

Discontinuing Methadone and Buprenorphine: A Review and Clinical Challenges

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This paper offers a review and recommendations for clinicians working with patients interested in discontinuing opioid agonist treatment. As buprenorphine/naloxone has gained widespread acceptance for opioid addiction, many treatment providers and patients have a range of hopes and expectations about its optimal use. A surprising number assume buprenorphine/naloxone is primarily useful as a medication to transition off illicit opioid use, and success is partially defined by discontinuing the medication. Despite accumulating evidence that a majority of patients will need to remain on medication to preserve their gains, clinicians often have to address a patient's fervent desire to taper. Using the concept of "recovery capital," our review addresses (1) the appropriate duration of opioid agonist treatment, (2) risks associated with discontinuing, (3) a checklist that guides the patient through self-assessment of the wisdom of discontinuing opioid agonist treatment, and (4) shared decision making about how to proceed.

Key Words: buprenorphine, methadone, MOUD, naloxone, opioid, taper

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An opioid crisis of unprecedented proportions¹ has led to a reconsideration of medications to treat opioid use disorder. Desperation about overdose deaths plus education campaigns for the public and professionals have made the use of

opioid medication for opioid use disorder (opioid agonist treatment) more understandable and acceptable.² The use of buprenorphine/naloxone (a prescription medication combining buprenorphine and naloxone) has increased greatly, and methadone has received renewed attention. Since 2002, when buprenorphine/naloxone was approved to be dispensed from physicians' offices,³ many patients have gained access to the medication who would not consider going to a structured and regulated methadone clinic. Also, widespread efforts have made buprenorphine/naloxone more available in prisons, jails, emergency departments, and primary care facilities. However, both patients and professionals hold widely varying expectations of what opioid agonist treatment can do, and variation creates challenges. Changing terminology reflects the evolution of the field at a time when the opioid epidemic brings a great sense of urgency. The acronym "MAT" or Medication Assisted Treatment is a term that, in the authors' experience, is widely used by treatment providers, especially clinics. However, the term "MOUD," or Medication for Opioid Use Disorder is emerging, to reflect the fact that the medications themselves bring significant improvement. The authors have chosen to use "opioid agonist treatment" to minimize confusion as the language continues to evolve.

Despite growing public acceptance, old misunderstandings and biases persist. Even though rehabilitation has long been the goal of opioid agonist treatment,⁴ one of the most prominent misunderstandings is the view that successful treatment requires the patient to discontinue the medication at some point and still maintain stable recovery. This view makes itself known in discussions with patients and staff. The narrative promoting discontinuation often goes unchallenged, even by those best situated to promote examination of the issues.⁵ A long and growing list of research studies suggests that when patients attempt to cease opioid agonist treatment, most will be unable to discontinue and preserve their gains. This is documented in the literature on treatment of opioid use using methadone,^{6,7,8} and the American Society of Addiction Medicine (ASAM) concluded decades ago that methadone is best considered a long-term treatment.⁹ A substantial subset of patients receiving buprenorphine/naloxone appear to achieve lasting rehabilitation, but discontinuing the medication is associated with relapse, overdose, and mortality.^{10,11,12,13,14} Research into effective methods for encouraging patients to stay in treatment must continue, yet physicians, counselors, and front-line staff are being asked

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to meet the needs of their patients expressing the urge to taper from opioid agonist treatment.

Best and Laudet define recovery as a lived experience with principles focused on “the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings.”¹⁵ (p2) When patients self-define recovery as discontinuing buprenorphine/naloxone, despite physician encouragement to continue opioid agonist treatment, it is the view of the present authors that a patient’s desire to discontinue should be fully respected as the patient grows in self-empowerment. The desire should also be addressed in a context so the patient is fully informed and prepared for the challenges.¹⁶ In this article, we suggest ways to discuss issues with patients and treatment providers, adapting the framework of “recovery capital” and using The Recovery Capital and Physician Risk Factor Checklists. Addressing recovery issues may be insufficient for patients to discontinue opioid agonist treatment, but addressing these tasks can greatly improve patients’ quality of life whether or not medication is continued. Best and Laudet’s understanding of recovery capital, originally from Granfield and Cloud,¹⁷ builds on the idea of recovery as a lived experience: Recovery is a process rather than an end state, with the goal being an ongoing quest for a better life.¹⁵ It thus encompasses a range of elements shown to contribute to quality of life.^{18,19} These elements include social support, life meaning, spirituality, and a community that supports the recovery process—all serving to reduce stress and increase stability of recovery. While some elements of recovery capital rest outside the clinical setting, immense variability exists in the type of support offered in the clinical environment. White and Cloud²⁰ assert that the appropriate interventions depend in part on the balance of recovery capital and problem severity/complexity. Opioid use disorders often have high levels of problem severity and complexity, so physicians, counselors, and other frontline staff must be prepared to respond to the acuteness of a patient taper with a high level of recovery capital. Though experienced clinicians working with patients in long-term care can address these issues over time, the checklist facilitates a more systematic approach.

HISTORICAL BACKGROUND

Methadone

Methadone was the first opioid medication to be used widely in outpatient addiction treatment, and it was controversial from the beginning.²¹ As a result, an extensive research base developed and continues to this day. During the 1960s and 1970s, it was assumed that methadone could stabilize patients, who were given up to 2 years to steady their lives before they were required to taper off. Over time, research indicated these hopes were unrealistic. Research suggests that most patients will be unable to discontinue the medication and preserve the gains they made during treatment with methadone.²²

Buprenorphine/Naloxone

Since the FDA approved buprenorphine/naloxone as an opioid use disorder treatment, clinicians and researchers discovered similarly discouraging results associated with discontinuing

the medication.² Meanwhile, clinicians observed high levels of success with continuation of buprenorphine/naloxone.²³ Compared with methadone, buprenorphine/naloxone offers some advantages as a partial opioid agonist with less toxicity^{24,25}; it is available through prescription services, though limited³—rather than enrollment at a licensed clinic—which may be more convenient for patients and viewed as less stigmatizing.²⁶

Methadone to Buprenorphine/Naloxone

Breen et al¹⁰ explored transferring patients’ opioid agonist treatment from methadone to buprenorphine/naloxone and then tapering off buprenorphine/naloxone, but without much success. While 38 of the 51 (75%) of patients reached zero dosage, only 31% were not using heroin or methadone at the 1-month follow-up. Four patients (13%) switched to buprenorphine/naloxone, one of whom tapered off of buprenorphine/naloxone. Twenty patients (67%) stopped their tapers due to feeling unstable/withdrawal symptoms, drug use/positive urinalysis results, and pain management problems.

Discontinuing Buprenorphine/Naloxone

Many studies have explored and compared methods for discontinuing buprenorphine/naloxone. Several review articles summarizing this literature found that the majority of patients who attempt withdrawal from buprenorphine/naloxone do not succeed. Dunn et al¹¹ compared 27 studies of the duration used to taper from buprenorphine/naloxone. The review included 8 studies that conducted posttaper follow-up (with lengths of follow-up varying widely from 8 to 365 days after last buprenorphine/naloxone dose). Collapsing across the 8 studies, a median of 23% of participants provided opioid-negative samples collected at the first post-taper follow-up visit (eg, samples gathered in closest proximity to the final taper day). Retention in buprenorphine/naloxone treatment also appears to be a problem when patients enter directly from illegal opioid use. In a retrospective longitudinal cohort analysis of 17,329 Medicaid patients (2013–2017), Samples et al²⁷ found over 25% of the participants discontinued in the first month of treatment and most discontinued before 180 days. Risk factors for early discontinuation include younger adults, minorities, those with a history of nonopioid substance use disorders, and a low initial dose. These authors did *not* find that psychiatric comorbidities were a significant risk factor. They recommended focusing on the treatment barriers for those at high risk for discontinuation.

A systematic review by Bentzley et al¹² found that most patients who discontinued buprenorphine/naloxone maintenance did it involuntarily, because they had been failing to meet strict program requirements. Rates of relapse to illicit opioid use 1 month after discontinuation were over 50% in every study; collapsing across studies, 18% of patients were abstinent from opioids in the first month following discontinuance of buprenorphine/naloxone. Sordo and colleagues¹³ conducted a meta-analysis that synthesized evidence from cohort studies published until 2016 on risk of mortality during and after treatment among patients receiving opioid agonist treatment. They examined cohorts on buprenorphine/naloxone and methadone separately and reported that retention in

either treatment was associated with substantial reductions in the risk for all cause and overdose mortality. Adverse events are common even among patients who discontinued after 6 months of continuous buprenorphine/naloxone treatment. In the large-scale study of patients with Medicaid, Williams et al¹⁴ found risks of acute care service use and opioid overdose were high. Almost half the patients were seen in emergency departments at least once, although adverse events diminished with longer time in treatment.

General Conclusion: Discontinuing Not Recommended

Although discontinuing therapy with methadone or buprenorphine/naloxone may be a personal goal for many patients, family members, and addiction treatment staff, there are discouraging odds of completing a taper and remaining abstinent from illicit opioids. Weinstein et al²⁸ conclude that, though many patients want to discontinue, few are successful, and the medical community “should direct its efforts to overcome the barriers to long-term maintenance.” Robert Newman went further, challenging the significance of attempting to build interventions to make patients medication-free when they are already doing well on a maintenance medication. Newman asked, “to what end?” (p.1429).²⁹ It is often useful to offer patients and others a definition of abstinence that works for all prescribed medications. One that is widely accepted in the opioid treatment community is: A patient is abstinent if he/she is not drinking alcohol or using illicit drugs and using medication as prescribed.

WITH ALL THE PROBLEMS WITH TAPERING, WHY DO PEOPLE STILL WANT TO DISCONTINUE OPIOID AGONIST TREATMENT?

The vignette below illustrates the factors that fuel the patient’s desire to stop taking buprenorphine/naloxone:

Sam was entering his third inpatient detoxification program since he began using prescription opioids and then heroin 16 years ago. He expressed shame over his relapse and doubts about his ability to remain abstinent. His longest period of abstinence occurred during the two years he was on buprenorphine/naloxone. When asked to describe his life then, he reported being comfortable and stable in his ability to meet work obligations. Under perceived pressure, he discontinued the medication and relapsed to heroin. When he entered a private-sector detoxification program, buprenorphine/naloxone treatment was instituted for detoxification from heroin, and he expressed the desire to taper off buprenorphine/naloxone by the end of this treatment episode. Asked why, he stated that he had concealed his addiction from his live-in partner, who would strongly disapprove of his being on medication. Treatment interventions during his 30 day stay included education about opioid addiction, buprenorphine/naloxone, and exploration of how his life would change if he could communicate honestly with his partner about this and other issues.

Several misconceptions drive the desire to discontinue opioid medications, which can be addressed in counseling

patients who are considering tapering off methadone or buprenorphine/naloxone.

Misconception: Discontinuing Medications is Necessary

Stigma^{30,31} is a powerful force in perpetuating negative attitudes toward opioid medication. It is at its most ferocious with respect to methadone, but similar issues influence attitudes about buprenorphine/naloxone. Many patients and treatment professionals implicitly or openly view discontinuation as a desirable or necessary goal. As a counter to that idea, treatment staff can point out that both methadone and buprenorphine are dependence-producing medications, a property they share with synthetic thyroid, antidepressants, antipsychotics, antihistamines, blood pressure medications, anti-epileptic drugs and others less influenced by stigma.

Misconception: People Are Not Really “Clean” if They Are on Methadone or Buprenorphine/Naloxone

A long-held attitude that needs to change is that receiving maintenance opioids reflects an illness, a defect, or moral weakness.³² With methadone, this stigma is common among patients, for example, that the medication “takes your heart,”³³ along with numerous misconceptions and myths about methadone.³⁰ Family members and peers were influenced by the persistent stigma and devalued the patients’ accomplishments if they remained on medications. Patients fear the medication would be detected in employee drug testing, and their jobs would be in jeopardy. As a counter to that idea, a counselor can express disagreement with the patient’s initial statement at face value and can probe further to clarify the issues. It is important to encourage them to elaborate, examine their reactions, and reconsider what is in their best interest. A counseling framework of shared decision-making is most likely to increase patient receptivity to cautions from the treatment provider.

Misconception: If I Tried Harder I Could Get Off Opioid Medications

This ignores the research suggesting that genetic factors influence vulnerability to opioid addiction³⁴ and that long-term opioid use alters neurobiological factors in ways that may mean that most of these patients are unlikely to be able to discontinue for extended periods of time.

Misconception: Medications That Are Easier to Taper Are Better

Buprenorphine/naloxone is seen as preferable in this regard. There is no consistent relationship between ease of discontinuation and long-term abstinence. Amato et al³⁵ conducted a Cochrane review of 23 studies comparing the use of methadone with other medications aiming to manage opioid withdrawal symptoms. The medications compared with methadone in the reviewed studies included: 1. Other opioid agonists (LAAM (levo-acetyl-methadol), buprenorphine, propoxyphene, etc); 2. Adrenergic agonists (clonidine, lofexidine, guanfacine); 3. Opioid antagonists (naltrexone, naloxone); and 4. Placebo. They found that, although some methods are

superior to others in reducing withdrawal symptoms, research comparing withdrawal methods has not identified any that are associated with long-term abstinence.

OPTIMAL CLINICAL STANCE

Despite clinician recommendations based on research, some patients still express a strong desire to taper. It is the authors' experience doing training and consultation in a variety of treatment settings that counselors and medical providers often do not know how to have a conversation with the patient surrounding the patient's desire to taper. It is desirable for treatment providers to maintain a balance between respect for a patient's choice and realistic feedback on what it will take to succeed no matter what the patient chooses. It is useful for the patient who wishes to remain on medication to have a plan that includes identifying a prescribing medical provider and a counselor to explore how to handle charged situations like peer and family pressure to discontinue. Patients who choose to taper can be asked to use the Recovery Capital Checklist to identify challenges and formulate specific plans for addressing them. Ideally, this includes minimizing stress in other aspects of their lives. This plan should also include signals that tapering is not working and resuming maintenance medication should be considered, preferably with a counselor knowledgeable about opioid addiction. Clinicians should address any sense of failure in patients who have done the recovery work but find themselves unable to taper. They should be encouraged to focus on their achievements in recovery and to focus on the goals that medication can make possible.

Also in the past few years, more attention has been directed toward the use of long acting injectable naltrexone (Vivitrol) as an effective form of treatment for opioid use disorder. Two recent large randomized clinical trials^{36,37} showed extended release naltrexone to be as effective as buprenorphine in maintaining short-term abstinence from heroin and other illicit substances. Therefore, an important part of the informed consent process when patients decide to discontinue buprenorphine/naloxone or methadone should be a strong recommendation to initiate long-acting naltrexone.

RECOVERY CAPITAL AND PHYSICIAN CHECKLISTS FOR PATIENTS AND COUNSELORS, AND MEDICAL STAFF

Should patients continue their line of inquiry into tapering, we introduce the Recovery Capital Checklist as an updated and expanded tool for patients, counselors, and medical providers to identify and address issues related to stable recovery. This guides patients to make their own assessment of whether they have made enough changes to tackle such a precarious effort. In the process of discussing the elements on this checklist, some may conclude they are not prepared to discontinue their medication. Whatever they decide, the checklist provides guidance in optimizing the recovery effort, whether or not the patient remains on opioid agonist therapy.

The Recovery Capital Checklist is based on an earlier tool, the Tapering Readiness Inventory, developed by Wermuth,

Brummett, and Sorensen in 1987³⁸ as part of a research study designed to investigate whether enriched psychosocial services could improve outcomes when patients discontinued their medication. This study and many subsequent studies did not find psychosocial interventions predicted long-term success in tapering. However, clinicians have downloaded and shared the original tool many times since 1987, demonstrating an ongoing need for tangible guidance in this complex endeavor despite the growing research that supports urging patients to stay on opioid agonist therapy. Counselors report the checklist provides a helpful framework for discussion, by facilitating a dialogue that simultaneously informs patients and does not endorse the goal of tapering. The patient and counselor's section of the checklist specifies elements of emotional growth and life-style changes that increase the potential for stability. It is important for counselors to be clear that no research to date has identified predictive factors for a successful taper, but other goals named on the checklist are more attainable and can support the overall recovery process.

The newly created medical provider's section, the Physician Risk Factor Checklist, indicates warning signs that the patient is likely not stable enough to consider a taper. The goal is to provide a framework for informed consent about the high risk of tapering, recommendations to maximize chances of a stable outcome whether the patient remains on medication or not, and to identify areas for future research (Tables 1 and 2).

The Recovery Capital Checklist—the section for patients and counselors—is based on updated literature for tapering from either methadone or buprenorphine/naloxone. We use the term “checklist” to signal that it has points of consideration or reminders in planning, rather than a comprehensive formal catalogue. The checklist highlights factors that have been associated with a readiness to discontinue methadone or buprenorphine/naloxone. It does not predict success; rather, it helps assess whether the patient is prepared for a high-risk venture. Having many factors working in one's favor may suggest that a person has a better chance of attempting a highly stressful endeavor without returning to illegal drugs. Having very few of the factors on one's side may indicate greater danger of serious relapse. The item on spirituality was added based on many patients' reports of its importance in their recovery. For example, in her large study of how people in recovery define the key elements, Kaskutas et al³⁹ reported strong support for “spirituality of recovery.” It may be a reflection of their participation in 12-Step groups but not necessarily so. Others report drawing strength from meditation, church attendance, and private prayer. Patients without a strong spiritual connection can do well, but it appears that this element is a key part of the support system for many who are struggling to make and sustain progress.

The Physician Risk Factor Checklist, the section intended for medical providers, is new and contains items that should be explored, as they represent factors associated with higher risk of return to illicit opioid use. It contains several indicators of possible drug-seeking behavior, or other signs of instability the patient might be experiencing. It gives the physician a framework to discuss unrealistic expectations

TABLE 1. The Recovery Capital Checklist (Patients and Counselors Section)

1.	Have you been abstaining from illegal drugs, such as heroin, cocaine, and speed?	Yes	No
2.	Do you think you are able to cope with difficult situations without using drugs?	Yes	No
3.	Are you employed or in school?	Yes	No
4.	Are you staying away from contact with users and illegal activities?	Yes	No
5.	Have you gotten rid of your drug paraphernalia?	Yes	No
6.	Are you living in a neighborhood that doesn't have a lot of drug use?	Yes	No
7.	And are you comfortable there?	Yes	No
8.	Do you have nonuser friends that you spend time with?	Yes	No
9.	Are you living in a stable household or family?	Yes	No
10.	Do you have friends or family who would be helpful to you during a taper?	Yes	No
11.	Do you have a spiritual practice?	Yes	No
12.	Have you been participating in counseling that has been helpful?	Yes	No
13.	Does your counselor think you are ready to taper?	Yes	No
14.	Do you think you would ask for help when you are feeling bad during a taper?	Yes	No
15.	Are you in good mental and physical health?	Yes	No
16.	Do you want to get off methadone or buprenorphine?	Yes	No

The purpose of this section of the Checklist is to help patients and counselors to decide if the patient is ready to taper or discontinue from MOUD at this time. Each item represents an important part of the process of being ready to discontinue MOUD.

The more questions that can honestly be answered "yes," the greater the likelihood that the patient is ready to taper from opioid medication. Consider that each "no" response represents an area that the patient and counselor probably need to work on to increase the odds of a successful taper and recovery. Circle the appropriate response.

in the light of clear warning signs. Specific responses need to be evaluated by the clinician familiar with the individual patient's history. For example, it is quite possible that prescriptions for anxiolytics or stimulant medications are appropriate, but they need to be closely monitored to identify possible misuse before the patient becomes unstable. We stress that the checklist is based on the authors' experience and, like the Recovery Capital Checklist, has not been psychometrically evaluated. There are a variety of published physician-administered screening instruments available to assess risk of opioid diversion.⁴⁰ In general, the items in the two sections of the Checklist can promote a fruitful conversation with the patient, potentially offering specific areas that need to be addressed if a taper is under serious consideration.

INDICATIONS THAT MAINTENANCE MEDICATIONS ARE NEEDED FOR BEST RESULTS

The Checklists' sections for patients and their counselors and for medical providers, provide criteria to guide clinicians and may promote future research. Many patients who wish to taper may not be ready to do so. Tapering is highly stressful, and a supportive social network, including family, helps to weather the storms. Although patients do succeed despite unfavorable social conditions, it is certainly desirable to do the recovery work prior to attempting a taper.⁴¹ Coping skills need to be strengthened, and psychological issues such as anxiety or depression need to be addressed.

Clinicians report that patients using alcohol and other drugs such as stimulants have less likelihood of success.

TABLE 2. Physician Risk Factor Checklist (Medical Providers Section)

1.	Any unexpected findings on PDMP*	Yes	No
2.	Frequent emergency department visits/minor injuries/MVCs†	Yes	No
3.	Recently appeared intoxicated/impaired	Yes	No
4.	Increased dose without authorization	Yes	No
5.	Needed to take medications belonging to someone else	Yes	No
6.	Patient or others worried about how patient is handling medications	Yes	No
7.	Had to make an emergency phone call or go to the clinic without an appointment	Yes	No
8.	Used pain medication for symptoms other than pain—sleep, mood, stress relief	Yes	No
9.	Changed route of administration	Yes	No
10.	Serious co-morbid mental illness	Yes	No
11.	Recent requests for early refills	Yes	No
12.	Recent reports of lost or stolen prescriptions	Yes	No
13.	Hoarding or stockpiling of medications	Yes	No
14.	Increasingly unkempt	Yes	No
15.	Attempted to obtain prescriptions from other doctors	Yes	No
16.	Concurrent benzodiazepine prescriptions	Yes	No
17.	Concurrent stimulant prescription	Yes	No
18.	Maintenance dose greater than 8 mg or buprenorphine or 80 mg methadone	Yes	No
19.	Current reports of disturbances in sleep	Yes	No
20.	Current reports of problems or lability in mood or energy	Yes	No

The purpose of this section of the Checklist is to help medical providers to assess potential signs or barriers that may lessen the patient's likelihood of being able to succeed with a taper or discontinuation of MOUD.

*PDMP – Physician Drug Monitoring Program, electronic database that tracks controlled substance predictions in a state.

†MVCs – Motor vehicle collisions.

Return to illicit opioid use may not occur immediately but can happen weeks or months after using another intoxicant. Many patients who use opioids report extended periods of sobriety, followed by opioid relapse when they use alcohol or stimulants. Some state that drugs like marijuana “help” them abstain from opioids, but this claim needs systematic examination. The Recovery Capital and Physician Risk Factor Checklists also call attention to alcohol and other drug use that should be discussed in any recovery process.

It is also important that patients be familiar with their own triggers and stressors and acquire skills to manage them. Various manualized treatments, such as cognitive behavioral therapy, help to develop and consolidate those skills.⁴² It is also important that co-occurring psychiatric disorders are appropriately addressed.

LIMITATIONS

Many gaps remain in the evidence base. Studies use different terminology, interventions, inclusion criteria, follow-up methods, and indices of success. There is a need for greater standardization of methodology when possible, so results can be compared. As noted in the review articles, most studies used very short follow-up windows; most were essentially open single-group follow-up studies with no blinding of participants or staff to dosage or intervention group. Studies with such blinding often had strict admission criteria, lessening their generalizability to the general patient population.

The National Institute of Health’s Helping to End Addiction Long-Term (HEAL) initiative⁴³ includes addressing the question of the optimal time that patients should be on opioid agonist treatment. It suggests adding the question of whether there are any predictors of completing tapering from opioid agonist treatment and remaining abstinent from illicit opiates. This question must be carefully addressed, with a follow up period of 1 year or longer. Connery and Weiss¹⁹ offer a recent summary of some of the outstanding questions in their editorial in the February 2020 issue *American Journal of Psychiatry*, which features studies on this topic. In the United States, treatment with methadone has relatively firm requirements for monitoring intake of medication, provision of counseling, and assessment of the use of other drugs. Little is known about how well patients receiving buprenorphine/naloxone do without the relatively firm requirements that are part of methadone treatment. What proportion of patients receiving buprenorphine/naloxone have discontinued on their own, for what reasons, and with what result? Most importantly, can we identify factors that predict long-term abstinence from opioids and other substances for both methadone and buprenorphine/naloxone? If studies find little of practical value, then the focus should remain on how to keep patients enrolled in opioid agonist treatment.

Studies of the workforce, particularly counselors, would be timely. How well do they understand opioid medications? Are physicians clear on how to train the counselors to discuss medications with their patients? Do either of the groups have skills beyond instruction (eg, “it is too risky to go off medication”) to help patients work through their resistance? These aforementioned areas are implementation

issues, and far too little is spent understanding these barriers to effective care.

CONCLUSIONS

Individuals who use opioids are at historically high risk for overdose or other negative consequences, likely related to the emergence of the synthetic fentanyl analogues. Thus, it is important for medication decisions to be reached carefully, with full knowledge of the high risks. We offer the Recovery Capital and Physician Risk Factor Checklists as frameworks to systematically examine and address these issues within a process of shared decision-making. The goal is for patients to focus on what they have achieved and what remains to be done, independent of whether they remain on medication.

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