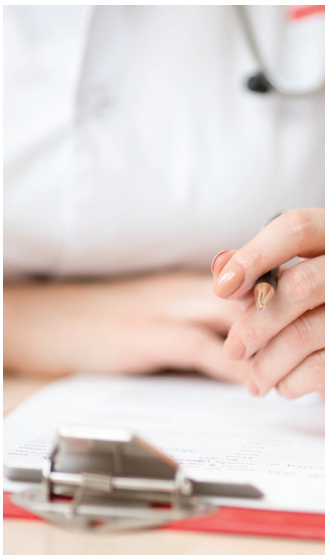
Created On: 9/29/2017

www.pa.gov/collections/opioid-epidemic | RA-DH-PDMP@pa.gov



Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Effective Opioid Tapering Practices

MODULE 7

GUIDE DOCUMENT

pennsylvania
DEPARTMENT OF HEALTH

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all health care providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose, and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any healthcare provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools, and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention, and Referral to Treatment (SBIRT), its main goals and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

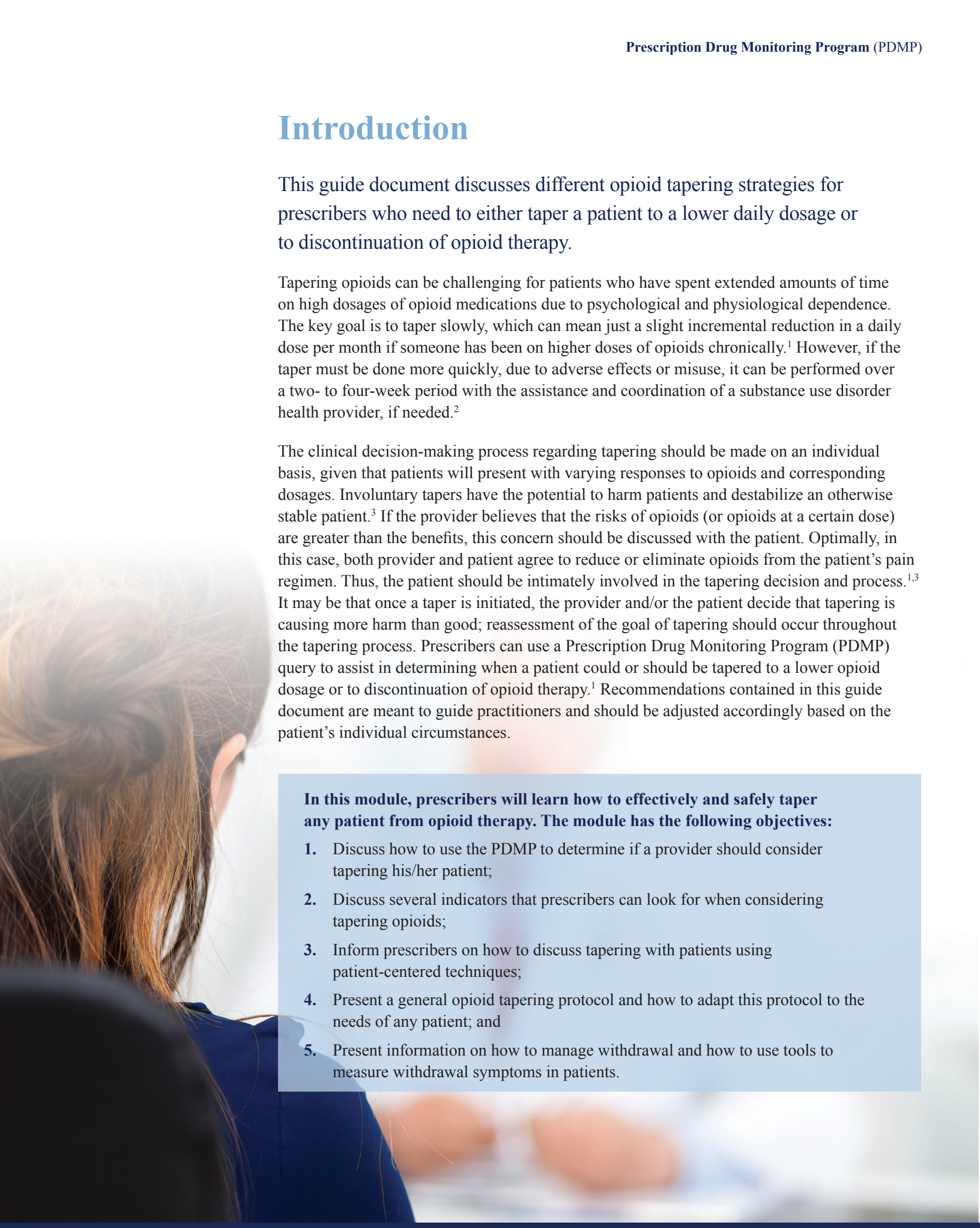
Table of Contents

Introduction

This guide document discusses different opioid tapering strategies for prescribers who need to either taper a patient to a lower daily dosage or to discontinuation of opioid therapy.

Tapering opioids can be challenging for patients who have spent extended amounts of time on high dosages of opioid medications due to psychological and physiological dependence. The key goal is to taper slowly, which can mean just a slight incremental reduction in a daily dose per month if someone has been on higher doses of opioids chronically.[1] However, if the taper must be done more quickly, due to adverse effects or misuse, it can be performed over a two- to four-week period with the assistance and coordination of a substance use disorder health provider, if needed.[2]

The clinical decision-making process regarding tapering should be made on an individual basis, given that patients will present with varying responses to opioids and corresponding dosages. Involuntary tapers have the potential to harm patients and destabilize an otherwise stable patient.[3] If the provider believes that the risks of opioids (or opioids at a certain dose) are greater than the benefits, this concern should be discussed with the patient. Optimally, in this case, both provider and patient agree to reduce or eliminate opioids from the patient's pain regimen. Thus, the patient should be intimately involved in the tapering decision and process.[1,3] It may be that once a taper is initiated, the provider and/or the patient decide that tapering is causing more harm than good; reassessment of the goal of tapering should occur throughout the tapering process. Prescribers can use a Prescription Drug Monitoring Program (PDMP) query to assist in determining when a patient could or should be tapered to a lower opioid dosage or to discontinuation of opioid therapy.[1] Recommendations contained in this guide document are meant to guide practitioners and should be adjusted accordingly based on the patient's individual circumstances.



In this module, prescribers will learn how to effectively and safely taper any patient from opioid therapy. The module has the following objectives:

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

Using the PDMP to Assess a Patient for Tapering

The PDMP can be a useful tool to help in the tapering process or when deciding whether or not to taper a patient.

For example, the PDMP can be used to engage the patient in a discussion about opioid dosage or to check for any concurrent interacting prescriptions, such as benzodiazepines, that can increase the risk of adverse opioid-related events. These PDMP checks can inform decisions about whether an opioid dose should be tapered or discontinued.[1,2]

The PDMP can also be used to provide evidence of several different types of opioid misuse by the patient. Aberrant behaviors such as obtaining opioid prescriptions from other prescribers and other behaviors that violate the patient-provider agreement can all be signs of potential opioid misuse or non-medical use of prescription opioids.[4,5] A PDMP query can also call attention to potential drug diversion by comparing the results of a urine drug test to the results of a PDMP query. If the prescribed drug(s) are not present in the urine drug test, and the test is appropriately interpreted, the prescriber should consider why - did the patient run out early, stopped taking the medication altogether or is he/she diverting the opioids? It is important to avoid assumptions based on PDMP data alone.[1,5] If necessary, the prescriber should use the results of the PDMP to talk to the patient about his/her opioid use. If the patient is assessed as having an opioid use disorder, the patient should be referred to appropriate substance use disorder treatment specialists.[1]

Indications for Tapering

In general, the most frequent indication for opioid tapering is lack of effectiveness of therapy, in which patients are not experiencing sustained improvements in pain and functioning.

It is important when initiating prescription opioids for chronic pain that appropriate expectations are instilled in the patient. For example, the provider should explain that opioids may not be effective in the long run and may need to be discontinued in the future. When tapering a patient to a lower dose or to discontinuation of opioid therapy, there is no validated, standardized approach, but there are best practices. These recommendations for when to begin an opioid taper are based on the Centers for Disease Control and Prevention opioid prescribing guidelines.[1]

Criteria for Identifying Patients Who Should Discontinue or Taper Opioid Treatment to a Lower Dosage[1,2,3,6,7]

1. There is a lack of clinically meaningful improvement in pain or function. The patient is demonstrating functional impairment or an inability to achieve or maintain the anticipated pain relief, even as the dose of opioids is increased. (See Module 4 for information on how to assess and reassess pain levels using the Pain, Enjoyment and General Activity Scale.)
2. The adverse effects brought on by opioid therapy are intolerable at the minimum dosage that relieves pain. (See Appendix for Clinical and Subjective Opiate Withdrawal Scales.)
3. The patient breaks aspects of the patient-provider agreement he/she signed before beginning treatment and affirmed during the course of treatment.
4. There are concerns about opioid use disorder or opioid misuse.
5. Physical and emotional deterioration can be attributed to opioid therapy.
6. The patient is no longer in pain or the issue that caused the original pain episode requiring opioids has resolved itself.

How to Discuss Tapering with Patients

In general, patient-centered techniques, such as motivational interviewing, should be used to regularly discuss the patient's opioid taper to decrease the risk that the patient will discontinue the taper.[2,5,8]

As noted, setting appropriate expectations at the beginning of opioid treatment is critical. Tapering can create a patient-provider relationship that is difficult to manage, since patients may report worsening pain and blame the provider for causing them to suffer. Patients may even become hostile toward the provider due to a physiological or psychological need or want to continue opioid therapy. Therefore, the discussion regarding tapering is vital to its success and can provide information regarding a potential need for referral to substance use disorder treatment. (See Module 5 for information on patient-centered communication techniques and referral to treatment.)[1]

The conversation should begin by discussing the rationale for why the patient is at risk for opioid-related harm. The provider should help the patient understand that opioids are not the only method to treat the patient's pain and the complexities of chronic pain.[5] If it is clear that opioids need to be discontinued for any given reason, such as known illegal activity by the patient, the prescriber should focus the conversation on helping the patient manage without opioids. The prescriber should also safely taper the patient off the current opioids and consider non-opioid options or medication assisted treatment options if indicated. Due to the fact that motivational conversations are usually part of an ongoing relationship, it is important to remember that they should not be accusatory or judgmental, but rather supportive and clinically oriented. These conversations should begin early, as concerns develop, rather than waiting until there is a concern that a full substance use disorder has emerged.

When the indication to taper or discontinue opioids is based on clinical judgement, the prescriber should consider saying:

> "It is my medical opinion, as your physician (or health care provider), that the risks of prescribing opioids are greater than the benefits you are receiving with them. I would like to talk to you about this opinion, and get your thoughts and feedback. You have to understand that I am trying to provide you the best care possible. Here are the reasons why I think we should taper your opioids: **(list reasons)**.
>
> In reaching this conclusion, I also considered your condition and these factors: **(list any PDMP findings, lab results, etc.)** I know this is a lot to consider; however, I would like your opinion on this so that we can come to a mutually agreeable plan of action."
>
> **(Obtain patient opinion.)**
>
> "You should be aware that if we do agree to taper, I will not abandon you, and during any tapering process, we will constantly reassess the decision to taper your opioids."

Continued

How to Discuss Tapering with Patients *(continued)*

During the conversation, the prescriber may need to "agree to disagree" with the patient. Always emphasize the difference between discontinuing opioid therapy and abandoning the patient. The patient may still require medical attention, even if he/she needs to be tapered or discontinued off of opioids, so the provider should not make the patient feel as though he/she will go medically untreated. Several objections should be expected when discussing opioid tapering or discontinuation with the patient:[9]

"I really need the opioids, doc."

"Don't you trust me?"

"I thought we had a good relationship!"

"I thought you cared about me."

"If you don't prescribe opioids to me, I will do drugs, drink, or hurt myself."

"Can you just give me enough until I can find a new doctor?"

These objections should be met with an empathetic review of the benefits and risks associated with opioid therapy to effectively manage the situation. If necessary, the prescriber should contact a pain specialist to assist with the taper.[1,3] Conversations with the patient about tapering can be difficult, and providers all want their patients to be pleased with the care provided. It is very reasonable for providers to feel uncomfortable in these situations, and it may help to let the patient know this, by saying:

"I understand that this medication has been an important tool for your pain management. As part of tapering, we are going to increase the use of other pain management techniques to help offset any change in pain levels."

"I wish that I did not have to taper you, and I don't want you to be unhappy, but it really is the best thing to do for the management of your chronic pain. I will continue to take care of your health in the best way I can."

Providers may want to broaden the discussion as well. For example, if the patient is claiming that he/she has not been responding to continued opioids, sometimes the cause is the development of tolerance or opioid induced hyperalgesia (an intensifying of pain caused by the use of opioids). For these reasons, reduction of opioids can actually reduce the experience of pain.

Opioid Tapering Protocol

The prescriber should carefully monitor and individualize the tapering protocol used for each patient to minimize increases in pain symptoms and signs of withdrawal.[1] If the tapering process is doing more harm than good, the entire tapering plan should be re-examined. The speed of the taper depends on: (1) how long the patient has been prescribed opioids; (2) his/her current dosage level; (3) the type of opioid formulation; and (4) the patient's medical history, including any present psychiatric conditions or substance use disorders.[1,2]

The Department of Veterans Affairs opioid prescribing guidelines recommend slowly reducing the original weekly dosage of opioid prescriptions by 5-20 percent every four weeks over months or even years when tapering.[2] Gradual tapers that allow for neurobiological, psychological and behavioral adaptations to take place are generally more tolerable for the patient.[2] Patients should receive psychosocial support from the prescriber or be referred to a mental health provider, as well as alternative pain treatments, when necessary. (See Module 3 for more details on alternative pain treatments.) If the prescriber is not familiar with tapering, the patient requires a more rapid taper, or if the patient has failed a previous taper, the prescriber should consider consulting a pain specialist or an appropriate substance use disorder treatment expert to reduce the possibility of adverse events.[1,2] However, it is unlikely that the opioid prescriber will find another provider to do the tapering, and thus it behooves the opioid prescriber to have the skills for tapering.

In some circumstances, a more rapid taper or abrupt discontinuation of opioid therapy may be justified. If there is evidence of diversion or if a patient exhibits extreme aberrant behaviors (e.g., threatening behaviors), the prescriber may consider an abrupt discontinuation of opioid therapy. In these situations, the prescriber should immediately provide an emergent psychiatric referral and medical care to manage the symptoms of opioid withdrawal. Non-opioid methods of pain management should be applied to the patient's treatment plan with careful documentation in the patient's medical records as to why discontinuation was necessary.[2]

The following general approach can be used when either tapering a patient to discontinuation or to a lower opioid dosage. In the absence of validated protocols, these recommendations are based on the Centers for Disease Control and Prevention, Department of Veterans Affairs and Washington State Interagency evidence-based opioid prescribing guidelines, as well as the most recently published literature on tapering opioids. They should be used as a guide and adjusted on a patient-by-patient basis.[1,2,3,5,6,10]

Before the Taper

Educate and assess the patient for related risk(s).

1. Discuss the patient's opioid use with proven patient-centered techniques, such as motivational interviewing.
2. Conduct a biopsychosocial assessment to evaluate patients. Assess patients for risks and benefits associated with continued opioid therapy versus tapering to a lower dose or to discontinuation.
3. Communicate with patients regularly throughout the tapering process to ensure that they do not feel abandoned and that non-opioid methods of pain management will be continuously added to the patient's pain management plan.
4. Educate patients and their families on the taper process and provide them with both written and verbal instructions of the taper protocol. Discuss the possibility of the formation of symptoms of withdrawal during the taper and provide patients with strategies to manage those symptoms.
5. Educate patients about overdose and offer naloxone to patients who are at risk for overdose, including those who are already in the process of tapering. The Department of Veterans Affairs guidelines recommend that prescribers strongly caution patients to abide by the taper plan by making patients aware that it takes as little as a week to lose tolerance to their prior dose and that they are at risk of overdose if they resume the prior dose at some point before the completion of the taper.[2]

Continued

Tapering Protocol *(continued)*

Begin the Taper Process

Calculate and determine the rate and speed of the taper.

6. Find a balance for each patient and adjust the speed of the taper accordingly, depending on the level of concern. The rate of the taper will depend on the opioid dose, duration of therapy, type of opioid formulation, and any psychiatric, medical or substance use disorder comorbidities.
7. Use the PDMP to determine the patient's current dosage of instant-release and/or extended-release opioids. Use an online morphine milligram equivalent calculator that can assist in the calculation of morphine milligram equivalent values. Also, the PDMP system calculates the average active daily MME as part of the patient report summary. If the patient is currently on both formulations of an opioid (instant-release and extended-release), the prescriber should consider which formulation to taper first on an individual basis. Consider tapering both simultaneously after assessing the risks and benefits related to the patient
8. Slow the pace of the taper during periods of intense stress or if withdrawal symptoms appear. Pauses for weeks or even months allow patients time to acquire new pain management skills and/or learn how to manage their emotions. This can also allow time for neurobiological equilibration that limits symptoms of withdrawal. Managing the taper this way can keep the patient on track and make him/her less likely to drop out of the taper.

Reassess the Patient

Follow up with patient and reassess him/her for related risk(s).

Symptoms of opioid use disorder may present themselves in the patient that were not present before the taper. Constantly be aware of signs of any substance use disorder throughout the taper and refer to treatment, if necessary. Patients on long-term opioid therapy with a diagnosed substance use disorder may require a medically-assisted taper with methadone or buprenorphine/naloxone. A primary or specialty care office can complete a medically-assisted taper if properly equipped with the necessary resources and provider education. Physicians are referred to the Substance Abuse and Mental Health Services Administration website** for more information on buprenorphine and medically assisted treatment. Slowing the taper may be considered until a "warm handoff" to substance use disorder treatment can be completed. (See Module 5 for information of "warm handoffs" and referral to treatment.)

9. Reevaluate the risks and benefits of the taper periodically and conduct further biopsychosocial assessments during follow-up appointments. The frequency of follow-up appointments should be individualized on a patient-by-patient basis, depending on the risk assessment performed by the health care team. Generally, follow-up should occur one week to one month after any opioid dosage change and should be used as an opportunity to further educate the patient on the risks associated with opioid therapy. At follow-up visits, continue to check the PDMP to ensure patients are not receiving opioids from another source and/or check for evidence that may suggest aberrant behavior.
10. Treat withdrawal symptoms accordingly using alpha-adrenergic agonists, such as clonidine 0.1-0.2 mg two or three times daily, and monitor the patient for significant hypertension and anticholinergic side effects.
11. Increase use of alternative pain treatment methods for the increased pain caused by short-term withdrawal symptoms. Acetaminophen and nonsteroidal anti-inflammatory drugs are often a part of taper protocols. Other multimodal pain management methods should be used throughout the taper, such as cognitive behavioral therapy, exercise and interdisciplinary physical therapy. Underlying mental health conditions may be exacerbated by the taper process and mental health professionals should become involved in the taper when deemed appropriate by the prescriber. (See Module 5 for information on referrals.)
12. Monitor special patient populations, such as pregnant women, individuals with substance use or mental health disorders and individuals concurrently prescribed other medications more carefully.

Meet the Goal of the Taper

Taper the patient to a lower dose or discontinuation.

13. Consider a taper successful if the patient is making progress and decreasing from the original dosage. The opioid can be discontinued when taken less than once a day or continued when the goal decreased daily dosage has been reached.
14. Following discontinuation of opioids, consider continuing risk mitigation strategies, since tapering may expose a substance use disorder. If the patient was tapered to a lower dosage, continue assessing the patient for risks and benefits of continued opioid therapy.

* https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

** https://www.samhsa.gov/

Managing Physical Withdrawal

Symptoms of withdrawal usually present themselves two to three half-lives after the last dose of an opioid. Symptoms include anxiety, restlessness, tremor, diaphoresis, mydriasis, piloerection, hypertension, tachycardia, nausea, diarrhea, abdominal cramping, anorexia, dizziness, hot flashes, shivering, myalgia or arthralgia, rhinorrhea, dysphoria and insomnia.[3,11]

Withdrawal symptoms will commonly make a patient more reluctant to continue the taper. Symptoms can be treated using alpha-adrenergic agonists, such as clonidine and tizanidine, which reduce the sympathetic activity stimulated by the decreased sympathetic antagonism from the opioids, and therapy to address gastrointestinal symptoms, including diarrhea (e.g., small doses of loperamide).[3,12] Other medications that can be used to treat withdrawal include lomotil, Motrin, trazadone and combined buprenorphine/naloxone therapy. For more information on medications used for withdrawal management, see Washington State Interagency Guidelines on Prescribing Opioids for Pain*.

Prescribers should use tools to measure withdrawal symptoms in their patients, such as the Subjective Opiate Withdrawal Scale (see Appendix I) or the Clinical Opiate Withdrawal Scale (see Appendix II) to assist in the risk/benefit determination process.[3,13,14] Additionally, there are often significant psychological withdrawal symptoms, such as craving, anxiety and dysphoria, that typically occur prior to any physical withdrawal symptoms. These symptoms may be evidence of psychological dependence on opioids that may not have been evident beforehand. Prescribers should closely monitor patients for signs of anxiety, psychiatric disorders like depression, and opioid use disorder that can be brought on by the taper.[1,3] Prescribers should work with pain specialists to assist with the patient's pain management and refer the patient to psychological, psychiatric and substance use disorder treatment experts, if necessary.[15] Prescribers should note that a successful taper is also one that minimizes the symptoms of withdrawal.

* http://www.agencymeddirectors.wa.gov/guidelines.asp

Sources

1) Dowell D, Haegerich T, Chou R. CDC guideline for prescribing opioids for chronic pain. *JAMA*. 2016;315(15):1624-1645.
2) Department of Veterans Affairs, Department of Defense. *Clinical Practice Guideline for Opioid Therapy for Chronic Pain.* 2016.
3) Berna C, Kulich R, Rathmell J. Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. *Mayo Clinic Proceedings.* 2015;90(6):828-842.
4) Cochran GL, Klepser DG, Morien M, Lander L. Health Information Exchange to Support a Prescription Drug Monitoring Program. *Innovations in Pharmacy.* 2015;6(1).
5) Washington State Agency Medical Directors' Group. *AMDG 2015 Intergency Guideline on Prescribing Opioids for Pain.* Olympia, WA: Washington State Agency Medical Directors' Group;2015.
6) Kral L, Jackson K, Uritsky T. A practical guide to tapering opioids. *Mental Health Clinician.* 2015;5(3):102-108.
7) Substance Abuse and Mental Health Service Administration. *TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders.* Rockville, MD,2012.
8) Elwyn G, Dehlendorf C, Epstein R, Marrin K, White J, Frosch D. Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. *The Annals of Family Medicine,*. 2014;12(3):270-275.
9) Boston Medical Center- General Internal Medicine. How to Discuss Stopping Opioid Therapy with the Patient. 2017.
10) Fishbain D, Rosomoff H, Cutler R, Rosomoff R. Opiate detoxification protocols: a clinical manual. *Annals of Clinical Psychiatry.* 1993;5(1):53-65.
11) Farrell M. Opiate withdrawal. *Addiction.* 1994;89(11):1471-1475.
12) Gowing L, Farrell M, Ali R, White J. Alpha2-adrenergic agonists for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews.* 2009;15(2).
13) Handelsman L, Cochrane K, Aronson M, Ness R, Rubinstein K, Kanof P. Two new rating scales for opiate withdrawal. *American Journal of Drug and Alcohol Abuse.* 1987;13(3):293-308.
14) Wesson D, Ling W. The clinical opiate withdrawal scale (COWS). *Journal of Psychoactive Drugs.* 2003;35(2):293-308.
15) Pennsylvania Medical Society, Pennsylvania Department of Health. *Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Noncancer Pain.* 2014.

Appendix I: Subjective Opiate Withdrawal Scale

Subjective Opiate Withdrawal Scale. Reprinted from *J Drug Alcohol Abuse*[13]

Score: 4-22=mild; 23-44=moderate; 45-64=high

Subjective Opiate Withdrawal Scale (SOWS)							
In the column below, write today's date and time, and in the column underneath, write in a number from 0-4 corresponding to how you feel about each symptom: RIGHT NOW. Scale: 0 = Not at all; 1 = A little; 2 = Moderately; 3 = Quite a bit; 4 = Extremely							
Date							
Time							
	Symptom	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
1	I feel anxious.						
2	I feel like yawning.						
3	I am perspiring.						
4	My eyes are teary.						
5	My nose is running.						
6	I have goosebumps.						
7	I am shaking.						
8	I have hot flushes.						
9	I have cold flushes.						
10	My bones and muscles.						
11	I feel restless.						
12	I feel nauseous.						
13	I feel like vomiting.						
14	My muscles twitch.						
15	I have stomach cramps.						
16	I feel like using now.						
	TOTAL						

Appendix II: Clinical Opiate Withdrawal Scale

Clinical Opiate Withdrawal Scale. Reprinted from *J Psychoactive Drugs*[14]

Score: 5-12=mild; 13-24=moderate; 25-36=moderately severe; more than 36=severe withdrawal

Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase in pulse rate would not add to the score.

Patient's Name: _____ Date and Time: ____/____ /_____

Reason for this assessment:_____

Resting Pulse Rate:_____beats/minute

Measured after patient is sitting or lying for one minute.

0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

Gastrointestinal Upset: *Over last ½ hour.*

0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 multiple episodes of diarrhea or vomiting

Sweating: *Over past ½ hour not accounted for by room temperature or by activity.*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor: *Observation of outstretched hands.*

0 no tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness: *Observation during assessment.*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 unable to sit still for more than a few seconds

Yawning *Observation during assessment.*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil Size:

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable or anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint Aches: *If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored:*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/muscles
4 patient is rubbing joints or muscles and is unable to sit

Gooseflesh Skin (piloerection)

0 skin is smooth
3 piloerection of skin can be felt or hairs standing up on arms
5 prominent piloerection

Runny nose or tearing: *Not accounted for by cold symptoms or allergies.*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Total Score _____

The total score is the sum of all 11 items

Initials of person

completing assessment: _____