder). The Agency for Healthcare Research and Quality, with sup-

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port from the CDC and the U.S. Department of Health and Human Services, is conducting a systematic review of nonpharmacologic treatments for common chronic pain conditions (10) to inform reimbursement decisions and use of effective nondrug therapies for chronic pain.

Although it will be important to confirm the results with more and higher-quality studies, Frank and colleagues' review provides evidence that patients who work with clinicians to reduce or discontinue opioid use can expect improvements in pain, function, and quality of life. Clinicians should find comfort in being able to communicate this hope to patients. As the authors note, "In the realm of opioid therapy, patient safety and pain relief have often been framed as conflicting and mutually exclusive goals . . . [new evidence] holds the potential to fundamentally alter the conversation about opioid tapering." It will be heartening for many clinicians and patients to realize that indefinite continuation of opioid therapy is not always a foregone conclusion. It is possible to reduce opioid use and associated risks while reducing pain and improving function and quality of life.

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