

# PHASES OF TREATMENT: TAPERING

At some point in the treatment process, MMT clients may express an interest in discontinuing methadone. If the decision to discontinue is reached, the client will enter the Tapering Phase.

Tapering is the gradual reduction of the dose until eventually methadone may be discontinued entirely. There are unique issues associated with this aspect of MMT treatment, and it merits description as a discrete phase of the MMT treatment process. In the first place, however, counsellors must fully understand the risks associated with proceeding to this phase.

A Phases-of-Treatment Model may suggest to some that working through the phases as efficiently as possible is the ultimate goal. In fact, research evidence indicates that the longer the client is in treatment before proceeding to the Tapering Phase, the better the treatment outcome.

There have been many attempts to promote the idea of short-term methadone treatment. Usually, these have been based on the assumption that methadone is merely drug substitution, and the sooner clients rid themselves of all drug use, including methadone, the better off they will be. It cannot be emphasized enough that this notion is seriously contradicted by research evidence.

There is now compelling evidence that opioid dependence is maintained in part by irreversible metabolic and neurological changes associated with chronic opioid use (Leshner, 1997). This evidence supports the suggestion that methadone should be viewed as a medication to be used indefinitely, just as Dole and Nyswander (1967) originally argued — more than 30 years ago.

Other research focusing on what happens to clients who leave MMT clearly shows that these people are at increased risk of relapse, even if they meet predefined criteria of stability and adjustment that would suggest to some their readiness for discontinuing methadone (Magura & Rosenblum, 2001).

Therefore, while some MMT clients will decide to discontinue methadone, counsellors should be familiar with the issues described in this chapter to minimize the risks associated with tapering.

The decision to initiate tapering should not originate with the counsellor.

## **Issues in the Tapering Phase**

The following issues should be considered in the Tapering Phase:

- motives for tapering
- timing of tapering
- readiness criteria
- decision making
- tapering plan
- dose reduction issues
- clinical issues in tapering
- supplementary services
- aftercare
- involuntary tapering.

## **Motives for Tapering**

Several factors may play into a client's interest in tapering. The counsellor should try to understand the reasons behind the request as part of the process of ensuring that the client is making an informed choice.

Possible client motives to consider include the following:

- The client may be reacting to pressures from family or other influential persons.
- Being "drug-free" may be perceived as a higher order of achievement or a way of escaping the stigma associated with MMT.
- Regular visits to the clinic may seem like an avoidable nuisance or risk.
- Changes in the client's social circumstances may be presenting barriers to continuing in MMT.
- There may be objectionable side-effects of taking methadone.

- The importance of methadone in controlling urges to use opioids may be discounted.
- The client may have made major lifestyle adjustments and feel ready to carry on without methadone.

All but the last of these motives should raise serious concerns about the appropriateness of tapering. Nonetheless, counsellors should be sympathetic to the reasons a client might wish to taper.

The desire to “get off this stuff” is one often voiced by clients in MMT, both those who have made significant changes in all areas of their lives, including drug use, and those who are continuing to use illicit drugs. Methadone limits people’s ability to travel, necessitates regular visits to a clinic and ties clients to a past they have worked hard to move on from. In visiting a clinic, clients may see acquaintances who have not stopped their drug use, they may be exposed to the sale of illicit drugs or they may feel slotted into an “addict” role by the staff. Tapering from methadone may seem like a way to establish greater distance between themselves and their former drug-using selves.

## The Timing of Tapering

There is no particular point in time when clients are more likely to be ready for tapering. Clients progress at different rates, and they will have different views about the value of remaining on methadone indefinitely, despite significant progress in treatment.

Changing public and clinic attitudes to methadone treatment have enabled people to remain on methadone indefinitely. Although some people may choose to remain on methadone for the duration of their lives, others may choose to taper after as little as two years or as long as 10 years on methadone.

The duration of methadone treatment is not a reliable predictor of the likelihood of a successful taper (Magura & Rosenblum, 2001).

## Readiness for Tapering

When a client raises the possibility of tapering, the counsellor and client should begin to discuss the client’s readiness for such a change. Some of the factors associated with a better chance of a successful taper include the following: abstinence from drug and alcohol use, a high degree of assimilation into the non-drug world,

social support (family, friends and clinical staff), and personal stability (Kleber, 1977; Hall et al., 1996; Weddington, 1990–91).

### **The Tapering Readiness Inventory**

One approach to evaluating readiness for tapering is to use the Tapering Readiness Inventory (Brummett et al., 1986; see Appendix F). This inventory takes into account a wide range of factors that the client and counsellor should consider. These include abstinence from drugs, disposal of drug use paraphernalia, development of effective coping strategies, stable living and vocational arrangements, supportive family relationships, development of a peer network that does not include people who use drugs, ability to use counselling effectively, physical and mental health and motivation to succeed.

### **Other Approaches**

Another approach to assessing readiness for tapering is to use the criteria specified for completion of the Stabilization Phase (see Chapter 8) and termination of counselling in the Action/Maintenance Phase (see Chapter 9). Ideally, clients considering tapering will meet all of these criteria.

## **Deciding to Taper**

Deciding to taper from MMT is an important treatment decision. The person receiving methadone rarely makes this decision without a great deal of thought. Staff of methadone treatment centres can aid clients in the decision-making process by helping them evaluate areas of their lives that may still require change, their motives for tapering, and their attitudes and beliefs about a methadone taper and life without methadone.

The initiative to consider a taper from methadone should normally come from the client and not the agency. A taper initiated by an agency may not be seen by the client as being in her or his best interest, and it may cause the client to believe she or he has no choice in the matter. Furthermore, research evidence indicates that clients' interests are usually best served by encouraging them to remain on methadone.

When a client requests tapering and meets the readiness criteria, or insists upon proceeding, the counsellor should support the client's decision and work with the client to make tapering successful. If the counsellor has expressed serious reservations about the wisdom of tapering and challenged the client in the decision-making process, there may be a need to re-establish a therapeutic alliance before working with the client to make tapering a success.

The counsellor has to balance the need to minimize the likelihood of premature tapering with the risks of alienating the client or undermining confidence to succeed.

As part of an agreement to proceed with tapering, the counsellor should always attempt to obtain a commitment from the client to return to maintenance if it appears that tapering is not working.

When tapering does not work out, the counsellor should encourage the client not to see the tapering attempt as a failure. Instead, the counsellor should instil hope and review the positive consequences that the client experienced during this process.

## Tapering Plan

When a client decides to taper, the treatment plan should be revised to include a tapering plan. A tapering plan should address the following:

- the rate of dose reduction (how much of a decrease and how often)
- the length of time over which the taper will occur
- procedures to follow if the client experiences cravings or wants to stop the taper
- psychosocial supports to assist in tapering.

Checking with clients about their goals for the taper and their perception of how they are doing while tapering will assist the counsellor in treatment planning and evaluating treatment progress. Because many clients who attempt to taper have made previous attempts to do so (Gold et al., 1988), the counsellor should carefully review what happened during any previous attempts and integrate the information into the current plan.

The client, in consultation with his or her physician and counsellor, should set the rate of taper. Slow tapers have been shown to be more successful than rapid tapers (Senay et al., 1977). Clients need to know they are in control of their taper and that they can stop tapering or increase their dose at any time (Kahan, 1998). Therefore, a good tapering plan will include procedures to follow if a dose adjustment appears necessary.

Among the procedures to consider are:

- the process to follow if the client thinks an immediate dose change is necessary
- how the client can arrange to see the physician as quickly as possible
- how quickly the system can respond to the client's needs
- how the client can cope with discomfort until the dose can be altered.

## Blind Tapers

It is not uncommon for clients to request a “blind taper” wherein the physician and pharmacist conceal the rate of the taper, or the timing of dose reductions. Just the thought that the dose is about to be reduced or that the dose is getting very low can create anxiety for some clients. Not knowing what their dose is can be reassuring.

The tapering plan needs to be individualized, so while a blind taper may be advantageous for one person, it will not be the choice of another.

### CASE STUDY

Melissa is a 25-year-old woman who entered into methadone treatment at age 22. Melissa had a two-year history of daily heroin use, and was pregnant with her first child, making her a candidate for methadone. After three years on methadone Melissa had been abstinent with one period of relapse to heroin use. Child protection agencies had monitored Melissa's progress and were no longer involved. Melissa expressed a desire to return to university to complete the Master's degree she had been accepted into before her heroin use had escalated.

Melissa met with her counsellor and physician to discuss a tapering plan. They discussed what Melissa might experience during the taper and made a preliminary plan for dose reduction. They reviewed strategies Melissa could use to cope with any discomfort she felt. They also agreed on a plan to monitor the effects of dose reduction. Melissa would increase the frequency of her contact with her counsellor to weekly and to biweekly with her physician. She was encouraged to contact her counsellor any time she began to experience withdrawal symptoms or had doubts about her ability to cope with the tapering process.

## Dose Reduction Issues

The final decision about dose changes rests with the physician. However, counsellors should be familiar with dose reduction issues to help clients through the tapering process.

Key issues about dose reduction include the following:

- Methadone is a long-acting opioid. Withdrawal from methadone starts later and lasts longer than withdrawal from shorter-acting opioids (e.g., heroin).
- Methadone tapering has been shown to be associated with a protracted “organic mood syndrome” (Kanof et al., 1993). Clients voluntarily tapering from methadone may experience insomnia, depression and anxiety, sometimes lasting for months after completion of the taper.
- Slow tapers are preferred. For voluntary tapers, *a maximum rate of taper of 5 mg per week* is recommended.

- A reduction in the rate of tapering should be considered when the client reaches a daily dose of 20 mg.
- Tapering should be delayed or reversed if the client experiences significant withdrawal symptoms.

## Clinical Issues in Tapering

Tapering for many clients is an uncomfortable and emotionally difficult challenge. Fears about relapse to drug use both during the taper and after its completion are common.

Counselling is very important during this phase. Usually it will be intensified from what characterized the latter stages of the Action/Maintenance Phase to closely monitor the client's physical and emotional responses to the tapering process and plan coping strategies.

## Tapering and Concurrent Disorders

Methadone appears to have some antipsychotic properties (McCann et al., 1994) that may hinder the identification of psychotic disorders. For example, some people have been observed to become increasingly psychotic after tapering from methadone. People undergoing a taper who are susceptible to psychosis should be monitored for the emergence of psychotic symptoms. Indications of more severe disorders should result in an immediate referral for confirmation of the diagnosis. Psychotic clients will usually require medication and may also need stabilization on an inpatient basis. (See also Chapter 12.)

## Orientation to the Tapering Process

One of the first issues for the counsellor to address is an orientation to the tapering process. Although many aspects of this process will have been discussed in the decision-making process, it is good practice to systematically review the steps involved, explore client expectations about the process and identify any particular worries or misconceptions that the client may have.

## Physical Consequences of Tapering

The symptoms associated with a decreasing methadone dose include physical discomfort such as teariness, perspiration and muscle aches, insomnia or inability to

fall asleep because of physical discomfort, loss of appetite, cravings and affective distress — including anxiety, irritability, restlessness and fatigue (Kanof et al., 1993). Relief from withdrawal symptoms may be obtained by adjustments to the rate of taper or by the use of other medications. However, it will often be necessary for counsellors to help clients learn to take care of themselves while experiencing any of those symptoms. Comparing withdrawal discomfort to the flu can be a useful strategy.

Ask clients how they take care of themselves when they are ill — time spent in bed, soup, hot baths, not exerting themselves — to devise strategies that can be applied to managing the physical symptoms of reduced dosage.

The protracted nature of the tapering process and the unpredictability of the withdrawal symptoms can, however, weigh on the client. Feeling sick, irritable or fatigued, or the anticipation of these feelings can be an ongoing feature of the tapering process.

One client said she was just tired of having the taper constantly on her mind and would be happy when she knew the taper would be completed. Not knowing whether she would wake up feeling well or feeling sick was an annoyance for another tapering client. The interference of the taper with the ability to plan for the day and complete tasks has been highlighted as a difficulty of tapering. Unlike people with the flu, which is usually a short-lived illness, clients report feeling variously well and unwell during a taper. The anticipation of what the next day will bring can increase anxiety for the client.

#### **CASE STUDY**

In the midst of the taper Melissa approached her counsellor saying that she needed to have her dose increased because she felt sick on her current dose. Melissa stopped her taper at 10 mg of methadone per day and returned to a higher dose before resuming the taper.

She found the second taper attempt much easier. During the first attempt Melissa spent a lot of time concerned about how she was feeling and how long the withdrawal symptoms would last. Having experienced a lower dose and significant withdrawal she was better able, with her counsellor's assistance, to identify gradations of discomfort and plan her days accordingly.

## **Psychological Consequences of Tapering**

One of the most common concerns about tapering from methadone is a fear of withdrawal symptoms. People prescribed methadone report being very sensitive to any changes in their dose. Many have strong memories of the sensation of opioid withdrawal experienced prior to MMT. These experiences can make clients apprehensive about withdrawal. Such fears may be exaggerated and undermine the



client's confidence. The counsellor may need to help the client distinguish normal concerns about withdrawal symptoms and relapse from excessive and unrealistic fears about the idea of tapering (Kaufman & Woody, 1995).

The persistence of such excessive anxiety should be cause to revisit the decision to taper and consider delaying the taper or making it more gradual.

In the course of MMT, clients may have learned to attribute much of their success to the effects of methadone and begin to doubt their self-efficacy to maintain the gains achieved during the earlier phases. For example, they may wonder, in the absence of methadone, about their ability to keep a job, raise their children or maintain interpersonal relationships that do not involve street culture and/or drug use. Exploring feelings of competency and helping clients to recognize the limited function of methadone and the credit they deserve for their achievements will help to maintain confidence to succeed.

Grief and feelings of loss may arise with a decision to taper. Grief may be expressed for friends who have died due to drug use, time and relationships lost to substance use, and grief for the past (Gentile & Milby, 1992).

Finally, after years of involvement with the clinic, some clients may experience termination anxiety. For many, the decision to taper will symbolize going it alone and raise fears of independence and loss of support. These concerns often surface early in the tapering process or even before it begins (Kaufman & Woody, 1995). It is important not to compound fears about withdrawal with anxiety about ending treatment. Contracting with the client to extend counselling to the point of satisfactory adjustment after tapering is one way to minimize this problem.

## Supplementary Services

During the tapering phase, clients may benefit from participating in a variety of supplementary services (e.g., couples counselling, a women's support group or leisure counselling). However, encouraging attendance and participation in counselling groups may take a great deal of effort on the part of the counsellor. Past negative experiences with groups and a long shared history with other methadone clients may lead to a hesitancy or unwillingness for a tapering client to attend groups.

### Tapering Support Group

A tapering orientation and support group can be a useful adjunct to individual counselling when there are several clients in the Tapering Phase. Being a part of such

a group helps to decrease feelings of isolation (“I’m the only one going through this right now”) and helps clients focus on the types of support that will aid their taper.

A tapering support group comprising people in various stages of their taper allows clients to share strategies for dealing with withdrawal symptoms, fears about relapse and other experiences of tapering. Former clients who successfully completed a taper could visit this group to offer advice. A psychoeducational orientation to the group may make it easier to engage reluctant clients.

### **Relapse Prevention Group**

Relapse to opioid use is of significant concern to those initiating a taper. Relapse prevention skills, such as creating a plan for the unexpected and becoming aware of risk situations, allow the client to plan for difficulties that they may experience and maintain their abstinence throughout the taper and after its completion.

A relapse prevention group may be a useful adjunct to individual counselling for the tapering client. Alternatively, relapse prevention strategies should be an important component of individual counselling sessions.

### **Coping with Withdrawal Symptoms**

A variety of interventions may help clients cope with withdrawal symptoms. One clinic included nutritional counselling that involved discussion of the use of herbal teas and “comfort foods” in treatment planning with tapering clients (Sorensen et al., 1992).

Exercise is mentioned repeatedly as useful for stress reduction, dealing with feelings of depression and as a means to deal with withdrawal. Massage and acupuncture may also be utilized to deal with the physical discomfort associated with methadone tapering.

### **Aftercare**

An aftercare plan should be developed for all clients completing a taper to ensure that counselling support continues well after methadone has been discontinued. Clients may experience anxiety and are vulnerable to relapse once they realize that they are off methadone. It may take a little time before their confidence is restored and counselling support can be crucial during this period.

Areas of focus should include social support networks, and involvement in mutual aid groups such as Narcotics Anonymous or Methadone Anonymous. Any outstanding issues from the Action/Maintenance Phase (e.g., vocational training or family counselling) should also be included in the aftercare plan.

Completion of methadone maintenance is a time of readjustment. Support should be focused on reinforcing the goals of treatment. Aftercare enables the client to see that relapse is not inevitable, and should an isolated incident of drug use occur it does not have to lead to a relapse.

### **CASE STUDY**

At the end of Melissa's taper, she elected not to continue in any aftercare activities. The counsellor and the doctor decided to write a letter to Melissa congratulating her on completing the taper and wishing her well. Also included in the letter was an invitation to return to the clinic at any future time. Five months after completing the taper, Melissa appeared at the counsellor's office looking for aftercare information. She had used heroin twice, and she stated that she did not want to use a third time. In their brief session her heroin use was discussed.

Melissa was able to identify the people and events that had led to her use and what she stood to lose if she relapsed to regular opioid use. Melissa agreed to attend Narcotics Anonymous and to participate in a women's treatment centre that offered aftercare services. Both were near her home. With the counsellor's and physician's reinforcement of her efforts and her involvement in these aftercare activities, Melissa was able to assert control over her recovery and maintain her achievements.

## **Involuntary Discharge**

Occasionally it is necessary to discharge a client from MMT against his or her wishes. This may result from a serious rule violation, such as violence. Clients should always be aware in advance of any actions or behaviours that will result in discharge. Because discharge from MMT often leads to relapse, it should be used as a consequence for only the most serious circumstances.

When a client is to be discharged, the counsellor's first task should be to try to find another MMT program to which the client can be referred.

Dismissing clients from one program and referring them to another is not necessarily a contradiction. On the one hand, clients must recognize that they are accountable for their behaviour. On the other hand, retaining clients in MMT is ultimately in their best interests. It has been observed that pushing the limits to the point of discharge can be a wake-up call for some clients, leading to better functioning in a new program.

When there are no other MMT programs available, other treatment alternatives should be considered. Clients may, understandably, be very angry at this point. In

such circumstances it may be best to try to facilitate a transfer to a counsellor outside the MMT program to discuss alternative treatments. It may also be helpful to specify the conditions under which the client would be eligible for re-admission to the MMT program.

Methadone should never be discontinued abruptly (Kahan, 1998).

When clients are involuntarily discharged, it is recommended that the physician carry out a taper slowly, at a rate of no more than 5 mg every three or four days. When indicated, the prescribing physician can also offer the client clonidine near the end of the taper, a drug that helps to relieve withdrawal symptoms. In these circumstances, the counsellor should collaborate with the other team members to define the conditions under which this brief taper will occur. The welfare and safety of other clients and staff are principal considerations in developing this tapering plan.

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