Engaging Patients with Care:

Tapering, Brief Interventions, and Substance Use Insights

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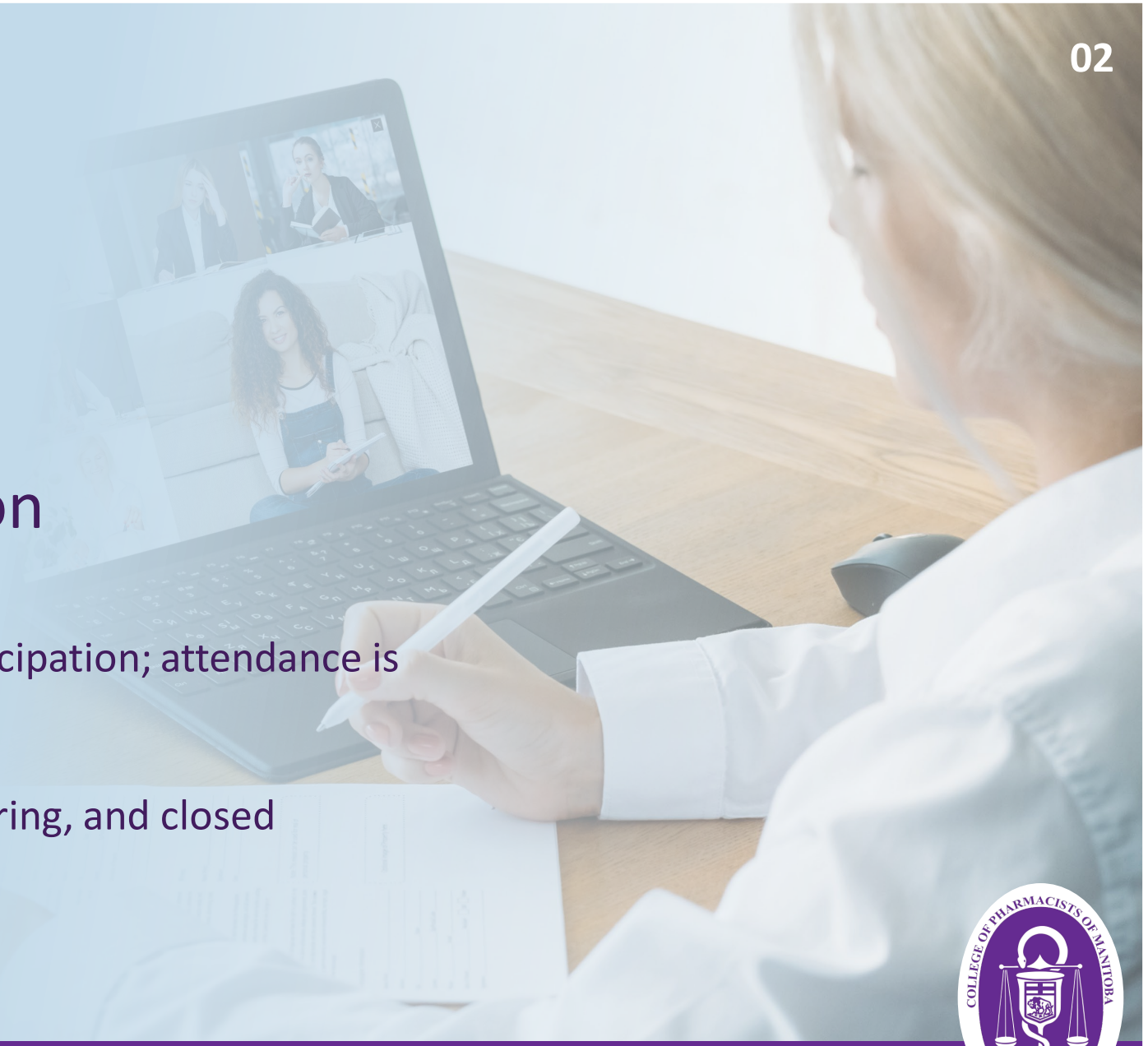

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Submitting Questions

- You can submit your questions at any time during the event.
- Questions will be read out loud, followed by the speaker's response through the audio feed.

Logistics

Completing the Learning Activity Evaluation Form

- You ***must*** complete the Learning Activity Evaluation form to receive your statement of participation and claim your Continuing Education Units (CEU)
- This learning activity is accredited for 1.5 CEU

Presenter Introduction

Karin Ens, BScPharm, MSc, EPPh (she/her)

- Winnipeg-based clinical pharmacist with extended practice license
- Works in primary care clinic, hospital, and community pharmacy
- Collaborates with University of Manitoba's College of Pharmacy since 2018
- Involved in applied and experiential education, instructing in Clinical courses
- Recently completed master's degree; coordinated multi-site opioid tapering trial

Tapering 101:

Deprescribing & Tapering Opioids and Benzos

Karin Ens, BScPharm, MSc, EPPh (she/her)

Nov. 28, 2023

Conflict of Interest Disclosure

- Presenter: Karin Ens
- I have no conflicts to disclose
- I will receive a speaker's fee for today's presentation from CPhM
- This presentation has received no financial or in-kind support from any commercial or other organization

Learning Objectives

- Discuss rationales and motivations to taper opioids and benzodiazepines
- Establish target populations for these tapers
- Compare different ways to broach and begin the tapering process
- Go through patient cases that explore tapering strategies
- List different withdrawal treatments and when they may be of benefit

Which is more important?

Tapering Benzos

Tapering Opioids

The Opioid Crisis

- Opioid dependence & addiction linked to overdose and death
- Over 30,000 Canadians have died of opioid toxicity since 2016 (~20 per day)
- Public health emergency per Public Health Agency of Canada
  - Called for “Response that is comprehensive, collaborative, compassionate and evidence-based”

OPIOID
Deprescribing & Tapering

Who should be tapered off OPIOIDS?

All patients with chronic, non-cancer pain

Cancer pain
Acute pain (<12w)
Acute on chronic pain (<12w)
Opioid use disorder*

Check out CPSM's SOP for more details

What % of **your** patients on opioids are taking for chronic (non-cancer) pain?

- 0-25%
- 26-50%
- 51-75%
- >75%

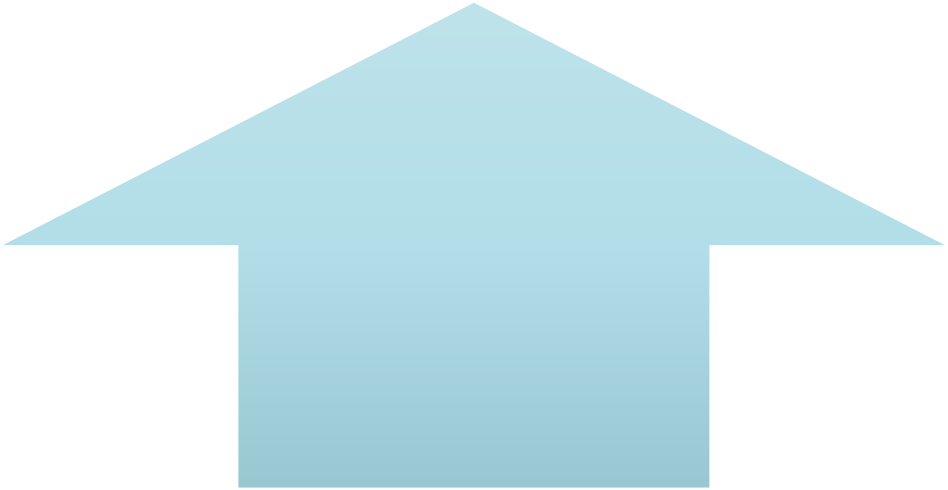
Why should we deprescribe opioids?

Benefits in *chronic* pain

- Opioids have little positive evidence in chronic pain[1,2,3]
  - Minimal changes to pain outcomes including QOL in trials[4,5]
- Any benefits limited by tolerance, hyperalgesia[2,3,5]
- Not listed as an acceptable indication by CPSM

Risks

- Short term use[1]:
  Drowsiness, Headache, Constipation, Nausea/Vomiting, Abdominal Pain, GERD/Dyspepsia, Rash, Anxiety, Tremor, Dyspnea
- Prolonged use[2,3,4,5,6,7]:
  Cognitive dysfxn, Liver damage, Sexual dysfxn/infertility, ↓ immune fxn, Tolerance, Hyperalgesia, Dependence & withdrawal, Addiction & overdose, **Death**



How to taper:
What does the (lack of) evidence say?

What are the gaps?

- Most effective / safest tapering rate / method / opioid

- Practical implementation

- Conclusive evidence on benefits vs risks
  - Emerging risks?

Why?

- Small sample sizes
- High drop-out rates
- Inconclusive data

Highlights:

- Fear of withdrawal and ↑ pain
- Need for supportive environment

What evidence *does* exist?

- Guidelines recommend to taper (but not how)

- Tapering ≠ ↑ pain
(↓ pain sometimes shown)
  - ?Due to ↓ in hyperalgesia
  - ?Due to alternative pain strategies

- Tapering ↑s in functional outcomes & QOL (mental health, sleep, w/d, opioid misuse scores)
  - ?Due to reduced side effects/harms

Our tapering trial in Winnipeg (2020-23):

- Randomized, prospective trial with a collaborative, multidisciplinary, patient-involved design
- Pharmacist-led opioid tapering, including medication reviews and frequent follow up
- Preliminary Results
  - 21.8% ↓ in opioid dose in 3 months (p=0.007)
  - No increase in pain
    - Trend *reductions* shown: 0.968-point reduction on NRS (-0.043 to 1.98 p=0.059)
  - No increase to health/wellbeing scores
    - Trend *improvements* in anxiety and pain disability

How to start?

Improve pain control

1

- Add other pain meds
  - *Duloxetine*
  - *Pregabalin*
  - *Nabilone*
- Improve other conditions causing/worsening pain (with meds or non-pharm)
  - *Diabetes*
  - *Mental health*
  - *Sleep disorder*
- Increase physical activity (+/- refer to PT/OT/other)

Start with other deprescribing

2

- Establish trust
- Accomplish goals that patients identify
- Reduce pill burden may improve SE or DI

  Examples:

  Stop calcium → improved constipation → reduced abdominal pain

  Stop HCTZ (BP below target or switch) → less nocturnal polyuria → improved sleep → better pain control

  Stop gabapentin (if not effective) → less daytime sedation (esp w/ opioid) → improved function (→ increased physical activity → improved pain???)

Switch opioid formulation (IR vs CR)

3

- Immediate Release
  - \+ More tablets & strengths = flexible tapers with smaller dose changes (↓ withdrawal?)
  - \+ More tablets may ↑ placebo effect
  - \- High peaks/troughs may ↑ withdrawal, ↑ potential for addictive symptoms
  - \- Complex regimen = ↑ med errors, ↑ risk overuse or OD
- Controlled Release
  - \+ Simpler regimens
  - \+ Stable release (↓ withdrawal?)
  - \- Less dosing availability = bigger reductions (↑ withdrawal?)

Switch opioid (opioid rotation)

4

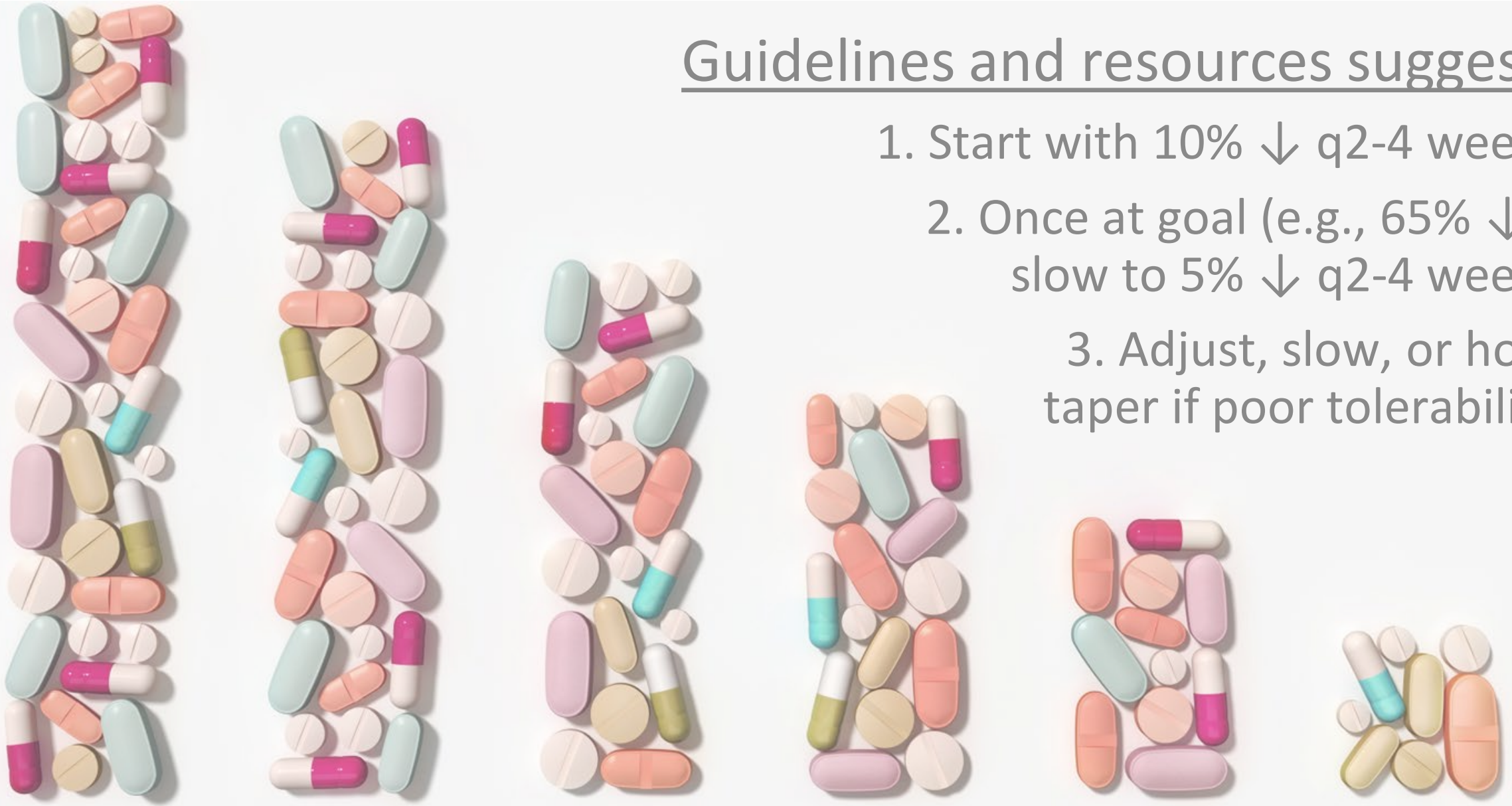
+ Reduces overall MED (dose reduction for cross sensitivity)
+ New opioid may be easier to taper:
    - Comes in more strengths: e.g. fentanyl -> hydromorphone
    - Has lower doses available, e.g. hydromorphone -> oxycodone
    - Comes in different formulations, e.g. oxycodone -> morphine liquid
+ ?Benefit to hyperalgesia

- Risk of withdrawal or OD due to imperfect conversion
- ↑↑ workload (calculations, prescribing, dispensing, monitoring)

Which has been a successful strategy for your patients?

a) Optimize pain control
b) Deprescribing
c) Switch formulation (IR or CR)
d) Opioid rotation
e) Nothing has ever worked

What does tapering look like?



Guidelines and resources suggest:

1. Start with 10% ↓ q2-4 weeks
2. Once at goal (e.g., 65% ↓), slow to 5% ↓ q2-4 weeks
3. Adjust, slow, or hold taper if poor tolerability

What works in practice?

- One reduction at a time
  - Follow-up, discuss what worked/what didn't
  - Decide on next ↓ based on successes/failures
- Allow reversal of tapering steps
  - Patients more willing to attempt
  - Can consider going to half original dose
- Pausing taper
- Fast and frequent follow-up
- Offering withdrawal education and treatments

What about withdrawal?

- Clonidine
  - Pain, shakes/tremor
- Loperamide
  - Diarrhea
- Antihistamines
  - Nausea, sweating
- Acetaminophen
  - Headache

Patient: 65yo F, "MTP001"

Pain hx: Severe IBS, fibromyalgia, OA

Opioid: Hydromorphone IR 4mg 5x per day

- Gastroenterologist advised opioid taper for IBS symptoms
- Also takes cyclobenzaprine, NSAIDs (po & topical), amitriptyline, among other Rx meds
- Started taper right away (resistant to antidepressant, deprescribing)
  - **Self-directed reduction plan**
  - **Switched to 2mg tablets, then eventually 1mg** to allow for flexible tapering
  - Paused frequently during taper
- Started anti-depressant for mood eventually
- **Tapered 100%** - today is off opioids and is tapering her zopiclone now
- Minimal benefit to IBS, but overall +++ improvements in mood, cognition, outlook on life & pain

Patient: 55yo M, "PEW001"

Pain hx: Chronic back pain, fibromyalgia, 2x knee surgeries [27]

Opioid: Oxycocet 8 tabs per day

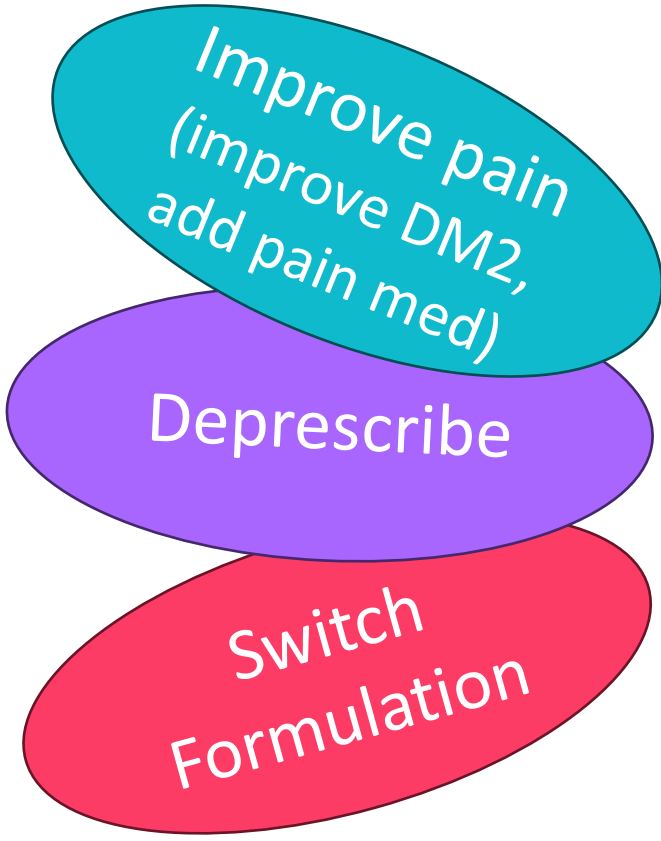
Opioid Rotation

- Resistant to taper
- Trialed switch **venlafaxine → duloxetine**
  - Minimal benefit to pain (did improve mental health, coping)
  - Not interested in trying other pain meds (previous poor tolerability)
  - Not interested in non-pharm efforts (already active)
- Converted to CR
  - **Oxycocet → hydromorphone CR** (oxycodone CR not covered) = 25% ↓ for cross sensitivity
  - Not successful - pt c/o SE (likely actually withdrawal)
  - **Hydromorphone CR → Oxycocet**, continued lower dose when converting back
- Remains on 7tabs/day, but does report overall satisfaction with changes

Patient: 57yo F, "MTP002"

Pain hx: "chronic pain", DM neuropathy, RA
Opioid: Morphine IR 40mg QID

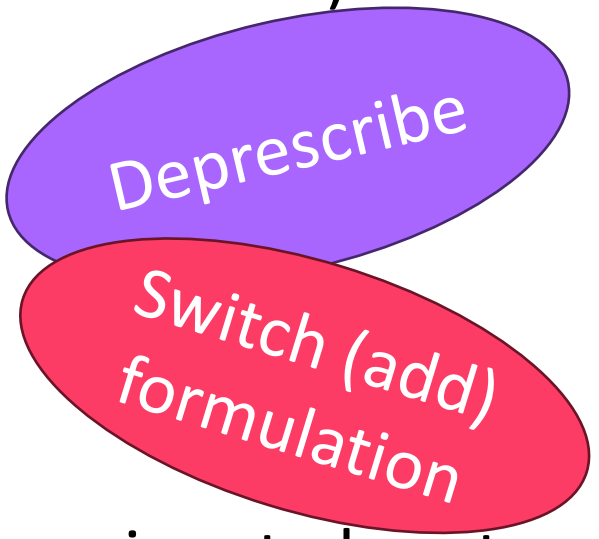
- Interest in tapering (weakness), but +++ worried about pain (already on DMARDs for RA, topical diclofenac, gabapentin 800mg qid)
- Started with morphine IR ↓ to TID (QID not consistent) AND:
  - **General deprescribing**
  - **Optimizing diabetes control**
  - **Adding Duloxetine**: quite helpful for mood and pain
- Trial change to SR, went back & forth
  - **IR TID → SR TID → IR TID → SR TID**
  - SR didn't kick in as fast but liked longer duration
  - Once stable on SR, was able to **taper one dose at a time**
- Taper paused when RA meds changed
- At almost 50% ↓



Patient: 45yo F, "PEW002"

Pain hx: Cerebral palsy with paraplegia and spasticity
Opioid: Fentanyl 50mcg/hr patches q3d

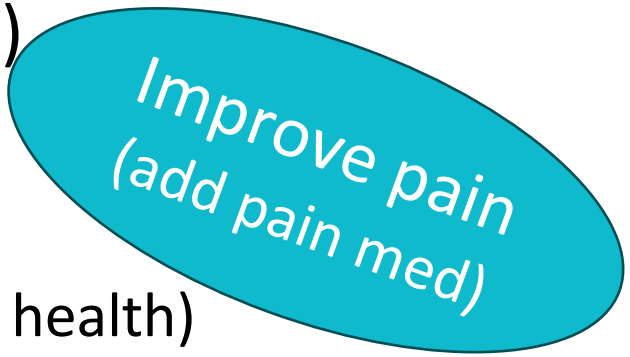
- Patient reported functional decline, preferred ↑ pain to current state
  - Already on +++ meds for pain and spasticity
  - Wanted to try big ↓: **50 → 37mcg patches** = unpleasant x 48h, but successful
- Paused taper and **stopped gabapentin** (sedating, unclear benefit)
  - Gabapentin stop > fentanyl ↓
- Slight pain ↑ but overall benefit = continue taper
  - Concern about a big drop (**37 → 25mcg**)
  - Add **hydromorphone IR bridge** (self administered/tapered)
  - Off hydromorphone in ~1 month
  - Well tolerated
- Cognition & function much improved with 50% ↓, no imminent plans to reduce further



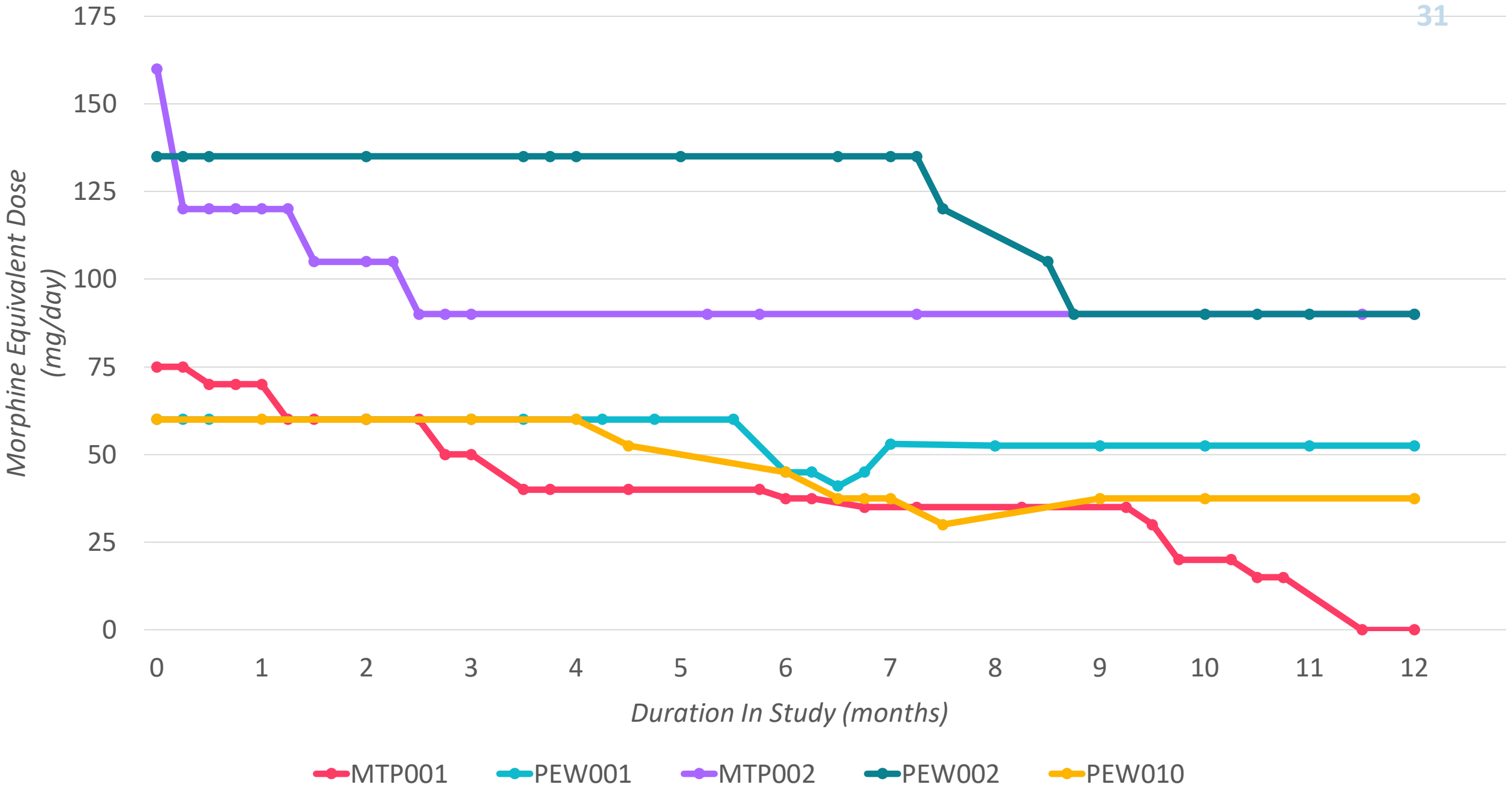
Patient: 62yo M, "PEW010"

Pain hx: Chronic neck & back pain, rotator cuff surgery
Opioid: Hydromorphone CR 6mg bid

- Outdoor contractor, dog walker's husband (very active)
- Hesitant to taper since ↑ pain affects work
- **Started duloxetine**: "changed his life"
  - improved anger management, coping (despite no hx mental health)
  - Pain almost disappeared (scores ↓↓↓), but did continue to have flares
- **Started slow taper with CR**, no issues
- A few unrelated setbacks - COVID infection, shingles
- Overall 50% dose ↓



Opioid Dose Reductions



BENZODIAZEPINE
Deprescribing & Tapering

Who should be deprescribed off BENZOS?

Indication unknown

RLS

Insomnia

Anxiety

Short vs long term?

Chronic vs intermittent?

Acute seizure rescue

Alcohol withdrawal

?Bipolar/psychosis

?Spasticity

CPSM has SOP with more details for benzos as well

What % of **your** patients on benzos are taking for anxiety and/or insomnia?

- 0-25%
- 26-50%
- 51-75%
- >75%

Why should we deprescribe benzos?

Benefits[1]

- Anxiety: NNT=7 @ 4-6 weeks
- Insomnia: NNT=13 @ 2 weeks
  - +34.2min of sleep, -0.6 awakenings/night
- Panic: NNT=5 (intermittent use)
- Tolerance (and dependence) occur

Risks

- Cognitive/memory impairment, confusion, delirium, falls, fractures, MVAs: NNH=6[1,2]
- ?Increased mortality in elderly shown in some trials[3,4]

Which age cohort gets Rx'ed benzos the most (16%)?

a) Age 0-17
b) Age 18-25
c) Age 26-39
d) Age 40-54
e) Age 55-65
f) Age >65

How to start - use the same strategies?

Improve mental health?

Avoid deferring benzo taper

- It will likely never be a good time
- Deferring until “next time” can ↑ taper anxiety (likely worse than the taper itself)
- Instead, try forcing a reduction (let patient suggest or give options), provide timely f/u (e.g., 1 week), and allow for reversal of reduction if unsuccessful
  - Reduces anxiety about taper
  - Empowers patient to be involved in taper
  - Even if not successful, predicts willingness/success with taper discussions in future

CEP | Providers

Managing Benzodiazepine Use in Older Adults

This tool is designed to help primary care providers assess and discuss with their patients 65 years of age or older, the potential risks and benefits of benzodiazepines. This tool also contains steps to support primary care providers in safely discontinuing, starting or continuing to prescribe benzodiazepines for their older patients.

Determine whether a benzodiazepine is appropriate or problematic [7]

Why is the patient taking/starting a benzodiazepine?

- Anxiety disorders
- Insomnia
- Panic disorder

→ See Section B: Discontinuing benzodiazepines → See Section D: Alternatives to benzodiazepines

- Seizure disorders
- Alcohol withdrawal
- Short-term use (<4 weeks)

→ See Section C: Starting and continuing benzodiazepines

DISCUSS WITH A PATIENT THEIR USE OF BENZODIAZEPINES WHEN THE PATIENT: [8, 9]
☐ Is 65 or over
☐ Comes in for a preventative health exam
☐ Comes in for a prescription renewal or refill
☐ Has had a recent hospitalization
☐ Is admitted to long-term care
☐ Has had a recent fall
☐ Presents with new cognitive concerns or early onset dementia
☐ Reports driving difficulty or their family, caregivers or friends reports concerns
☐ Demonstrates rapid escalation of medication use
☐ Has an active substance use disorder that could trigger inappropriate or problematic use of benzodiazepines
☐ Has a potential benzodiazepine use disorder

Talking points

Ask patients what they take the benzodiazepine for

"What concerns did you originally start the benzodiazepine for? Have the concerns that led to your initial benzodiazepine prescription changed?" [10]

Highlight the benefits versus risks of benzodiazepine use for older adults

"Although benzodiazepines sometimes offer small benefits in the short term, they stop working and become harder to wean from over time. Despite this, the serious side effects of taking benzodiazepines remain, such as cognitive impairment, delirium, falls, fractures and increased risk of motor vehicle accidents." [7]

"To maintain your independence, it is important to reduce or remove any medications that increase your risk of cognitive impairment, delirium, falls, fractures and motor vehicle accidents." [7]

"While taking a benzodiazepine you have an increased risk of side effects: [11]

- 5 times higher risk of memory and concentration problems
- 4 times higher risk of daytime fatigue
- 2 times higher risk of falls and fractures (hip, wrist)
- 2 times higher risk of experiencing a motor vehicle accident"

"The benzodiazepine may cause problems with your memory and concentration which could result in an assessment of your driving privileges." [9]

What does tapering look like?

Talk to the patient:

Discuss risks vs benefits & expected outcomes

Provide education:

Withdrawal & rebound symptoms (based on patient's indication, dose, and dose frequency)

Give patients input into tapering strategy

- Switching?
- Size, rate of ↓
- Style of ↓ (QID->TID->BID vs ↓ all doses)

Frequent follow-up

Adjust taper as needed

Offer alternatives to treat primary diagnoses, e.g. CBT

CEP | Providers

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1. PLAN THE TAPERING

- ☐ **Engage patients** in developing a clear plan for tapering, incorporating goals and preferences regarding benzodiazepine use[7]
  - Discuss a goal of discontinuation versus lowest possible dose
    - If a medication cannot be completely discontinued, a decrease in dose is still a win!
  - Ensure patients know what is required of them (e.g. schedule for primary care provider visits and schedule for picking up prescriptions at designated pharmacy)
  - Reassure patients that they have control in the taper; taper can go as slow as they need and can be paused and adjusted as needed
- ☐ **Establish the formulation** to be used for tapering
  - See Benzodiazepines available in Ontario if switching patient to another benzodiazepine before tapering
  - There is insufficient evidence to support the use of one particular benzodiazepine over another (or for long- vs. short-acting benzodiazepines) for a tapering schedule[7]
- ☐ **Establish the dosing interval**
  - Scheduled doses are preferred over prn doses (to help with the withdrawal)
  - Keep the dosing interval constant (e.g. bid)
- ☐ **Establish the rate of the taper** based on the patient's health and preferences, as well as formulations available for the current benzodiazepine (see Benzodiazepines available in Ontario)
  - For older adults, it is recommended to taper the benzodiazepine dose slowly: **25% reduction every 2 weeks and then a slower taper of 12.5% every 2 weeks near the end**[7]
  - See Alternative rates for tapering
- ☐ **Contact the patient's pharmacy** to discuss the tapering plan (by phone and/or fax depending on what is feasible)
  - Discuss with the pharmacist any pill splitting or liquid formulations necessary to accommodate tapering doses as well as packaging options for older adults (e.g. dosette or blister pack)

2. CONSIDER ADJUNCTIVE THERAPY

- ☐ **Consider cognitive behaviour therapy** to improve tapering success rates
  - Cognitive behaviour therapy has the highest success rate for patients discontinuing benzodiazepines compared to usual care or other prescribing interventions (see Patient resources, services and supports)[7]
  - The use of pharmacological adjunctive agents has limited evidence to support success

3. INITIATE THE TAPER AND MONITOR

- ☐ **Decrease patient's dose** by 25% (or decided upon rate) every 2 weeks until dose is close to end goal (discontinuation or lowest possible dose), then slow the dose reduction to 12.5% (or decided upon rate) every 2 weeks until the end goal is reached[7]
- ☐ **Schedule follow-up appointments** with patient for every 1-2 weeks (in-person or over the phone) to monitor for expected benefits as well as severity and frequency of adverse drug withdrawal symptoms[7]
  - See ii. Monitoring during a taper
  - If withdrawal symptoms are bothersome for a patient or if the taper is not going well, consider maintaining the current dose for an additional 1-2 weeks before attempting the next dose reduction, then continue to taper at a slower rate if appropriate[7]

ii. Monitoring during a taper

During a taper, monitor a patient for expected benefits as well as adverse drug withdrawal symptoms and manage accordingly. If a patient is at high risk of withdrawal symptoms, refer to a supervised setting during taper initiation.

MONITOR PATIENTS DURING A TAPER FOR: [7, 12]

Expected benefits	Common withdrawal symptoms	Severe withdrawal symptoms*
☐ Less daytime sedation	☐ Rebound anxiety disorders and/or panic disorder	☐ Agitation
☐ Improved cognition	• Use validated assessment tools such as, the GAD-7 and PHQ (PHQ section 4 on panic disorder)[15]	☐ Confusion
• Use validated assessment tools such as, the Montreal Cognitive Assessment [22]	☐ Rebound insomnia	☐ Disorientation
☐ Fewer falls	• Use a validated assessment tool such as, the Insomnia Severity Index [16]	☐ Depersonalization
☐ Fewer fractures	☐ Irritability	☐ Delirium
☐ Fewer motor vehicle accidents	☐ Sweating	☐ Seizures
☐ Improved function	☐ Gastrointestinal symptoms (i.e. diarrhea, abdominal cramps, nausea and vomiting)	☐ Unstable vital signs
☐ Fewer respiratory exacerbations	☐ Chills	
	☐ Tremors	
	☐ Dizziness	
	☐ Visual distortion (patient should be told to see their primary care provider if they are experiencing visual distortion)	
	☐ Tinnitus	

- Withdrawal is only for patients taking benzos around the clock (not a risk for intermittent or HS-only users, unless very high dose or decreased clearance)
- Withdrawal only lasts 1-2 weeks but the onset can be variable (benzos with longer half lives/active metabolites will have delayed withdrawal)

Patient: 66yo F, "CR"

Benzo: Clonazepam 0.5mg BID

Indication: unknown (?seizure vs behaviour) - lives in group home

- New patient with polypharmacy, pt & sister motivated to deprescribe, except benzo
  - **Optimized other meds first**
- At 1 month f/u, convinced to start scheduled benzo taper:

  (confirmed with neuro: not for seizure)

Week 1: Clonazepam 0.25 mg AM and 0.5 mg HS
Week 2: Clonazepam 0.25 mg BID
Week 3: Clonazepam 0.125 mg AM and 0.25mg HS
Week 4: Clonazepam 0.125 mg BID
Week 5: Clonazepam 0.125 mg HS
Week 6: discontinue

- F/u q1-2 weeks:
  - Weeks 1-4: Tolerating well: pt very involved, no change in mood, no w/d sx
  - Week 5: Pt much moodier, withdrawn, outbursts
  - **Last step of taper reversed (week 5 → 4), paused**
  - 2wk f/u: no change to symptoms... turns out was an incident, likely caused change
  - Sister hesitant to make further changes
- Currently on 0.125mg BID (75% reduction), in-person f/u planned

Patient: 56yo F, "SA"

Benzo: Clonazepam 1mg AM, 0.5mg PM, 2mg HS

Indication: Complex mental health: BPD, GAD, MDD (**also on opioid)

- Hospitalization for fall, pt c/o memory issues - taper started by MD (Sept 2022), followed by RPh
  - **Noon dose stopped** first, then ↓ **AM and HS in turn**
  - Unclear how pt is taking despite bubble packs (?stockpiling)
  - Pt presents distressed, c/o benzo withdrawal, sx consistent with neuropathy. Education provided, options discussed
- Clonazepam 0.25mg AM + 1.5mg HS → **Diazepam 17.5mg BID** (Mar 2023)
  - C/o daytime sedation, **self-tapers AM dose** to 1.25-2.5mg prn
  - Taper plateaus
- Unrelated admission (ARF associated with other medical conditions)
  - **Stepwise benzo reductions while in hospital**
- Discharge home on Diazepam 12.5mg/day = ~80% reduction (Oct 2023)

How much MORE optimistic are you about tapering after this?

- 0-25%
- 26-50%
- 51-75%
- >75%

References

- *Busse JW, Wang L, Kamaleldin M, et al. Opioids for Chronic Noncancer Pain: A Systematic Review and Meta-analysis. JAMA. 2018;320(23):2448-2460. doi:10.1001/JAMA.2018.18472*
- *Chou R, Turner JA, Devine EB, et al. The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop. Ann Intern Med. 2015;162(4):276-286.*
- *College of Physicians and Surgeons of Manitoba. (Jan 2019). Standard of Practice: Prescribing Opioids. Retrieved from http://www.cpsm.mb.ca/laws-and-policies/standards-of-practice-of-medicine*
- *College of Physicians and Surgeons of Manitoba. Standard of Practice: Prescribing Benzodiazepines & Z-Drugs. November 2020.Accessed Oct. 6, 2023. <https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Prescribing%20Benzodiazepines%20and%20Z-Drugs.pdf>*
- *Cox, J, S Christensen, D Steele. Benzodiazepine Use. Centre for Effective Practice. Toronto, ON. July 2019. Accessed Oct. 6, 2023. https://cep.health/clinical-products/benzodiazepine-use-in-older-adults/*
- *Farrell B, Tsang C, Raman-Wilms L, Irving H, Conklin J, et al. (2015) What Are Priorities for Deprescribing for Elderly Patients? Capturing the Voice of Practitioners: A Modified Delphi Process. PLOS ONE 10(4): e0122246. https://doi.org/10.1371/journal.pone.0122246*
- *Genova A, Dix O, Thakur M, Sangha PS. Chronic Non-cancer Pain Management and Addiction: A Review. Cureus. 2020;12(2). doi:10.7759/CUREUS.6963*
- *Glass J et al. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. BMJ. 2005 Nov 19;331(7526):1169. Epub 2005 Nov 11. PMID: 16284208.*
- *Government of Canada. Opioids - Canada.ca. Published July 2022. Accessed July 17, 2022. https://www.canada.ca/en/health-canada/services/opioids.html#shr-pg0*
- *Green AR, Aschmann H, Boyd CM, Schoenborn N. Assessment of Patient-Preferred Language to Achieve Goal-Aligned Deprescribing in Older Adults. JAMA Netw Open. 2021;4(4):e212633. doi:10.1001/jamanetworkopen.2021.2633*
- *Gupta S, Atcheson R. Opioid and chronic non-cancer pain. J Anaesthesiol Clin Pharmacol. 2013;29(1):6. doi:10.4103/0970-9185.105784*
- *Højsted J, Sjøgren P. Addiction to opioids in chronic pain patients: A literature review. European Journal of Pain. 2007;11(5):490-518. doi:10.1016/J.EJPAIN.2006.08.004*
- *Korownyk C, et al. PEER simplified chronic pain guideline. Canadian Family Physician. 2022;68:179-190. Accessed March 9, 2023. https://www.cfp.ca/content/cfp/68/3/179.full.pdf*
- *LexiComp. Published online 2022.*
- *Mathieu C et al. Patterns of Benzodiazepine Use and Excess Risk of All-Cause Mortality in the Elderly: A Nationwide Cohort Study. Drug Saf. 2021 Jan;44(1):53-62. PMID: 33125663.*
- *National Pain Centre. (2017). The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. Retrieved from: https://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf*
- *Opioid- and Stimulant-related Harms in Canada - Public Health Infobase | Public Health Agency of Canada. Accessed October 28, 2022. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/*
- *Patorno E et al. Benzodiazepines and risk of all cause mortality in adults: cohort study BMJ 2017; 358 :j2941*
- *Regier LD. Pain Management & Opioids: Addressing Important Challenges and Introducing a Chronic Pain and Opioids Mini-Book. RxFiles. Published online 2017. Accessed July 17, 2022. https://www.rxfiles.ca/rxfiles/uploads/documents/Opioids-Pain-2017-Newsletter.pdf*
- *Special Advisory Committee on the Epidemic of Opioid Overdoses (SACEOO). Opioid- and Stimulant-related Harms in Canada - Public Health Infobase | Public Health Agency of Canada. Ottawa: Public Health Agency of Canada. Published September 28, 2022. Accessed July 17, 2022. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/*

Questions?

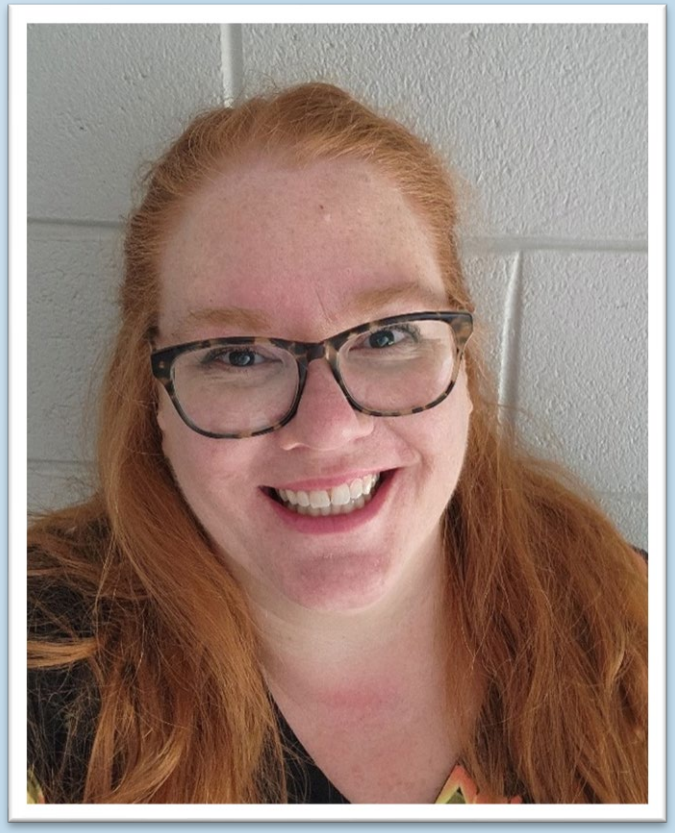
Tapering 101:

Deprescribing & Tapering Opioids and Benzos

Karin Ens, BScPharm, MSc, EPPh (she/her)

Presenter Introduction

Lori Nicholson, RN, BN



- Clinical Specialist for Shared Health Mental Health and Addictions
- Over 19 years of nursing experience
- Currently Addictions in Mental Health Resource Nurse at Selkirk Mental Health Centre
- Advocates for a person-centered, trauma-informed, and recovery-oriented approach
- Enjoys facilitating education sessions for staff, students, and the public

Strategies to Engage Individuals in Conversations About Substance Use

Presented by Lori Nicholson RN BN,

Clinical Specialist for Shared Health and Addictions in Mental Health Resource Nurse at SMHC

Health services across Manitoba are provided in facilities located on the original lands of First Nations, Inuit, and on the national homeland of the Red River Métis Nation.

Manitoba's health authorities respect that First Nations treaties were made on these territories, acknowledge harms and mistakes, and we dedicate ourselves to collaborate in partnership with First Nations, Inuit, and Métis peoples in the spirit of reconciliation.

We acknowledge discrimination and racism still exist (and caused harm) across Manitoba's healthcare system today, affecting Indigenous, Black and racialized Individuals and communities and we resolve to take real and impactful steps to disrupt and dismantle racism and discrimination in all forms across Manitoba's health system.

Conflicts of Interest/Disclosure:

Presenter: Lori Nicholson RN, BN

- I have no conflicts to disclose.
- Shared Health – Mental Health and Addictions has received a program fee to cover the creation and facilitation of this presentation.
- This presentation has received no financial or in-kind support from any commercial or other organization.

Objectives

- Understanding the importance of including Welcoming, Empathy, and Hope principles into your interactions with clients.
- What is Brief Intervention?
- How to incorporate elements of Brief Interventions and Motivational Interviewing Skills into everyday care.
  - Let's Meet Gary (case study)
  - Raising the subject.
  - Provide feedback.
  - Enhancing Motivation.
  - Negotiate and advise.
- A review of mental health and addictions resources and services.

Welcoming, Empathy and Hope

Spirit of Welcoming Practice

Empathy

- The individual's job involves living with a mental health and/or substance use disorder, wanting neither one, yet having to build an identity that involves accepting a need to address both
- Empathetic Message: You come first. Your needs, interests and desires will direct us, What has brought you to us and how do you think our service will fit into your needs?

Hope

- **Recovery is possible** for anyone with a co-occurring disorder or substance use disorder, and it is important that a hopeful vision of recovery is established at the beginning
- Communicating Hope
  - **Empathize with reality of despair**
  - **Establish legitimacy of need to ASK for extensive help**
  - **Emphasize a hopeful vision of pride and dignity to counter self-stigmatization**

Welcoming, Empathic & Hopeful Attitudes & Values

- Accepting regardless
- Valuing the person and validating their feelings/needs
- Expressing, eliciting and amplifying hope
- Providing opportunity regardless of motivation
- Using a non-judgmental stance
- Viewing people as capable and resourceful and inquiring into their experience of resilience & triumphs (strengths)
- Privileging Individual's views
- Respecting their pace
- Valuing involvement of family and friends

Growing Our Empathy

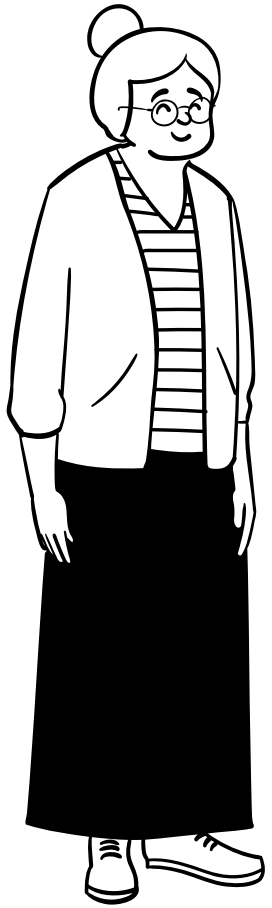
- Empathy is an inherent ability of many health care providers, leading to positive and meaningful connections with others.
- In health settings, high levels of empathy are related to better therapeutic outcomes, making it a worthwhile skill to hone.
- Practicing accurate empathy involves demonstrating a genuine desire to understand the other person's viewpoint.

Meet Helen:

- Helen is a 72-year-old female who was recently admitted to your hospital ward. She's on a high dose benzodiazepine for anxiety and is also taking a high dose z-drug for insomnia, along with multiple other psychoactive medications. She was admitted to hospital due to a fall and you're concerned that her medication may have been the cause of it.

- You want to discuss this with Helen. However, whenever you try to bring up the subject, she gets very defensive and says she doesn't want to talk to someone she isn't familiar with about this.

- **How could we incorporate Welcoming, Empathic and Hopeful Attitudes and Values into our interactions with Helen?**



What is Brief Intervention?

What is Brief Intervention?

- A language techniques approach related to Motivational and Solutions Focused therapy used to elicit positive behavioural change

- A significant body of research exists supporting the use Brief intervention in primary care as effective best practice

- Since it has proven effective and fits with developing effective and supportive relationships, BI is fully supported in Health Canada's Best Practice for Early Intervention, Outreach and Community Linkages

How Brief is Brief?

- Single contact lasting less than 10 minutes to up to an hour
- One or more in-person brief contacts plus materials given
- In-person, phone, or mailed feedback (generic, tailored, or personalized) based on assessment/conversation
- Multiple interactions of limited length and number

Why use Brief Intervention?

- Brief Intervention is an **evidence-based**, **proactive**, and **patient-centred** approach to eliciting behavioural change

Examples of Brief Interventions:

- Screening Brief Intervention & Referral (SBIR), this is sometimes referred to as Screening Brief Intervention & Referral to Treatment (SBIRT)
- The 5As (Ask, Advise, Assess, Assist, Arrange)
- The 5 R's (Relevance, Risks, Rewards, Roadblocks, and Repetition)

How to Utilize Elements of Brief Interventions and Motivational Interviewing Skills

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Manitoba

Self-Positionality

Consider how your own attitudes, values, and beliefs around substance use and addiction have been created:

- Personal involvement
- A loved one's involvement
- What you see on the job
- What you see in the media and popular culture

Let's Meet Gary

- Gary is a 24 year old male who was prescribed an opioid for post-surgery pain in February 2022.
- Never requested an early refill until this year
- Regular early refill requests for the last several months.
- His doctor has approved the early releases.
- Gary becomes irritable when you bring up the pattern of early refills.
- You are concerned that he may or has developed an addiction to his prescribed opioid.

Step 1: Raise the Subject

- Establish rapport
- Ask permission to raise the subject
- Screen & Assess

"Would it be okay if we had a further conversation about your opioid refills"?

Gary has agreed (although reluctantly) to hear your concerns.

Step 2: Provide Feedback – How do we do This?

- Express concern with empathy
- Understand their priorities & highlight shared goals
- Acknowledge/explore natural consequences
- Talk about what others do

Gary: "I may take extra doses of my medication to help with my stress, but I still need this medication for pain.

"We both want to make sure that you have the best plan to manage your pain safely and effectively".

Provide Feedback – Traps to Avoid

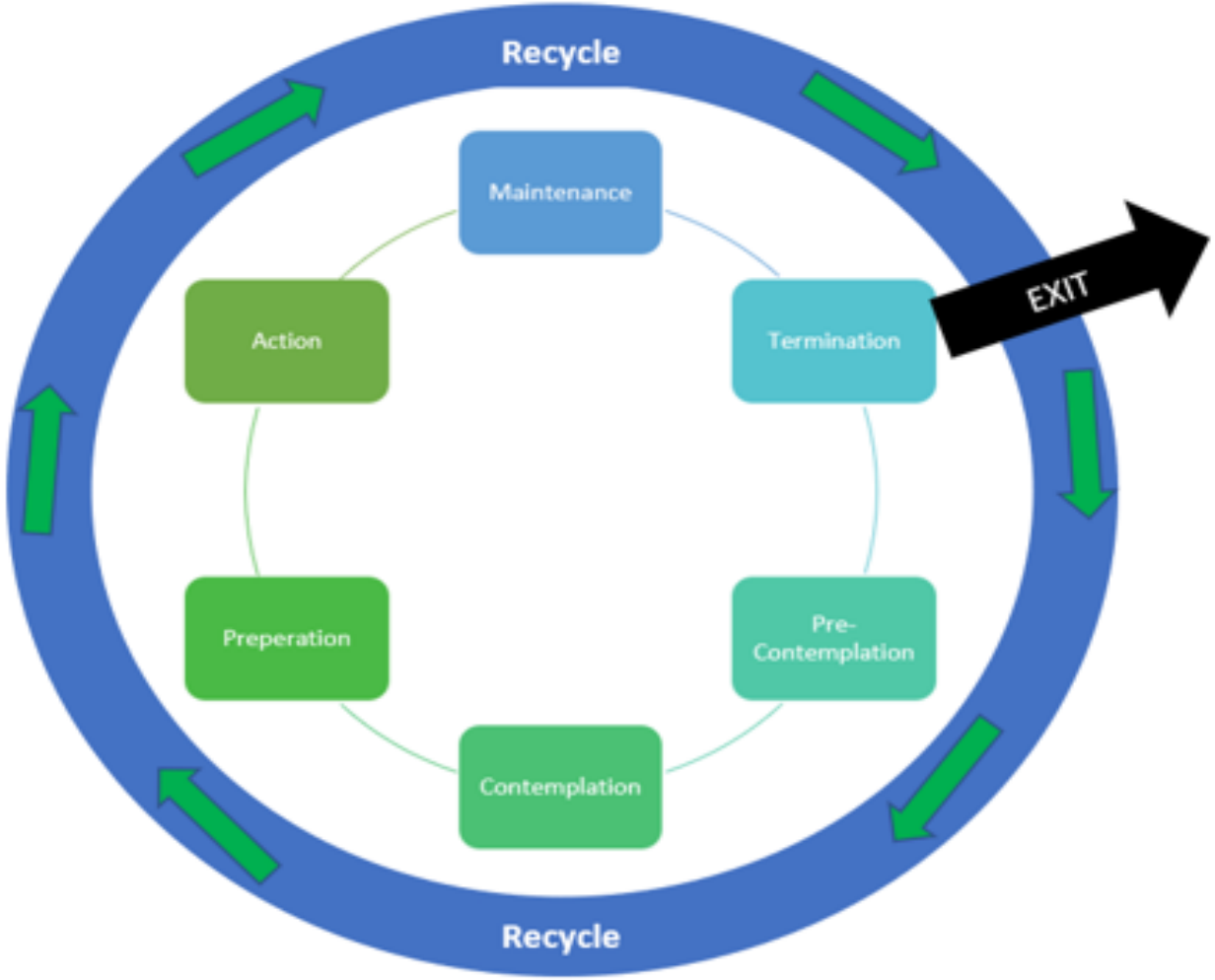
1. Question/Answer
2. Confrontation/Denial
3. Expert Trap
4. Labelling
5. Premature Focus
6. Blaming

Step 3: Enhance Motivation

- Assess readiness (Stage of Change)
- Enhance motivation for change
    - Motivational Interviewing approach & techniques

Gary: "I can see what you are saying, but I don't think I have a drug problem or anything".

Stages of Change



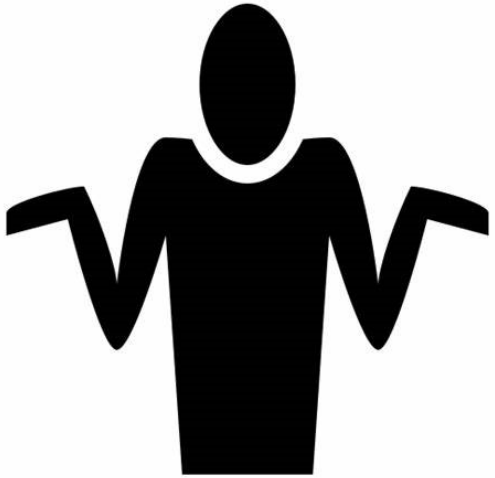
(Adapted from Prochaska and DiClemente, 1984 and DiClemente 2018)

Enhancing Motivation With Gary

- **O**pen-ended Questions
  - Example: “What are the good things about taking opioids and what are the less good things about it”?
  - Example: “You mentioned that you were feeling stressed. Can you tell me more about that”?
- **A**ffirmations
- **R**eflective Listening
  - Example: “It sounds like you have been feeling a lot of stress lately”.
  - Example: “ What I hear you saying is that you feel stressed/anxious when you run out of your prescription early” .
- **S**ummaries

Rolling with Resistance

- Ambivalence is a normal part of the change process.
- Can be a person's reaction to the clinician's approach in the moment.
- If presented with reasons to change, people may tend to argue to stay the same (creates discord).
- Don't take resistance personally, consider changing direction or listening more carefully by using open-ended questions and reflecting listening (OARS skills).
- Ensure accurate stage matching (not arguing for change if a person is in the pre-contemplative stage of change).



(SAMHSA TIP35, 2019 and WRHA-HBC, 2021)

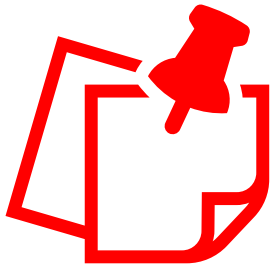
Step 4: Negotiate & Advise

- Provide a menu of options & advice
- Keep it Interactive
  - Goals and plans should belong to the client
  - Breaking down the plan into smaller steps and shorter time frames might be helpful
  - Build on positive language
  - Affirm successes both past and present
- Follow Up

Gary: “I am not sure about talking to my doctor, but I will think about it ”.

A Quick Note about O.A.T.

- Create a safe and welcoming environment
- Use initial visits/ daily doses as an opportunity to establish rapport and build a trusting, therapeutic relationship
- Use an empathic approach (apply the strategies we just learned).
- Clearly communicate your concern and information on what happens when doses are missed.
- Consult Opioid Agonist Therapy Guidelines for Manitoba Pharmacists for information re: missed doses and reporting requirements.



Resources and Services

Rapid Access to Addictions Medicine (RAAM) Clinic Locations:

Winnipeg: Crisis Response Centre (CRC)(817 Bannatyne Avenue*): 12pm Tuesday, Wednesday, Friday.
*Harm Reduction Supplies are available 24 hours – 7 days a week at this location.

Virtual Clinic: Video appointments are available Thursday afternoons for those with mobility, transportation or other challenges. This service requires an email address and reliable internet.

Call (204) 792-7159 for more information and to book an appointment.

Winnipeg: River Point Centre (146 Magnus Ave):12:30 p.m. on Mondays & 9:00 a.m. on Thursdays.

Brandon: Access Centre (20 – 7th Street): 10:45 a.m. on Mondays**,** Tuesdays & Wednesdays.

Selkirk: Community Health Office (237 Manitoba Avenue): 12 noon on Tuesdays

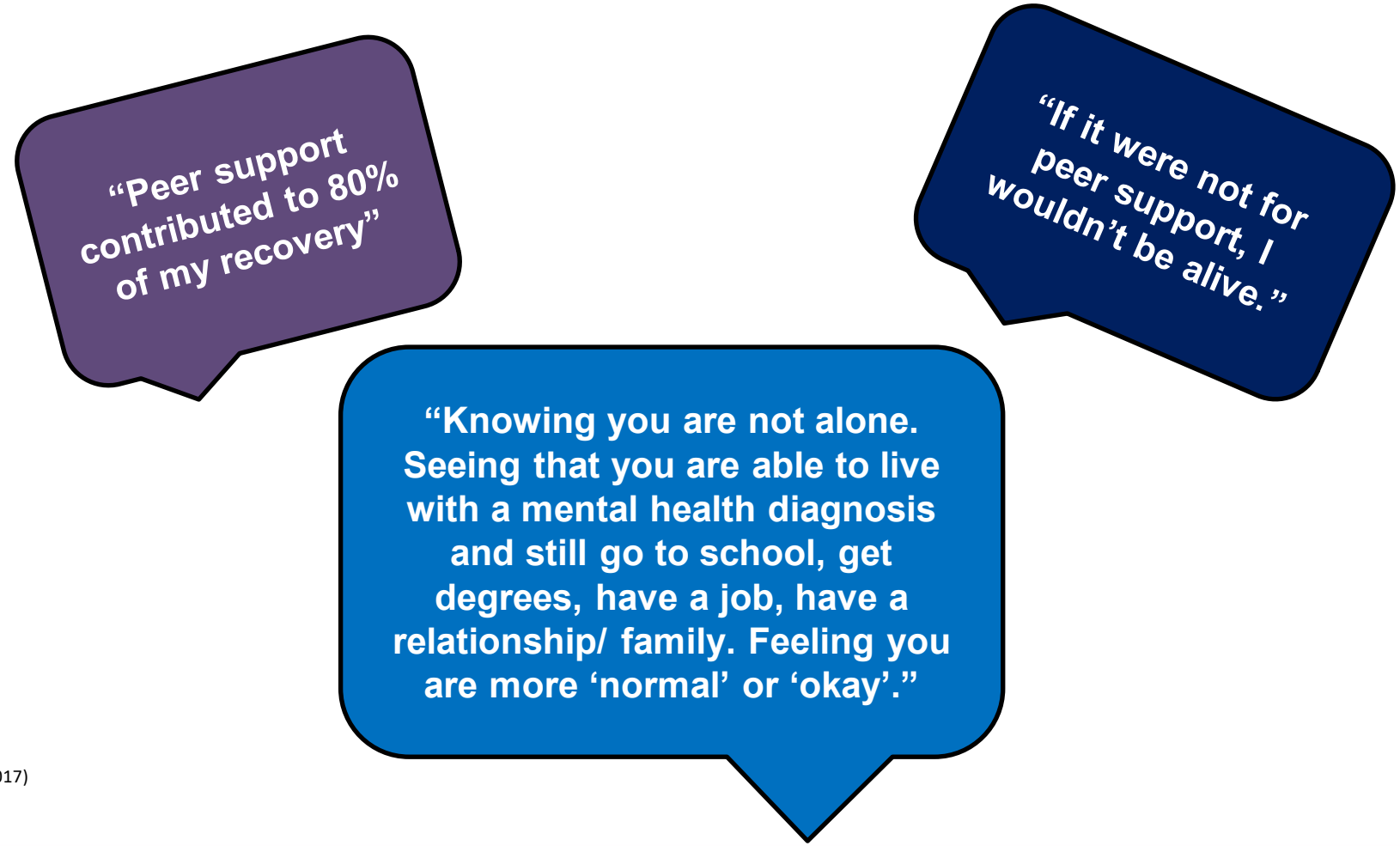
Thompson: Eaglewood Treatment Centre (90 Princeton Drive):9 a.m. on Tuesdays and 12:30 p.m. on Wednesdays & Thursdays.

Portage la Prairie (159 – 5th Street S.E.): 12:30 p.m. on Tuesdays and Thursdays

For more information, call the Manitoba Addictions Helpline at **1-855-662-6605**.

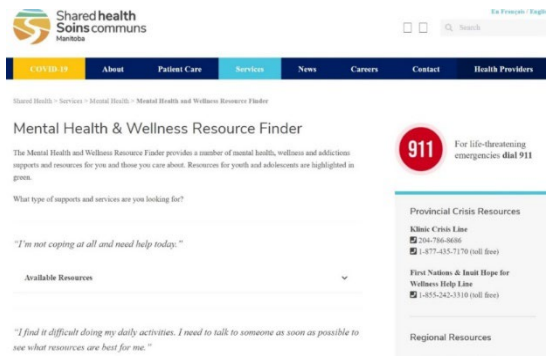
https://sharedhealthmb.ca/services/mental-health/raam-clinic/

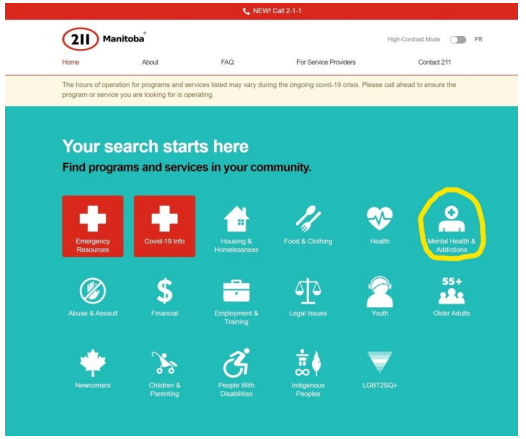
Self-Help, Peer Lead, and Mutual Support Groups



(MHCC,2017)

Knowing Your Resources





- [Mental Health Resources for Winnipeg Guide https://mbwpg.cmha.ca/](https://mbwpg.cmha.ca/)
- [Shared Health Mental Health and Wellness Resource Finder https://sharedhealthmb.ca/services/mental-health/mental-health-and-wellness-resource-finder/](https://sharedhealthmb.ca/services/mental-health/mental-health-and-wellness-resource-finder/)
- [Manitoba 211 call or visit mb.211.ca/](mb.211.ca/)
- Substance Use Treatment Centres for Indigenous Individuals: https://www.sac-isc.gc.ca/eng/1576090254932/1576090371511#a4
- Hope for Wellness Help Line [1-855-242-3310](tel:1-855-242-3310)

Other Training and Literature

- Printable RAAM Brochure: https://sharedhealthmb.ca/files/raam-brochure-eng.pdf
- Screening, Brief Intervention & Referral to Treatment (SBIRT) - MAKE (makeconnections.ca)
- SBIRT Toolkit https://kmb.camh.ca/ggtu/sbirt-toolkit/
- Substance Abuse and Mental Health Services Administration. (2019). Enhancing motivation for change in substance use disorder treatment. Substance Abuse and Mental Health Services Administration. TIP 35. Retrieved from: https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003
- Mental Health and Addictions Library: https://sharedhealthmb.ca/services/mental-health/ *select MHA library and it will direct you to the current website.
- Opioid Agonist Guidelines for Pharmacists: https://cphm.ca/wp-content/uploads/Resource-Library/Opioid-Agonist-Therapy/OAT-Guidelines-May-1-2023-approved.pdf
- Opioid Agonist Maintenance Treatment - A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders: https://store-camh.myshopify.com/products/p6500
- Co-Occurring Disorders Education Curriculum, CODEC by Shared Health (LMS)
- Motivational Interviewing & Health Behaviour Change by Shared Health (LMS)
- Canadian Centre for Substance Use (CCSA) website https://www.ccsa.ca/

Screening and Assessment Tools

- Screening and Assessment Tool Chart: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
- CAGE-AID Screening Tool: https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/all_plans/cage-substance-screening-tool.pdf
- Drug Abuse Screening Test (DAST): https://sbirt.care/pdfs/tools/DAST.PDF
- CAGE-AID Screening Tool: https://docs.clinicaltools.com/pdf/sbirt/CAGE-AID.pdf
- Clinical Opiate Withdrawal Scale (COWS): https://www.bccsu.ca/wp-content/uploads/2017/08/Clinical-Opiate-Withdrawal-Scale.pdf
- Searchable Database of screening/assessment tools: http://lib.adai.washington.edu/instruments/


Thank
You

References

- Alberta Health Services (2016). Enhancing concurrent capability: a toolkit for managers and staff. Retrieved from: Enhancing Concurrent Capability (ECC) Toolkit | Alberta Health Services
- Addictions Foundation of Manitoba. (2017). Stages of Change Manual and PowerPoint
- Canadian Centre on Substance use and Addiction. (2017). Moving toward a recovery- orientated system of care: a resource for service providers and decision makers. Retrieved from: https://www.ccsa.ca/moving-toward-recovery-oriented-system-careresource-service-providers-and-decision-makers
- Canadian Centre on Substance Use and Addiction. (2019a). Overcoming stigma through language: a primer. Retrieved from: https://www.ccsa.ca/sites/default/files/2019-09/CCSA-Language-and-Stigma-in-Substance-Use-Addiction-Guide-2019-en.pdf
- Mental Health Commission of Canada. (2017). Declaring our commitment to recovery. Retrieved from: https://www.mentalhealthcommission.ca/sites/default/files/201703/Recovery_Declaration_march_2017_eng.pdf
- Minkoff, Kenneth. (2001). *Best practices: developing standards of care for individuals with co-occurring psychiatric and substance use disorders*. Psychiatry Online. Retrieved from: https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.52.5.597
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.
- Prochaska, J.O. & DiClemente, C.C. (1984). *The Transactional approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin; 1984. ISBN 0-87094-438-X
- Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (2013). Applying the stages of change. In G. P. Koocher, J. C. Norcross, & B. A. Greene (Eds.), *Psychologists' desk reference* (pp. 176–181). Oxford University Press. https://doi.org/10.1093/med:psych/9780199845491.003.0034
- Shared Health. (n.d.) Co-occurring Disorder Educational Curriculum (CODEC). Shared Health training sessions. Retrieved from LMS: https://sharedhealthmb.learnflex.net/include/login.asp?url=/users/index.asp
- Shonesy, B. C., Williams, D., Simmons, D., Dorval, E., Gitlow, S., & Gustin, R. M. (2019). Screening, Brief Intervention, and Referral to Treatment in a Retail Pharmacy Setting: The Pharmacist's Role in Identifying and Addressing Risk of Substance Use Disorder. *Journal of addiction medicine*, *13*(5), 403–407. https://doi.org/10.1097/ADM.0000000000000525
- Substance Abuse and Mental Health Services Administration. (2019). Enhancing motivation for change in substance use disorder treatment. Substance Abuse and Mental Health Services Administration. TIP 35. Retrieved from: https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003
- Substance Abuse and Mental Health Services Administration (2020). Substance use disorder treatment for people with co-occurring disorders. Treatment Improvement Protocol (TIP) Series, No. 42. SAMHSA Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf
- Winnipeg Regional Health Authority. (n.d.) Health behaviour change. WRHA training sessions. Retrieved from: https://professionals.wrha.mb.ca/old/professionals/primary-care-providers/health-behaviour.php

Questions?

Strategies to Engage Individuals in Conversations About Substance Use

Lori Nicholson, RN, BN

Thank you for your participation.

- ✓ Any questions that were not addressed will be compiled into a Q&A document and made available on the CPhM website for future reference.

- ✓ Please remember to fill out the Learning Activity Evaluation Form to secure your CEUs. An email containing the form link will be sent to you within 24 hours.