Opioid Tapering for Chronic Non-Cancer Pain

Guidance for adults in primary care
(Adapted from West Suffolk CCG with permission)

Indications for opioid tapering and/or discontinuation

- Patient request
- > 120 mg oral morphine equivalent per day
- Opioid not providing useful pain relief
- Opioid trial goals not met
- Medical complications
- Overdose risk increased
- Opioids used to regulate mood
- Underlying painful condition resolves or stable for ≥3 months
- Side effects intolerable or impairs function
- Patient receives a definitive pain relieving intervention
- Strong evidence that the patient is diverting their medication
- Non adherence to treatment plan
- Indicators for dependence (hyperlink not working)

Precautions: Pregnancy, unstable psychiatry and medical conditions and opioid addiction

Step 1

Assess Risk (consider use of opioid risk tool)

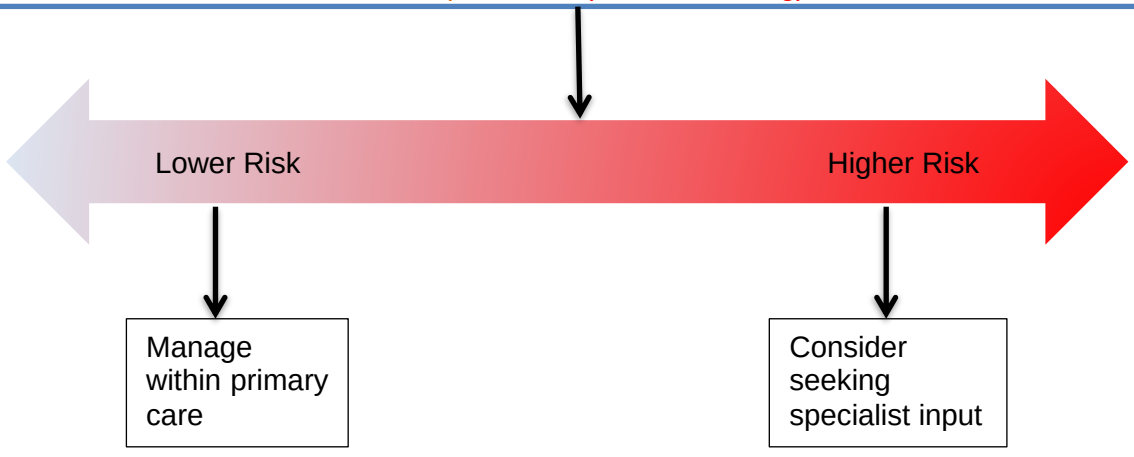
Patient factors

- Depression, anxiety & history mental health
- History of alcohol or substance abuse
- History of opioid or prescription drug misuse
- Inability to engage in services to meet educational and psychological health needs

Drug factors:

- High doses > 120 mg oral morphine equivalent/day
- Multiple opioids
- Multiple formulations of opioids
- More potent opioids
- Concurrent benzodiazepines, gabapentinoids or sedatives

Further information- indicators for dependence (link not working)



Consider referral at any stage to York Hospital Pain Services for optimisation of non-pharmacological pain management strategies and /or education & support for opioid tapering

Step 2

Prescription
Discuss with patient

- Risks and benefits of opioid tapering
- Agreed opioid tapering goals & plan and review appts
- Not to miss or delay doses
- Increased risk of overdose if a higher dose of opioid is taken following tapering as tolerance is reduced
- Frequency of dispensing interval may be dependent on their control
- Provide Opioid Tapering written information or signpost through patient resource padlet or QR code to opioid aware website.

- Optimise non-opioid management of pain

Taper opioids first if co-prescribed benzodiazepines

- Give patient choice of reducing slow release preparation first or intermittent short acting. Whichever they choose, stick to it.
- Use short acting PRN doses for **task** orientated pain only. Set max daily **and** weekly limit
- Fentanyl patches: reduce in 12mcg increments. Prescribe multiple smaller patches to achieve this

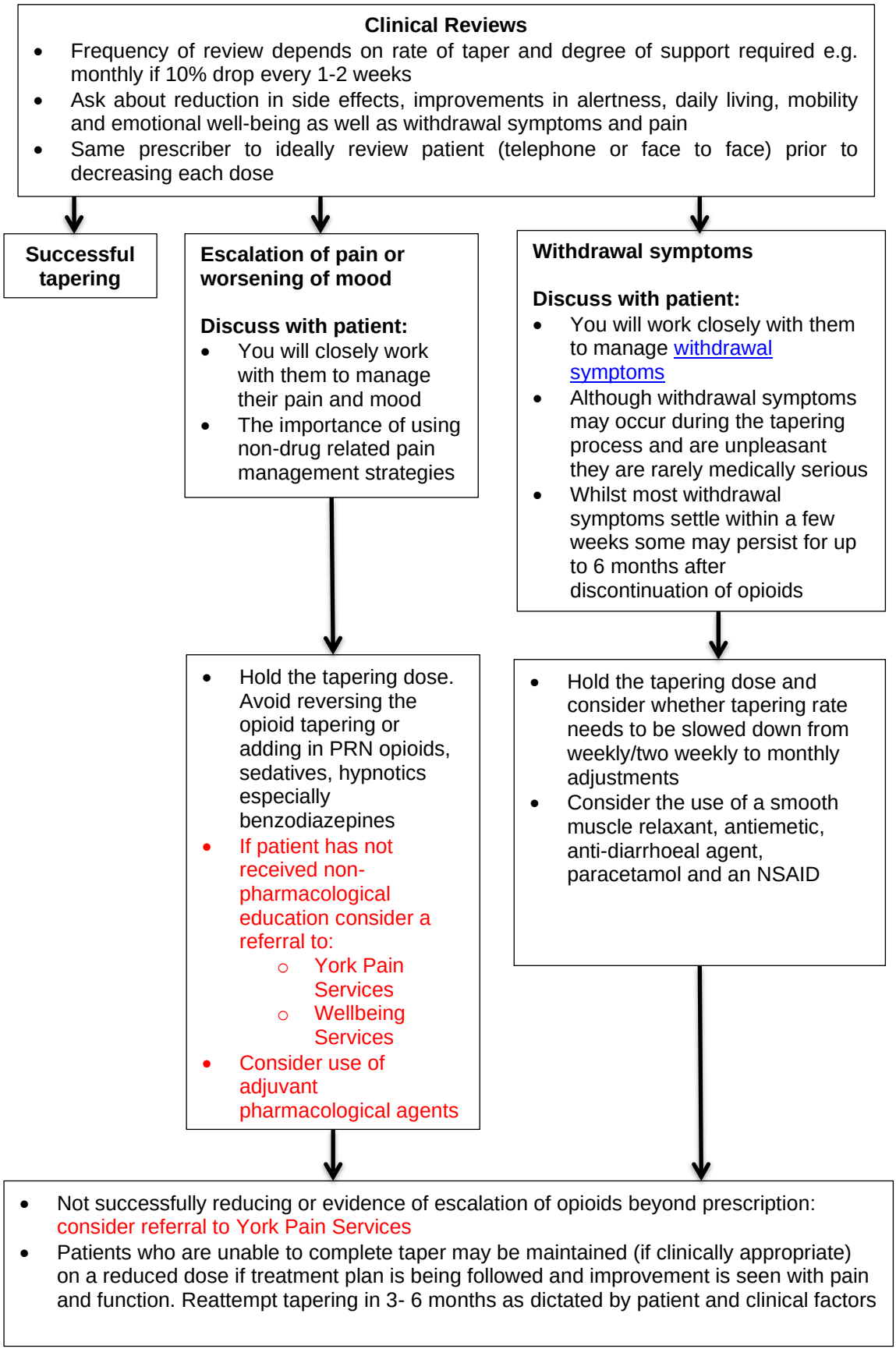
Step 3

Rate of taper
Discuss with patient

- A decrease by 10% of the original dose per week is usually well tolerated
- Tapering rate may vary according to response
- Completion of tapering is variable from weeks/months
- Once smallest available dose preparation is reached the interval between doses can be extended
- Prescriptions will not normally be renewed sooner than expected

Rate	Reduce 10% of the total daily dose every 1-2 weeks
Slower tapering	May be indicated for patients who are anxious, feel psychologically dependent on opioids or who have cardiorespiratory conditions
Faster tapering	May be indicated for patients experiencing significant adverse effects, displaying aberrant drug taking or drug seeking behaviours
One third of the original dose is reached	Consider slowing the taper down to half of the previous rate if clinically indicated e.g. 5-10% every 2-4 weeks

Step 4


Clinical Reviews
Frequency of review depends on rate of taper and degree of support required e.g. monthly if 10% drop every 1-2 weeks
Ask about reduction in side effects, improvements in alertness, daily living, mobility and emotional well-being as well as withdrawal symptoms and pain
Same prescriber to ideally review patient (telephone or face to face) prior to decreasing each dose
Successful tapering
Escalation of pain or worsening of mood
Discuss with patient:
You will closely work with them to manage their pain and mood
The importance of using non-drug related pain management strategies
Withdrawal symptoms
Discuss with patient:
You will work closely with them to manage withdrawal symptoms
Although withdrawal symptoms may occur during the tapering process and are unpleasant they are rarely medically serious
Whilst most withdrawal symptoms settle within a few weeks some may persist for up to 6 months after discontinuation of opioids
Hold the tapering dose. Avoid reversing the opioid tapering or adding in PRN opioids, sedatives, hypnotics especially benzodiazepines
If patient has not received non-pharmacological education consider a referral to:
York Pain Services
Wellbeing Services
Consider use of adjuvant pharmacological agents
Hold the tapering dose and consider whether tapering rate needs to be slowed down from weekly/two weekly to monthly adjustments
Consider the use of a smooth muscle relaxant, antiemetic, anti-diarrhoeal agent, paracetamol and an NSAID
Not successfully reducing or evidence of escalation of opioids beyond prescription: consider referral to York Pain Services
Patients who are unable to complete taper may be maintained (if clinically appropriate) on a reduced dose if treatment plan is being followed and improvement is seen with pain and function. Reattempt tapering in 3- 6 months as dictated by patient and clinical factors

Evaluation Criteria	Yes	No
1. Clinical Diagnosis		
(a) Is there a comprehensive documentation of the patient's pain condition, general medical condition, psychosocial history, psychiatric status and substance use history?		
(b) Is the indication/diagnosis for prescribing opioids clearly supported and documented?		
(c) Is opioid medication clinically appropriate in this condition?		
2. Opioid Treatment		
(a) Has opioid therapy produced and maintained a measurable improvement in the patient's pain and/or functional capacity (30% reduction in pain intensity, or specific functional improvement/ improvement in sleep)		
(b) Are the total doses of opioids below 'ceiling' dose levels? (>90 mg in 24 hours of oral morphine equivalent/day unless on the advice of the York Hospital Pain Services)		
(c) Is the patient substantially free from adverse side effects of opioid therapy including harm associated with long term use?		
(d) Is there continued absence of inappropriate dose escalation, aberrant behaviours, misuse or abuse of opioids?		
(e) Has a reduction in opioid therapy been trialled?		
3. Additional Treatment		
(a) Are non-pharmacological strategies optimised or has a referral to West Suffolk Integrated Pain Management Service Single Point of Access been considered?		
(b) Have the potential benefits, adverse effects, risk of harm of long term opioid therapy, opioid safety and impairment to driving skills been discussed with the patient?		
(c) Has the patient been provided with / Taking Opioids for Pain, Driving and Pain and Opioid Safety leaflets? Opioids Aware | Faculty of Pain Medicine (fpm.ac.uk)		
(d) Given the clinical complexity and risk, is the current level of specialist care and multidisciplinary intervention adequate and appropriate? In general the following scenarios are considered as complex and high risk and may require specialist and/or multidisciplinary review: • Those who use two or more psychoactive drugs in combination (polydrug use) (e.g. opioid, benzodiazepines, antipsychotic, anti-epileptics, or and antidepressants) • Patients with serious mental illness comorbidities, or antipsychotic medication • Mixed use of opioid and illicit drugs • Mixed use of opioids and benzodiazepines • Recent discharge from Drugs and Alcohol Services • Patients discharged from other general practices due to problematic behaviours • Signs of potential high risk behaviours		
4. Compliance		
(a) Is current opioid prescribing compliant with relevant legislation, regulations and NICE guidance for prescribing Controlled Drugs?		

Answering 'no' to any of the above options should prompt a consideration to alter the management plan.

Recommendations:

- ☐ Continue Therapy
- ☐ Pursue alternate therapies
- ☐ Reduce opioid dose
- ☐ Suggest specialist review
- ☐ Reduce and cease opioid

Template Patient Letter

Invitation for opioid review

Dear [Patient name]

We are currently undertaking a review of prescriptions for medications collectively known as opioids, which may be prescribed to patients within our practice.

This review is required as current evidence suggests that although opioids are very good for both acute and end of life pain there is little evidence that they are helpful for long-term pain. A small proportion of people, however, may obtain good pain relief with opioids in the long term if the dose can be kept low and its use is intermittent, but it is difficult to identify these people at the start of treatment.

The enclosed patient information leaflets titled ‘Taking ‘Opioids for Pain’ discusses common side effects as well as health risks that can occur when opioids are taken at high doses for a long period. The ‘Driving and Pain - Information for Patients’ leaflet discusses further information relating to driving whilst taking opioids.

We are therefore writing to all patients who from our records have received a number of opioid prescriptions, above a specific dose, during the past 12 months and are requesting that they make an opioid review appointment with their GP.

At this appointment, the GP will undertake a comprehensive assessment and medication review. They will be able to discuss the benefits and risks associated with the drugs prescribed for your long-term pain and explore with your treatment options.

Please make an opioid review appointment with your GP.

Opioid Tapering Resources

Opioids Aware | Faculty of Pain Medicine (fpm.ac.uk)