

Tapering and Discontinuing Addicting Medications

Taper and Discontinue Addicting Medications using a respectful, patient-centered approach. This often means identifying the patient's personal and emotional reactions to refractory pain that has been helped only with narcotics and tranquilizers; e.g., "It's the only thing that works." Dosage decreases must be negotiated using shared decision making rather than prescribed unilaterally. And, for the clinician's comfort, it means being aware that there are no data supporting the chronic use of opiates in chronic pain and that such use often is counterproductive, producing seemingly paradoxical exacerbations of pain as well as significant side effects and addiction⁷ Nor is it necessary in all cases to completely discontinue when patients have gone as far as they can tolerate psychologically and the depression has improved. Moreover, we do not stop medications 'cold turkey' as patients fear but, rather, indicate it would be slowly be tapered at a pace they set and, then, only after starting adequate doses of a 'better pain medication,' which refers to antidepressants.⁸ While it may be surprising, we have had excellent results using this approach, which we now outline for use in outpatient settings.^{9,10} The slow pace of reduction described is largely for psychological withdrawal, not physiological, and is designed to address the patient's long dependence on the medications. If this program is not effective, consultation with a pain/addiction specialist is indicated and inpatient detoxification may be necessary, but that has seldom been needed.

We first establish a baseline dose, negotiating with the patient how much they think they would need on a typical worst day; e.g., in a patient varying from 4-10 tablets of Vicodin per day, they agree that 8/day should work. Even though perhaps a higher total weekly dose than they took before, we provide this on a regular, scheduled basis. Great detail goes into the scheduling: we specifically negotiate exactly at what time they will take each tablet; e.g., 2 upon arising, 1 mid-morning, 1 at noon, 2 at 4:00 p.m. when the kids get home from school, 1 at supper, and 1 at 10:00 just before going to bed. There is no effort yet to reduce the dose, but we tell them at the first visit to begin thinking about which tablet could be removed at the next visit (in one week) to get them down to 7/day. At follow-up visits, the patient's specific time of use is verified, and one ascertains that they

are taking the full dose even if having fewer problems and not going beyond it if having greater problems. A similar approach is used for subsequent visits. Reframing this issue to 'when' patients take the medications, rather than arguing about 'if' they are to take them, is very helpful in establishing the relationship and an effective reduction in dose over time.

By 8-12 weeks, most will have completely discontinued the medications at rates of 1 tablet every 1-3 weeks. Problematic patients benefit from written contracts, but this has not often been needed. Persistent failure to reduce narcotics, especially in conjunction with poor participation in other parts of the program, are indications for referral to a pain/addiction specialist.

To operationalize this process, we negotiate up-front that patients use one pharmacy, pick up medications themselves, and receive prescriptions from clinicians only at the time of visits. Then, we provide sufficient medications only until the next visit, generally giving only one 'grace period' in the event the medication is lost. Urine and serum toxicology screening are used only if tapering does not proceed as outlined above. But, monthly, we review statewide pharmacy reports (available only in some states) of controlled substance use.^{11,12} This verifies that patients are obtaining medications only in the pharmacy already identified in prescribed numbers and there should be no substances not prescribed by the clinician being obtained – and no substances from any other providers.

Not uncommonly, patients are taking more than one opioid and also are taking one or more tranquilizing agents. It is negotiated with the patient whether they wish to taper these concomitantly or sequentially.

In addition to using full-dose antidepressants, for pain as well as for depression,¹³ symptomatic medications on a scheduled basis also are used; e.g., ibuprofen, anticholinergics.