

Opioid Tapering/Discontinuation: Implications for Self-Directed Violence and Managing High Risk Patients in the Context of Suicide Prevention

November 19, 2018

Travis Lovejoy, PhD, MPH

Center to Improve Veteran Involvement in Care,
VA Portland Health Care System
Department of Psychiatry,
Oregon Health & Science University

Poll Question #1

- What is your primary role in VA?
 - Student, trainee, or fellow
 - Clinician
 - Researcher
 - Administrator, manager or policy-maker
 - Not yet working in VA

Disclosures and Conflicts of Interest

We have no financial, personal, or other relationships that would cause conflicts of interest with the information reported here.

Overview

- Dr. Lovejoy: Trends in opioid prescribing; the relationship between pain and suicide; SI and SDV following opioid discontinuation
- Dr. Frank: Opioid discontinuation and patient engagement
- Dr. Dobscha: Clinical approaches to addressing suicide risk among Veterans with pain

A Case

A 66 year old Veteran with chronic back pain, depression, and PTSD presents to your clinic. For the second time in 6 months, despite having recently signed an opioid use agreement, he has run out of his prescription opioids early. He acknowledges he has been taking extra because the current dose “just doesn’t do the trick.” He is hoping you can further increase his dose.

Instead, you decide that it would be safest and most clinically appropriate to taper him off of the opioid and offer other types of pain treatment. When you tell him this, he says “I am at the end my rope, and don’t know what I might do if you stop my meds.”

Figure 1. Opioid Prescriptions Dispensed in the U.S. Annually, 1992-2016.

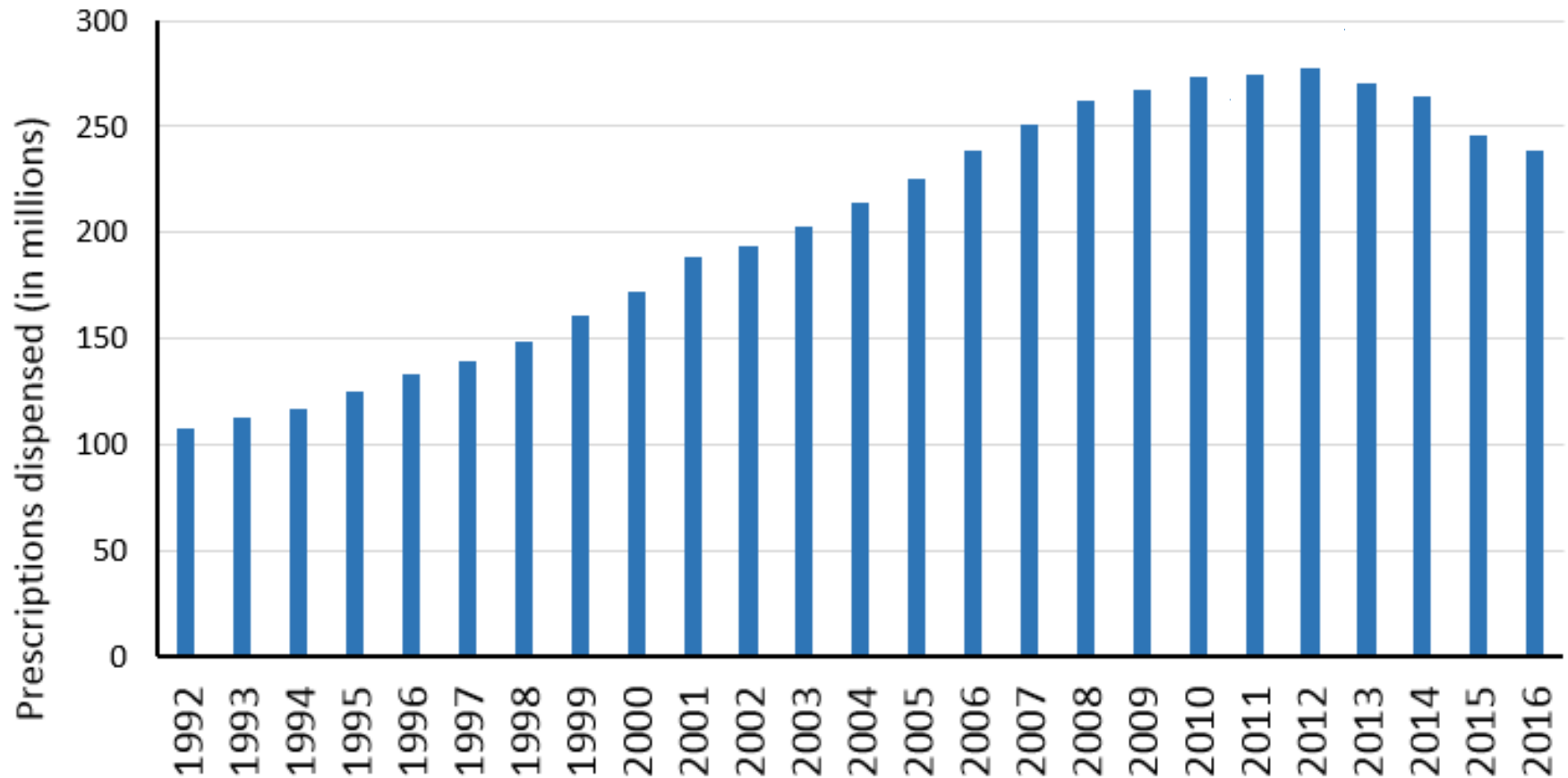
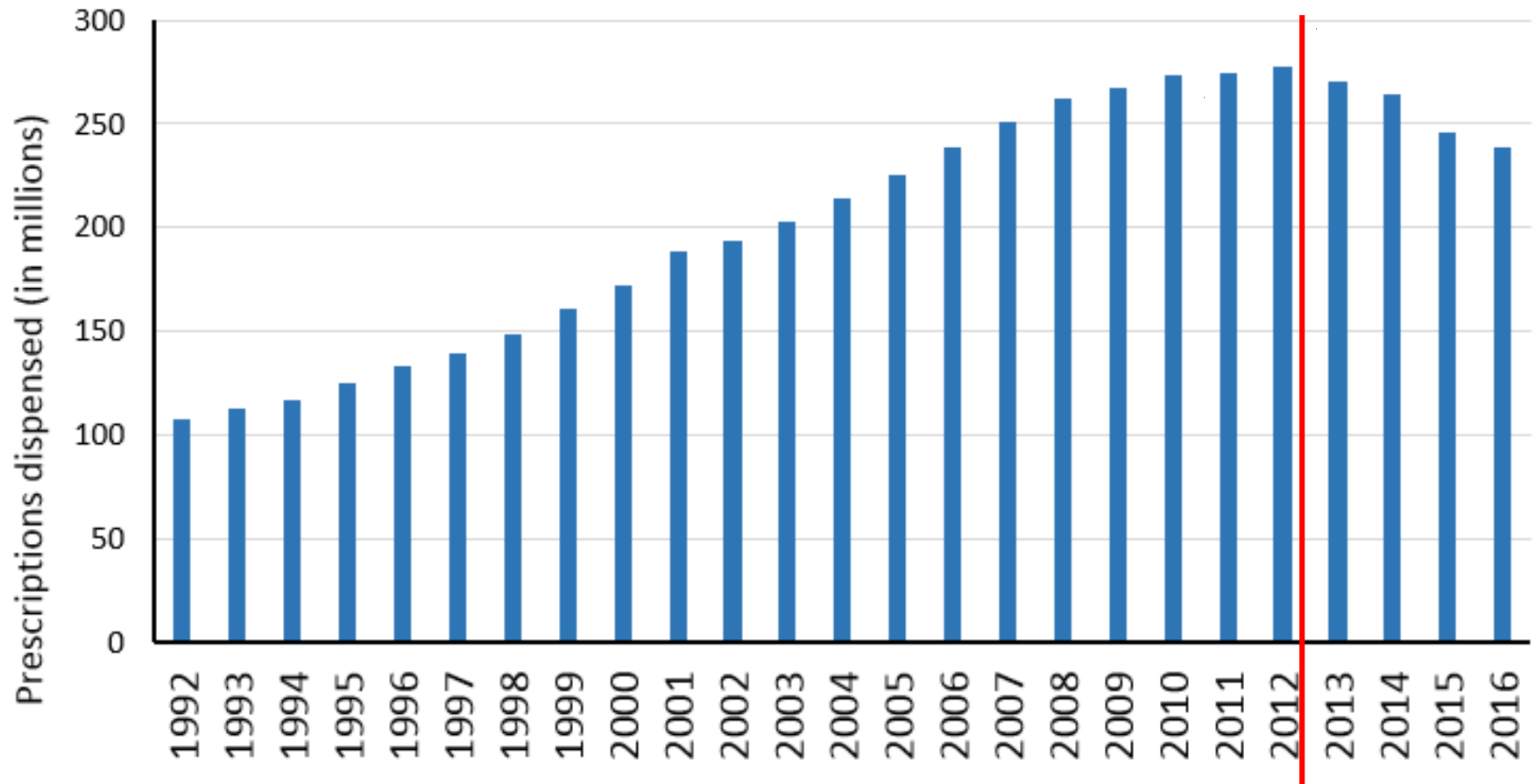
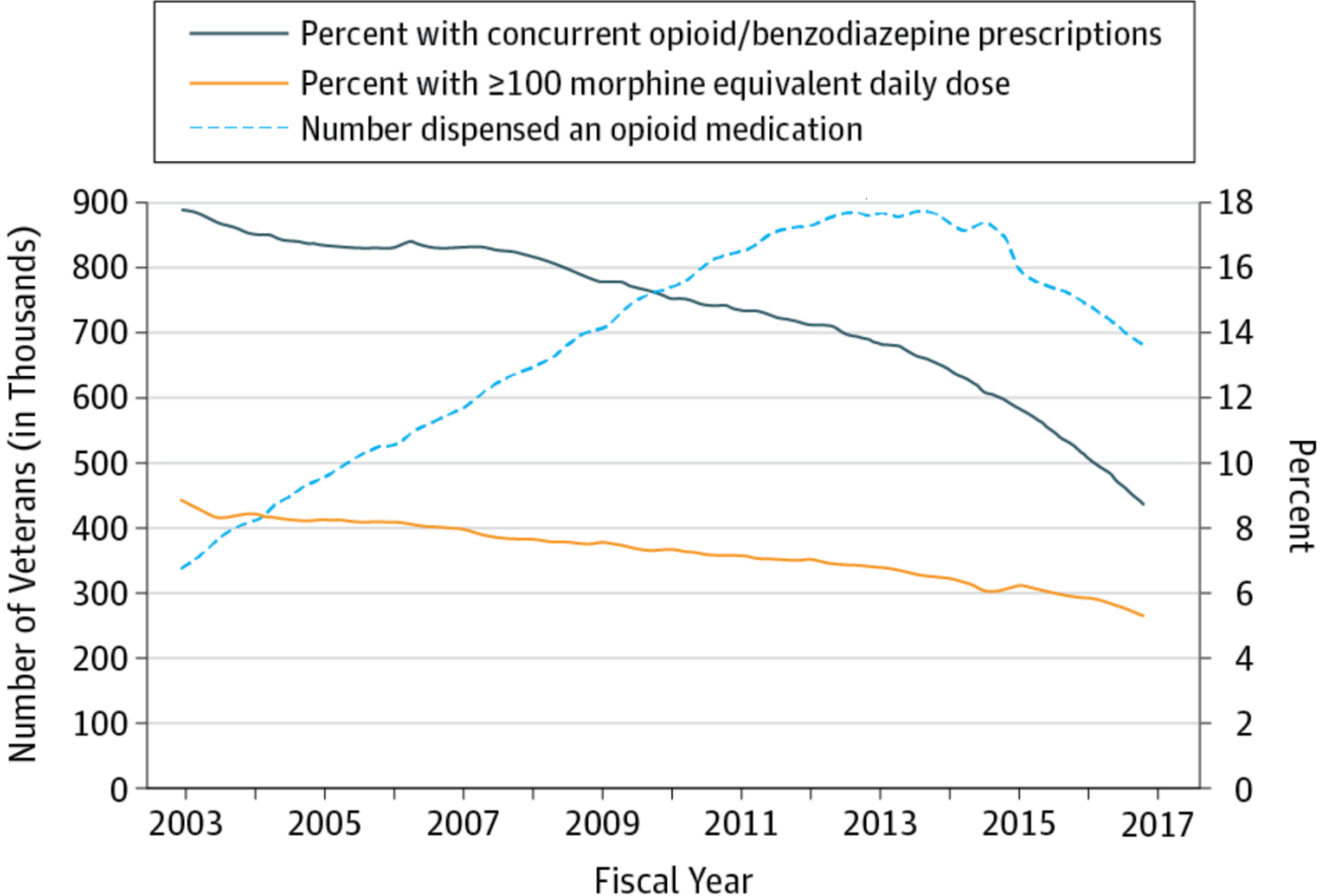


Figure 1. Opioid Prescriptions Dispensed in the U.S. Annually, 1992-2016.



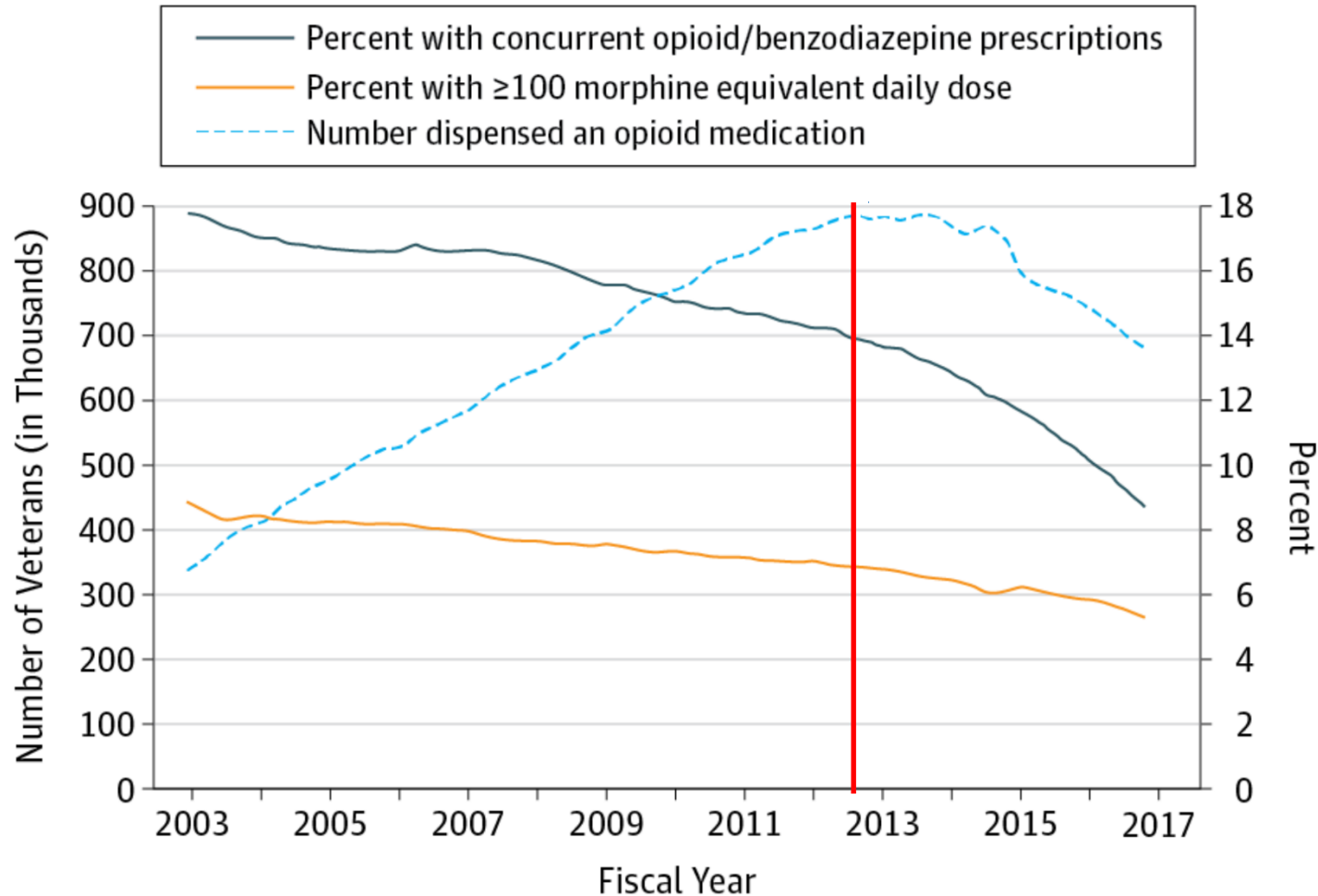
Veterans Dispensed at Least 1 Opioid Medication in the VA Health Care System, and Percent of Opioid Recipients With Concurrent Benzodiazepine Prescriptions and High Opioid Dosage



Gellad et al. Addressing the Opioid Epidemic in the United States Lessons From the Department of Veterans Affairs. JAMA Intern Med. 2017;177(5):611-612.

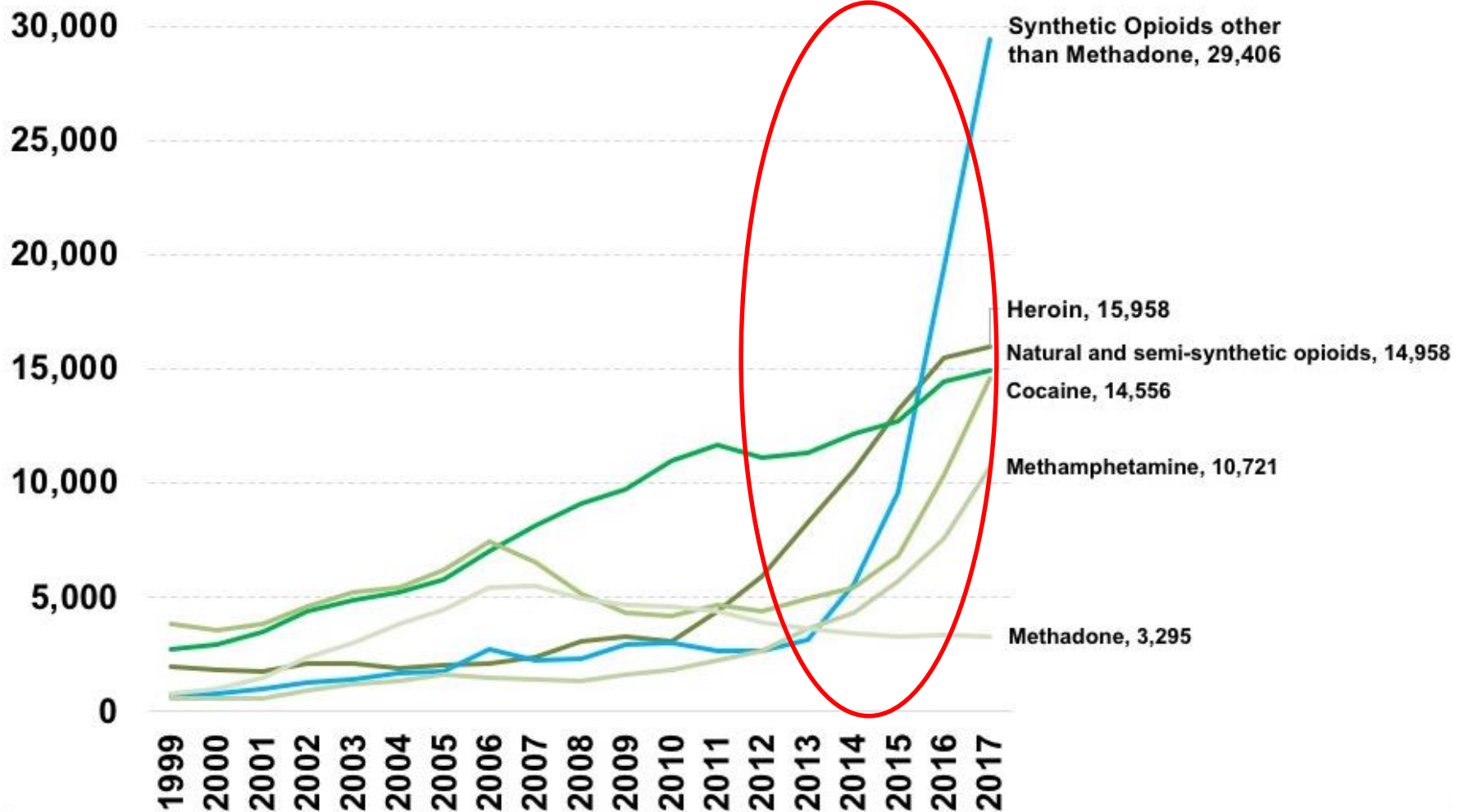


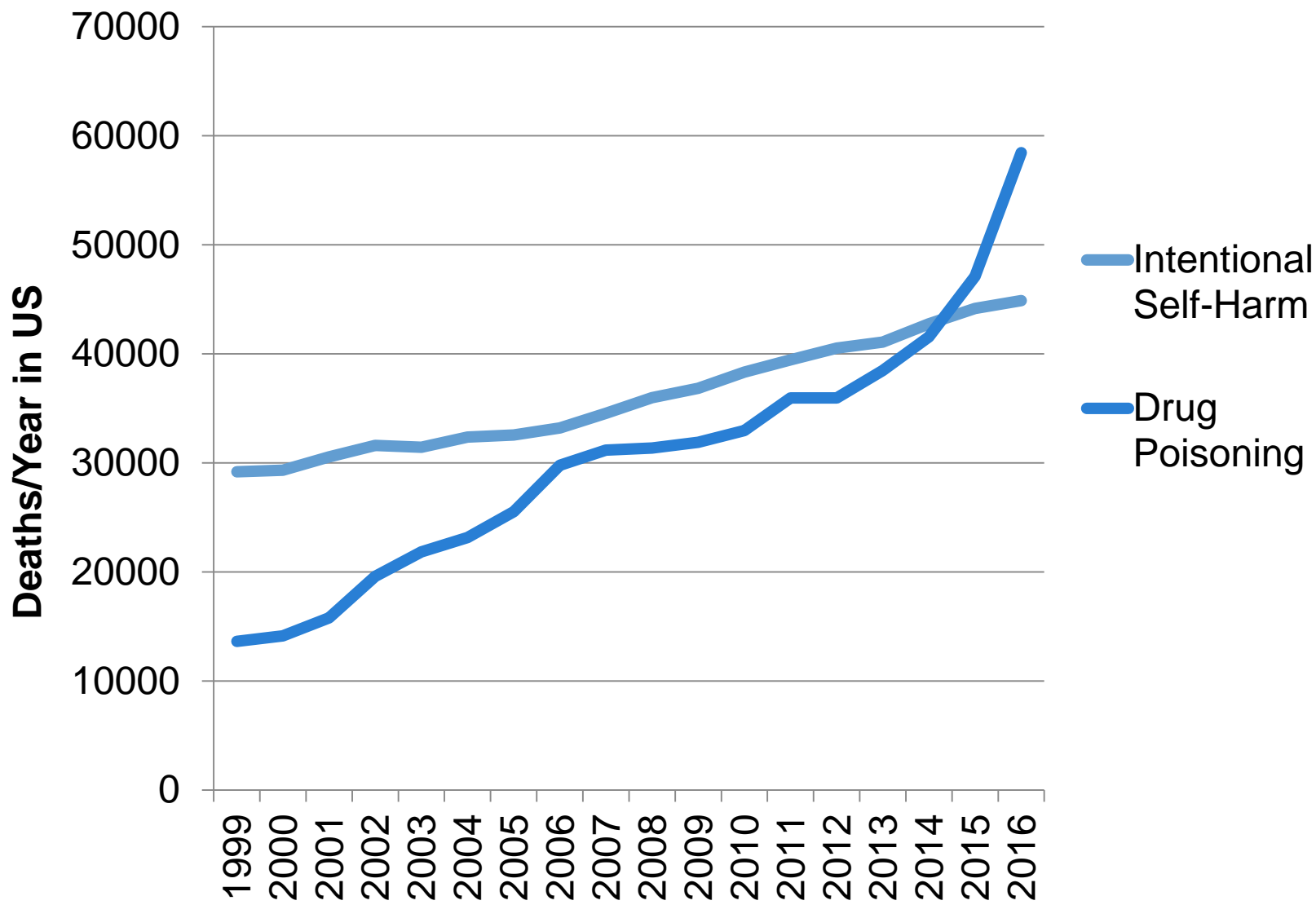
Veterans Dispensed at Least 1 Opioid Medication in the VA Health Care System, and Percent of Opioid Recipients With Concurrent Benzodiazepine Prescriptions and High Opioid Dosage



So what could go wrong?

Drugs Involved in U.S. Overdose Deaths, 1999 to 2017





Pain and suicide behaviors risk

- Association between pain and suicidal behaviors
 - 20% to 30% of patients with chronic pain report recent SI
(Edwards et al., 2006, Tang & Crane, 2006)
 - 5% to 20% of patients with chronic pain report lifetime attempts
(Hinkley & Jaremko, 1994; Saffier et al., 2007, Tang & Crane 2006)
 - 9% of suicide decedents have chronic pain
(Petrosky et al., 2018)

PRESIDENT'S MESSAGE

Pain and Suicide: The Other Side of the Opioid Story

“We fail to accept that pain can progress to be more of a disease than a symptom and, as a consequence, the many people who suffer from severe pain become desperate without relief and, consequently, lose all hope.”

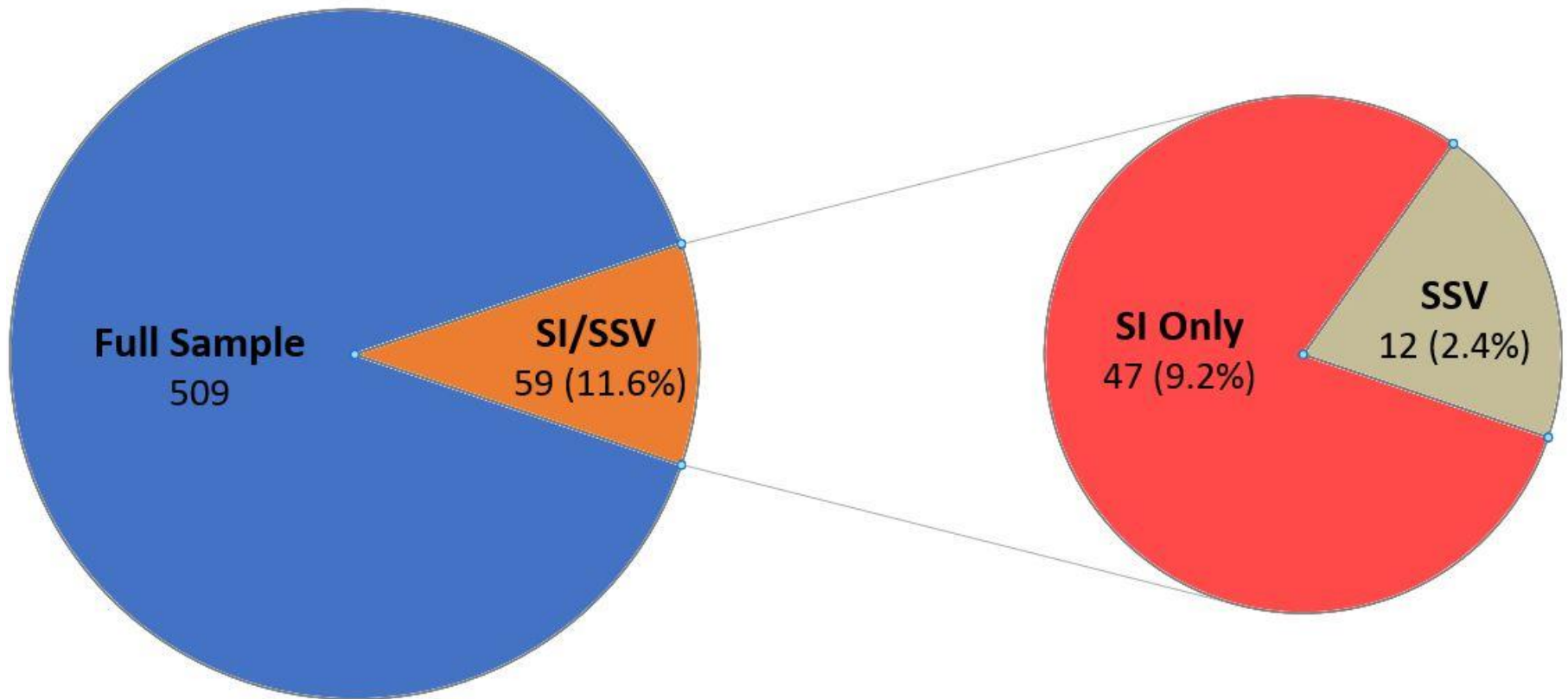
Study of opioid discontinuation in Veterans with and without substance use disorders

- Retrospective electronic medical record review and administrative data abstraction
- Cohort of Veterans prescribed opioids through VA in 2011
- Discontinued LTOT in 2012
- Randomly sampled 300 with SUD diagnosis
- Propensity score matched 300 without SUD diagnosis

Likelihood of LTOT discontinuation between patients with and without SUD, n = 600

| Discontinuation Reason | SUD, % (n) | No SUD, % (n) | Unadjusted odds ratio (95% confidence interval) | Adjusted odds ratio (95% confidence interval) |
|-------------------------------------|------------|---------------|---|---|
| <u>Aberrant behaviors</u> | 70% (211) | 57% (171) | 1.79 (1.28-2.51)* | 1.93 (1.34-2.80)* |
| Known or suspected substance abuse | 52% (157) | 35% (105) | 2.04 (1.47-2.83)* | 2.26 (1.58-3.22)* |
| Aberrant urine drug test | 39% (118) | 35% (105) | 1.20 (0.86-1.68) | 1.21 (0.85-1.73) |
| Opioid misuse | 18% (53) | 13% (39) | 1.44 (0.92-2.25) | 1.31 (0.80-2.14) |
| Nonadherence to pain plan of care | 9% (27) | 14% (41) | 0.63 (0.37-1.05) | 0.59 (0.33-1.04) |
| Known or suspected opioid diversion | 5% (14) | 2% (7) | 2.05 (0.82-5.15) | 1.65 (0.61-4.48) |

Suicidal ideation and suicidal self-directed violence in patients discontinued from LTOT by the opioid-prescribing clinician



New onset suicidal ideation or suicidal self-directed violence following LTOT discontinuation by the opioid-prescribing clinician, n = 509

| | Model 3 |
|--|---------------------------|
| Mental health diagnoses | |
| Depressive disorder | 0.93 (0.38–2.31) |
| Bipolar disorder | 0.28 (0.03–2.37) |
| PTSD | 3.78 (1.41–10.14)* |
| Other anxiety disorders | 1.06 (0.43–2.60) |
| Psychotic-spectrum disorders | 6.72 (1.73–26.17)* |
| Substance use disorder diagnosis | 0.86 (0.39–1.87) |
| Prescribed benzodiazepine in the year prior to discontinuation | 0.73 (0.21–2.59) |
| Average MEDD in the year prior to discontinuation | 1.00 (1.00–1.01) |

Limitations

- Data obtained exclusively from the electronic medical record likely underestimates prevalence of some clinical phenomena (e.g., SI, SUD)
- Focused on patients at risk of discontinuation due to aberrant behaviors (SUD and matched controls)
- We did not compare rates of SI/SSV in opioid discontinuers to rates in those who remained on LTOT

Opioid dose reduction and Veteran engagement

Joseph W. Frank, MD, MPH

Center for Veteran-Centered & Value-Driven Care

VA Eastern Colorado Health Care System

Division of General Internal Medicine

University of Colorado School of Medicine

VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

- Evaluate for tapering for patients taking high-dose opioid therapy (>90 mg MED)
- Evaluate risks and benefits of continuing long-term opioid therapy **along with** risks and benefits of opioid tapering
- Taper opioid medications when risks exceed benefits using individualized tapering treatment plan

Challenges during opioid tapering

Patients (N=24)

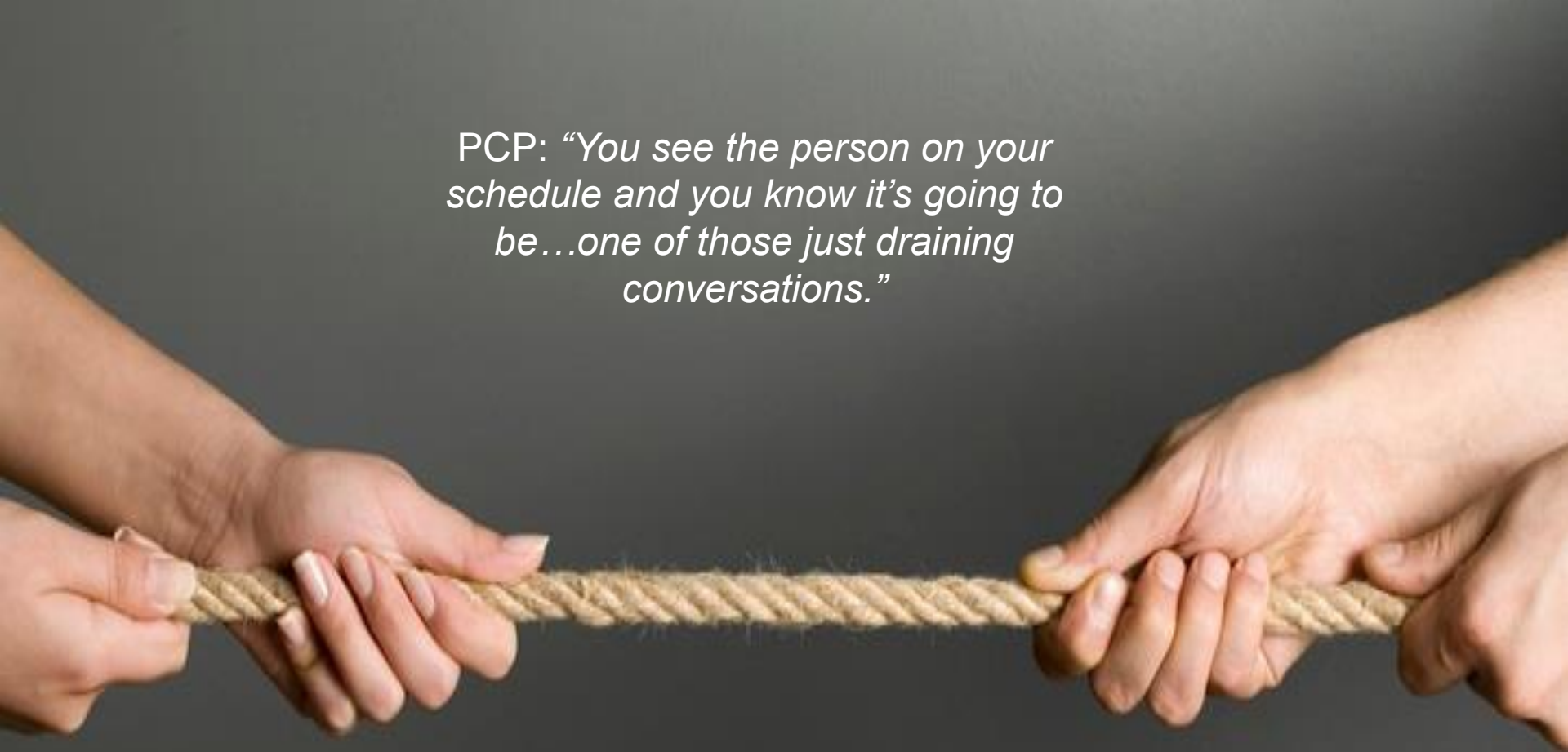
- Low perceived risk of overdose
- Pessimism re: non-opioid therapies
- Prior opioid withdrawal symptoms

Primary care providers (N=40)

- Emotional nature of discussion
- Inadequate training & resources
- Lack of trust between patient & provider

Patient: *“I also had lots of fears about, let’s say there was an apocalypse in our society... What would happen to me? Where would I get my medication from? What was going to happen?”*

Patient: *“I have a tremendous fear in a doctor saying I want you to taper off the methadone and get totally off the methadone with no alternative whatsoever.”*

A close-up photograph of two hands, one on the left and one on the right, pulling a thick, light-brown rope. The hands are positioned as if in a tug-of-war, with the fingers wrapped around the rope. The background is a dark, solid color.

PCP: *“You see the person on your schedule and you know it’s going to be...one of those just draining conversations.”*

PCP: *“It’s my license that’s on the line for this so I ultimately do get to choose. Obviously, I do want to do shared decision-making. Absolutely. But if a patients not, you know... It’s on me ultimately.”*

Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

A Systematic Review

- Very low quality evidence
- Some may benefit in setting of voluntary opioid tapering supported by multidisciplinary care
- Few studies in primary care settings
- Few studies of effect of dose reduction on adverse events (e.g., suicide risk, overdose)
- No studies of mandatory, involuntary dose reduction



Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice

Chantal Berna, MD, PhD; Ronald J. Kulich, PhD; and James P. Rathmell, MD

“A plan that an individual patient can embrace with a ***significant degree of personal engagement*** might be more important than following a specific protocol”

The Effects of Prescription Opioid Changes for Veterans (EPOCH) Study

- Ongoing prospective, national cohort study (PI: Dr. Erin Krebs)
- Veterans receiving long-term opioid therapy in prior 6 months (2015-2016)
 - N=9,253 for baseline survey
- Structured survey by mail or phone at 0, 12 and 24 months



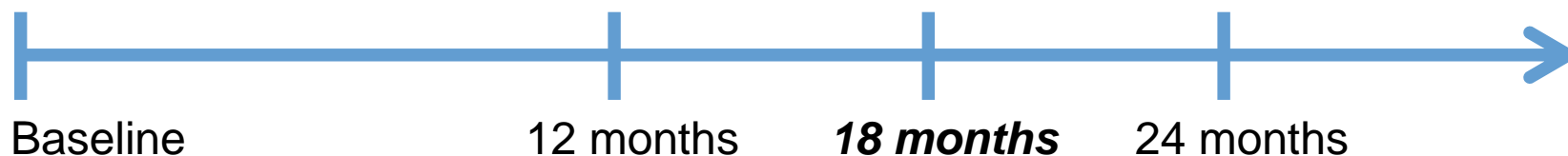
Baseline Results (N=9,253)

| Variable | Mean (SD) or N (%) |
|--------------------------------------|--------------------|
| Age, years | 63.5 (10.6) |
| Male sex | 8,547 (92%) |
| Opioid MEDD, mg | 51.5 (63.2) |
| Opioid dose category | |
| Low dose (<20mg) | 2,627 (28%) |
| Moderate dose (20-49mg) | 3,930 (43%) |
| High dose (50-99mg) | 1,580 (17%) |
| Very high dose (100+mg) | 1,108 (12%) |
| Average past week pain NRS | 6.8 (1.8) |
| Wanted to stop/cut down on opioids* | 1,340 (16%) |
| Wanted stronger/higher dose opioids* | 3,113 (38%) |

* Strongly Agree/Agree

Methods

- Aims:
 1. Examine Veterans' experiences with opioid tapering
 2. Describe prevalence and correlates of perceived nonconsensual opioid tapering
- Random sample of 600 Veterans who:
 - Received LTOT >50mg MED at baseline
 - Completed mail survey at baseline
- Structured phone interview at 18 month time point



Self-reported health status at T18 (N=316)

| Variable | Mean (SD) or N (%) |
|------------------------------|--------------------|
| Self-reported health status | |
| Excellent/Very good | 23 (7%) |
| Good | 78 (25%) |
| Fair/Poor | 215 (68%) |
| Pain severity vs. 1 year ago | |
| Much/Slightly better | 50 (16%) |
| About the same | 104 (33%) |
| Slightly/much worse | 162 (51%) |

Opioid tapering status

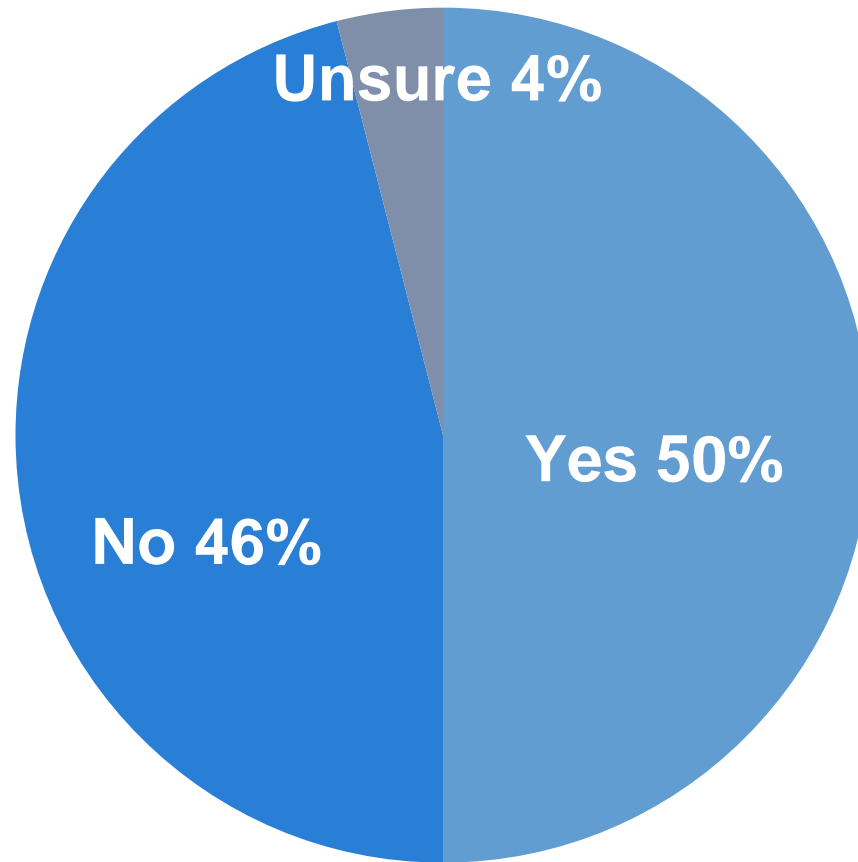
Not currently tapering opioid medications
126/316 (40%)

Current opioid tapering
84/316 (27%)

Past year opioid tapering
66/316 (21%)

Discontinued opioid medications
39/316 (12%)

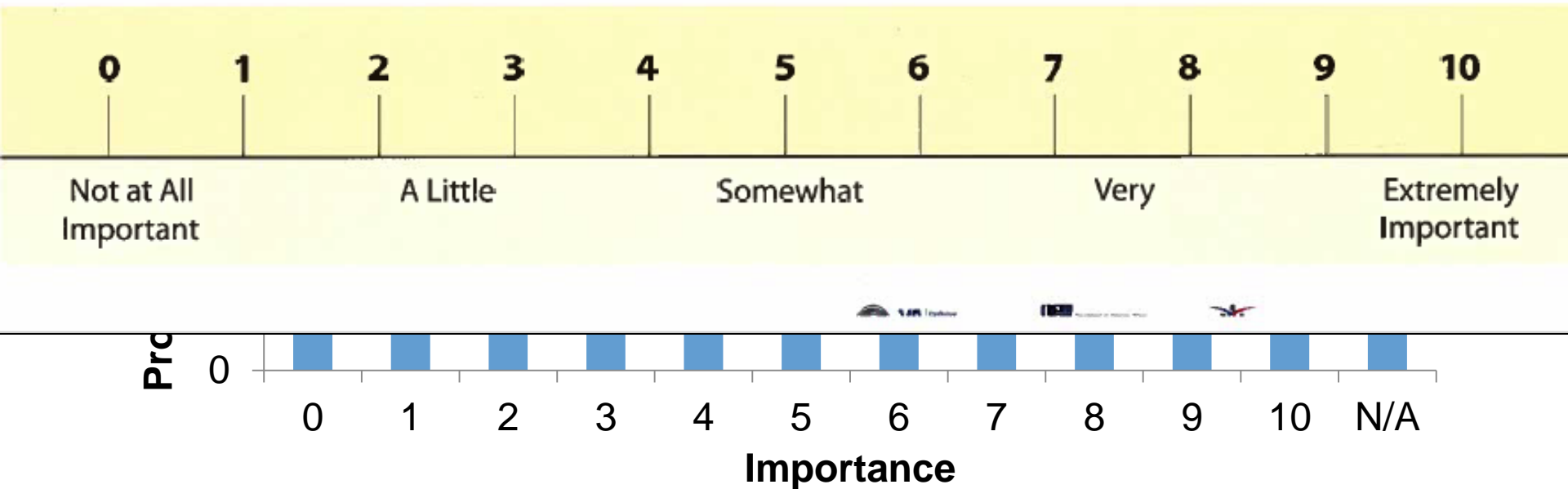
“Cut down or stopped your opioid medicines without your consent or against your wishes” (N=150)



Importance of opioid tapering

Importance RULER

“On a scale of 0–10, how important do you think it is to . . . ?”



“In the past 12 months, has any doctor, dentist, nurse or other health professional...”



Opioid Taper Decision Tool

Limitations

- Self-reported perceptions of past events likely impacted by recall bias and social desirability bias
- Additional analyses needed to better understand self-reported opioid tapering & experience of non-consensual opioid tapering

Summary

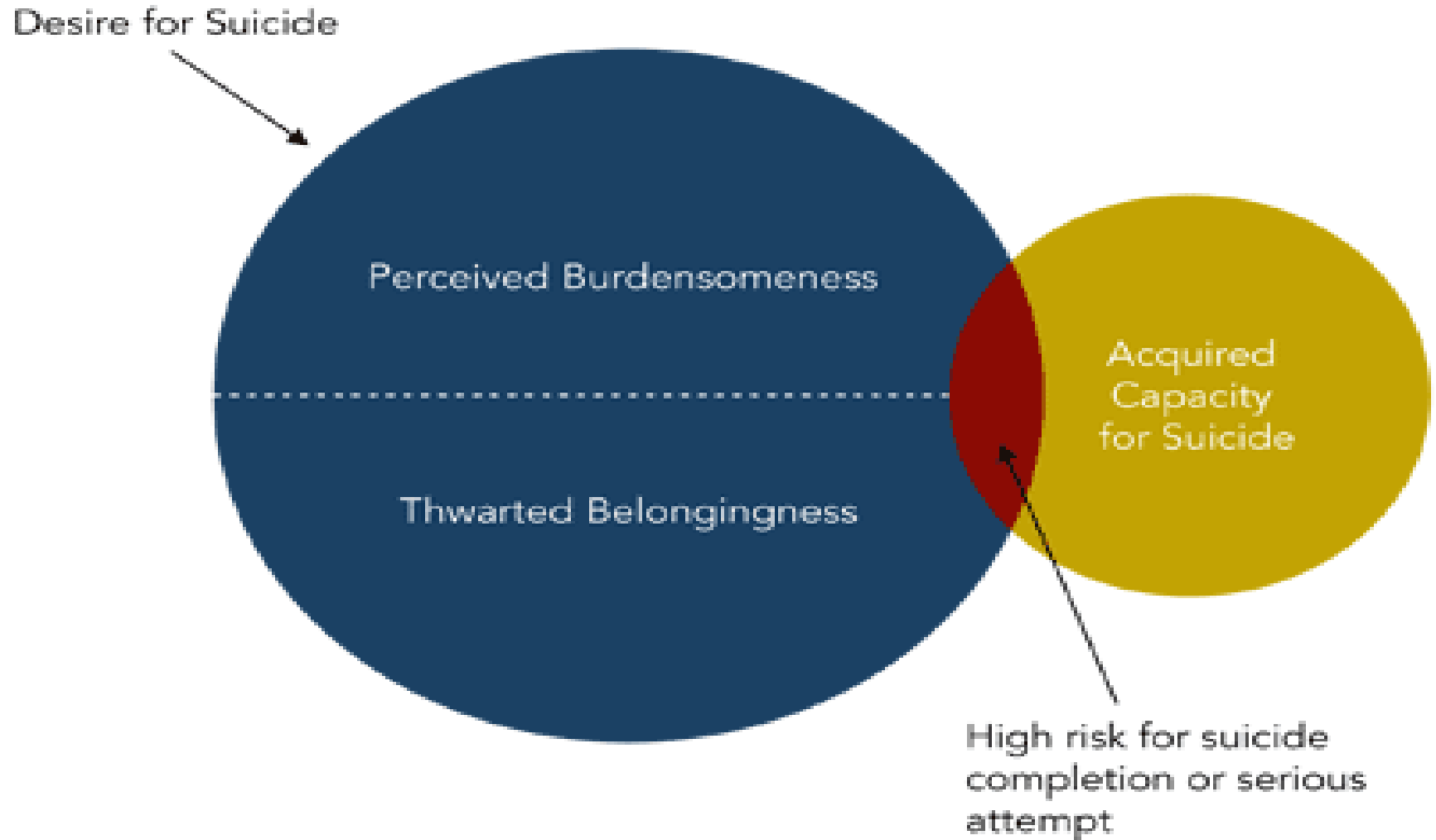
- Veterans prescribed long-term opioid therapy experience high rates of pain, poor health status & ambivalence about opioids
- Opioid dose reduction & discontinuation offers both potential benefits and risks
- Not all opioid tapering is created equal
 - Shared decision-making & collaboration, when possible
 - Empathy & non-abandonment
 - Individualized treatment planning & team-based care

Clinical approaches to addressing suicide risk among Veterans with pain



Steven K. Dobscha MD
VA Portland Health Care System

How might pain contribute to suicide?



General approaches for patients at risk

- Evaluation of Risk
- Crisis Management
- Engage others
- Assess and Restrict Means
- Self-management
- Collaborative treatment planning and implementation

Evaluation of Risk

- Assess severity of ideation

| | In the Past Month | |
|--|----------------------|----|
| Answer Questions 1 and 2 | YES | NO |
| 1) Have you wished you were dead or wished you could go to sleep and not wake up? | | |
| 2) Have you actually had any thoughts about killing yourself? | | |
| If YES to 2, answer questions 3, 4, 5 and 6 If NO to 2, go directly to question 6 | | |
| 3) Have you thought about how you might do this? | | |
| 4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them? | | |
| 5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? | | |
| Always Ask Question 6 | In the Past 3 Months | |
| 6) Have you done anything, started to do anything, or prepared to do anything to end your life? | | |
| Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc. | | |

Any YES must be taken seriously. Seek help from friends, family, co-workers, and inform them as soon as possible.

- Review Risk Factors

- Suicide behavior history
- Recent psychosocial stressors
- Access to lethal means
- Mental health conditions
- Recent hospitalization
- Social connectedness
- Trauma history
- Family history

- Other warning signs

- Talking about suicide
- Impulsive behaviors
- More substance use
- Hopelessness
- Preparation
- Mood changes
- Isolation

- Barriers to care

- Responsibilities to others
- Logistic

- Strengths and Resources

- Social support
- Hopeful
- Engaged in treatment
- Responsibility for others

- Build rapport

- Personalize conversation and pay attention
- Non judgmental approach
- Validate

HIGH ACUTE RISK

Essential Features

- **Suicidal ideation with intent to die by suicide**
- **Inability to maintain safety independent external support/help**

Common Warning Signs

- A plan for suicide
- Recent attempt and/or ongoing preparatory behaviors
- Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse)
- Exacerbation of personality disorder (e.g., increased borderline symptomatology)

Common Risk Factors

- Access to means
- Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)

Action

Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.

These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords/tubing, toxic substances).

During hospitalization co-occurring psychiatric symptoms should also be addressed.



INTERMEDIATE ACUTE RISK

Essential Features

- **Suicidal ideation to die by suicide**
- **Ability to maintain safety, independent of external support/help**

These individuals may present similarly to those at high acute risk, sharing many of the features.

The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety.

Preparatory behaviors are likely to be absent.

Action

Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis).

Outpatient management of suicidal thoughts and/or behaviors should be intensive and include:

- frequent contact,
- regular re-assessment of risk, and
- a well-articulated safety plan

Mental health treatment should also address co-occurring psychiatric symptoms.



LOW ACUTE RISK

Essential Features

- **No current suicidal intent AND**
- **No specific and current suicidal plan AND**
- **No preparatory behaviors AND**
- **Collective high confidence** (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety

Individuals may have suicidal ideation, but it will be **with little or no intent or specific current plan**. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.

Action

Can be managed in primary care.

Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.



Determine level of risk

• Crisis Management

- Address needs for Immediate safety
- Problem solve/identify untapped strengths/resources
- Collaborate with patient to identify and agree on next steps
- Instill hope
- Let patient know you will not abandon him/her

• Engage Others

- Family and Friends
- Other members of social network
- Clinical services

• Assess and Restrict Means

- Firearms
- Sedative medications (*including opioids*)



• Self-Management

- Safety planning/Crisis Response Planning
- Self care—distraction/relaxation
- Self/family identification of warning signs
- Facilitate ability of patient to communicate
- Encourage engagement with support network
- Assertively seek clinical care

• Collaborative treatment planning

- Identify and treat psychiatric conditions
- Psychotherapeutic support
- Patient preferences
- Problem-solve barriers to care
- Support transitions in care—warm handoffs
- Follow-up and outreach

How does pain or opioid discontinuation change this approach?

- Ask/think about risk as approach discontinuing
- Recognize and integrate additional risk factors into your evaluation and determination of risk
 - Access to lethal means
 - Recent psychiatric hospitalization?
 - Active substance use disorder?
 - Loss and abandonment
- Must address pain needs and fears concurrently
- Be clear in approach (ambiguity can enhance anxiety)
- Get help from colleagues
- Attempt to *collaborate* with patient

Patient-Centered Framework (Nicolaidis 2011)

Police Officer, Deal-Maker, or Provider?

Table 1 Comparison of common frameworks for the use of opioids in the management of chronic nonmalignant pain

| | Law Enforcement Framework | Bargaining Framework | Benefit-to-Harm Framework |
|---|--|---|---|
| Clinical questions | Is the pain real? Is the patient telling the truth? Is there proof that the patient has or has not done something wrong? | How low a dose of opioids will the patient accept? Is the patient keeping up his or her end of the bargain? | Do the benefits of opioids outweigh the risks for this patient at this time? |
| Goal of initial assessment of addiction/misuse potential | Catch "addicts" early. | Decide whether or not to enter into negotiation or how strict to be during negotiation. | Assess risk (to be balanced with benefit) and determine appropriate level of monitoring for degree of risk. |
| Goal of patient care agreements | Set up way to catch "addicts"; protect clinic from DEA. | Set up "contract" that parties must uphold. (Or complete annoying paperwork to fulfill clinic policies). | Ally with patient to protect against harms of treatment; explain how clinic will monitor for risk and what behaviors will raise concern for misuse. |
| Goal of urine drug screens or pill counts | Prove guilt or innocence. | Assess if patient is keeping up with his or her end of the bargain. | Monitor for addiction as one of the ways that medication can be harming patient. |
| Goal of functional assessment | Assess if pain is severe enough to warrant treatment. | Help assess "worth" of treatment to patient. | Measure actual or potential benefit of treatment (to be balanced against risk). |
| Mindset framework promotes in patients who wish to continue opioids | "My pain is really terrible, so I need my pain meds." "I am a good person, so I deserve pain meds." | "I have done what you wanted me to do, so you should keep prescribing." | "My opioids allow me to do X, so it is worth it to me to keep taking them despite the risk." |

A Case

A 66 year old Veteran with chronic back pain, depression, and PTSD presents to your clinic. For the second time in 6 months, despite having recently signed an opioid use agreement, he has run out of his prescription opioids early. He acknowledges he has been taking extra because the current dose “just doesn’t do the trick.” He is hoping you can further increase his dose.

Instead, you decide that it would be safest and most clinically appropriate to taper him off of the opioid and offer other types of pain treatment. When you tell him this, he says “I am at the end my rope, and don’t know what I might do if you stop my meds.”

Strategies

- Take comments or concerns about suicide seriously
- Provide context:
 - You are concerned about Veteran's well-being
 - National growing knowledge and concern about opioids
 - Why is it important for this particular Veteran's health...
- Validate Veteran's experience and fears
- Communicate
 - Be transparent and clear
 - Know your bottom-line
- Collaborate with Veteran
 - Managing his/her pain is important to both of you
 - Review and offer resources/options as possible—solicit input
 - You will not abandon him/her—offer access and alternatives

Thanks!

- Funding
 - HSR&D Career Development Award #13-268 (PI: Lovejoy)
 - HSR&D Career Development Award #15-059 (PI: Frank)
 - HSR&D Merit Review Award #14-295 (PI: Krebs)
- HSR&D Centers of Innovation
 - Center to Improve Veteran Involvement in Care (CIVIC)
 - Denver/Seattle Center for Veteran-Centered and Value-Driven Care
 - Travis.Lovejoy@va.gov
 - Joseph.Frank@va.gov
 - Steven.Dobscha@va.gov