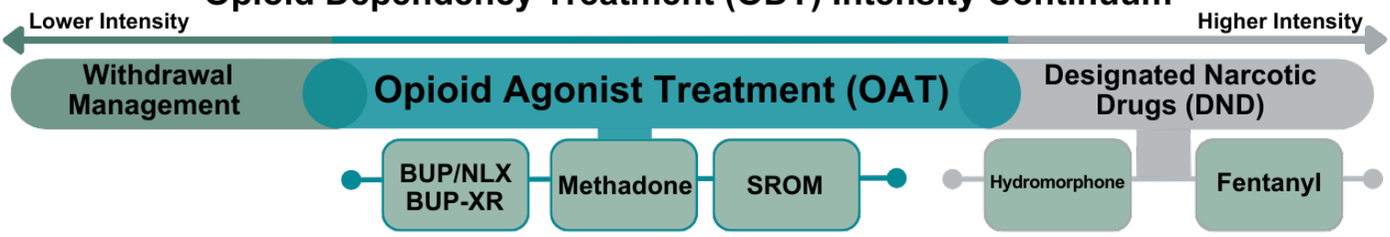
De-prescribing Opioid Dependency Treatment

Along the Intensity Continuum for the Treatment of Opioid Use Disorder (OUD)

Opioid Dependency Treatment (ODT) Intensity Continuum



Individuals may utilize different medications along the continuum, at different times, depending on preference, comorbidities, efficacy, treatment goals, and life circumstances. Deprescribing opioid dependency treatment (ODT) allows stable individuals to safely taper their medication dosages, or transition to less intensive treatment options. Deprescribing ODT should be individual led and trauma-informed, it is not to be used as a punitive measure. The provider and individual should discuss treatment options to select the most therapeutically suitable intervention based on their specific needs. Meeting an individual's self-identified needs is imperative for sustaining treatment retention, reducing unregulated and non-prescribed opioid use, and minimizing risk of morbidity and mortality.

Narcotic Transition Service (NTS) is a transitional service to help people with severe OUD to stabilize and then transition under expert medical supervision to evidence-informed OAT medications. In alignment with the Mental Health Services Protection Regulation (MHSPR) Section 23(3), if an individual cannot transition from a DND to OAT an assessment by an AMP is required. If this physician, along with a second AMP, concludes that the person is unable to transition now or in the future, they must document their findings in the treatment plan and within Connect Care.

NTS healthcare providers must review individual treatment plans according to the Community Protection and Opioid Stewardship Standards. This review should occur monthly for the first six months and then every three months thereafter. Providers should make best efforts to transition individuals to evidence-informed OAT medications as appropriate. Providers will create a safe environment for discussions to assess an individual's readiness to transition to OAT medications. Indicators of readiness may include the individual's expression of interest or signs of increased stabilization.

SAFELY TAPERING BOTH OAT AND DND MEDICATIONS

MEDICATION	TAPER SCHEDULE Dose reduction rate is individualized and largely guided by the individual's ability to manage withdrawal symptoms. The below table is designed as a guide.	CHECK IN
Slow-Release Oral Morphine (SROM)	• Dose reduction of **approximately 10% of the current dose every 4-6 weeks.**	Check-ins should occur **5-7 days after a dose reduction** to assess whether the taper should be slower. The reduction rate is individualized and largely guided by the individual's ability to manage withdrawal symptoms. This is an opportunity to discuss possible stressors such as surgery, injury, or illness that may require additional opioids or cessation of tapering for a period of time.
Methadone	• Dose reduction may vary from **2.5% to 10%** of the total daily dose every 1-2 weeks, or **approximately 10% of the current total daily dose every 6 weeks.**	
Hydromorphone Requires AMP approval prior to initiation.	• Dose reduction of **approximately 10% of the current dose every 4 weeks.** If the individual is also on long-acting opioid, consider increasing the long-acting dose during the taper.	
Fentanyl Requires PMDA approval prior to initiation. Transdermal fentanyl may ONLY be used for Chronic Non-cancer Pain (CNCP).	• Dose reduction of **approximately 10% of the current dose every 6 weeks.**	
Buprenorphine/naloxone (BUP/NLX)	• Dose reduction of **approximately 10% of the current dose every 6 weeks.**	
Buprenorphine Extended-Release (BUP-XR)	• If BUP-XR is discontinued, the individual should be monitored for several months for signs and symptoms of withdrawal and treated appropriately. • Prescribers may provide a script for BUP/NLX 2mg PRN for withdrawal management, individuals may keep these tablets at their residence or choose to keep an active script at the pharmacy if needed. • After a steady state has been achieved (4-6 months), individuals discontinuing BUP-XR may have detectable plasma and urine levels of buprenorphine for twelve months or longer.	

Once the dose of each medication gets low, the reduction may be even more gradual to minimize withdrawal symptoms. Tapering should be done at intervals of 8-12 weeks, as each reduction can be significant for the individual. In addition, adjunct medication may be prescribed to help alleviate any withdrawal symptoms.

SAFELY TRANSITIONING HYDROMORPHONE TO OAT

TYPE OF MEDICATION	MEDICATION	TRANSITION
Full Opioid Agonist	**SROM**	**Hydromorphone PO to SROM ratio of 1:5** • Dose can be decreased by **25%** to account for cross tolerance when switching between opioids. • Cross tapering can be utilized due to delayed peak time (i.e., 25% drop of HM x24-48hrs add 25% of intended SROM dose x 24-48 hrs.)
	Methadone	• The morphine milligram equivalent (MME) of methadone is unreliable, due to methadone's prolonged and variable half-life. Transitioning from hydromorphone to methadone requires more frequent check-ins and an individualized approach. Caution is necessary when switching from high doses of other opioids to methadone due to extreme individual variability.
Partial Opioid Agonist	**Buprenorphine/naloxone**	• Follow guidelines for either a traditional, micro or macro buprenorphine/naloxone induction.
	BUP- XR	• Stabilization on sublingual buprenorphine/naloxone for a minimum of 7 days is required prior to BUP-XR.

Research indicates that treatment durations of at least one year are linked to lower mortality rates and improved treatment outcomes. Medications for opioid dependency should never be discontinued abruptly; instead, they should be tapered off gradually. Providing individuals with accessible and safer alternatives to unregulated opioids reduces the risk of serious harms, including fatal poisonings, and encourages engagement with the health care system and society.

Each individual should be provided with harm reduction resources and education, including a community based naloxone kit and information on where to access Supervised Consumption Services.

The decision to taper an individual's medications or transition them to a less intensive medication should be tailored to the individual's needs and preferences, considering factors such as:

- Prescriber evaluation of individuals clinical and social stability
- Re-entry into school, work, and/ or volunteering
- Individual has insight into triggers and a well-developed return-to-use prevention plan
- High visit attendance/ adherence
- Housing stability
- Any existing physical and mental health issues have been addressed and are well-controlled
- Continued abstinence from unregulated and non-prescribed opioid use
- Family stability and the presence of a support system
- Individuals who wish to taper medication or transition to less intensive treatment options voluntarily, and not due to external pressures or circumstances

References

British Columbia Centre on Substance Use and BC Ministry of Health. (2023, November). *A Guideline for Clinical Management of Opioid Use Disorder.* Retrieved from British Columbia Centre on Substance Use: Opioid Use Disorder: https://www.bccsu.ca/wp-content/uploads/2023/11/BC-OUD-Treatment-Guideline_2023-Update.pdf

Canadian Research Initiative in Substance Misuse. (2018). *CRISM National Guideline for the Clinical Management of Opioid Use Disorder.* Retrieved from CRISM: National Opioid Use Disorder Guideline: https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-ENG.pdf

Date Updated: 2/4/2025

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MENTAL HEALTH AND ADDICTION SERVICES