Clinician information sheet on opioid analgesic tapering

This information sheet aims to:

- Summarise agreed principles and highlight some key points of, and signpost to, a number of Australian guidelines
- Recommend language that guides and supports patients
- Support opioid analgesic tapering for patients with complex problems, noting that in these cases referral to a specialist service may be required, but there will likely be a waiting period before these services can be accessed
- Support taper in situations where the patient may not fully cooperate, but the prescriber feels the current dose is causing harm thus is unable to continue current prescribing
- Emphasise that every practitioner attempting a taper must create a patient-specific plan to ensure ongoing monitoring and support to avoid serious withdrawal symptoms, worsening of pain or psychological distress

Treatment indication: opioid analgesics and Chronic Non Cancer Pain (CNCP)

Opioid analgesics are no longer indicated for CNCP other than in exceptional circumstances following changes to the TGA registered indications and PBS reimbursement criteria in 2020.

Goals of intervention and target patient groups

- **Chronic Non-Cancer Pain patients on opioid analgesics**, for whom the prescriber considers does not meet the criterion of exceptional circumstances, and where the prescriber and patient believe they can collaborate to achieve a reduction in opioid analgesic dose.
- **Indications for opioid analgesic tapering include** suspected lack of efficacy of opioid analgesic in pain management (including increased pain sensitivity), hazardous/harmful use of opioid analgesics, other adverse events (respiratory depression, tiredness, constipation, difficulty in concentrating, difficult to treat depression and/or sexual dysfunction).
- The **oMEDD** (oral morphine equivalent daily dose) is a measure of how potent the opioid analgesic dose is. The Faculty of Pain Medicine have a simple dose calculator www.opioidcalculator.com.au that is free to download, including as an app. The 'traffic light' system on the app is also a useful, visual tool when discussing concerns with patients taking high doses of opioid analgesics. (Note the ratios for conversion of morphine and other full agonist opioids to buprenorphine do not apply at high doses).
- **In particular, CNCP patients taking more than 60mg oMEDD** should aim to taper to below this dose to improve safety outcomes. While the 60 mg oMEDD figure is based on expert opinion only, use of 60 mg or higher likely indicates pain that is poorly responsive to opioid analgesics and that the analgesic response is not justified by the potential for harm. **For frail or older patients and those prescribed other sedative medicines** such as benzodiazepines, gabapentinoids or antipsychotics, a better oMEDD threshold is lower, at 30 to 40 mg.
- **Patients with CNCP taking less than 60 mg oMEDD** should have an opioid analgesic tapering plan developed after discussion of possible tapering.

Having the opioid analgesic tapering discussion

The patient may have commenced, maintained and increased opioid analgesics on advice from their doctor. A number of patients may not be aware that the analgesics they have been taking are opioids, and that little benefit may be expected from long term opioids. It may be helpful to explain to the patient that evidence shows taking opioid analgesics for long periods may not be safe or beneficial. Outline the potential side effects of long-term opioid analgesic use, relating this to the patient, and the benefits of reducing their dose.

Discussions about future opioid analgesic prescribing with patients who have been on opioids for a significant period are challenging. The discussion should not always start from the view that a lower dose of opioid analgesic is preferable for each patient who is on less than 60 mg oMEDD. Noting a lower threshold oMEDD of 30 mg in older, frail patients and those prescribed other sedating medicines. It is important to reassure the patient that opioid analgesic tapering does not mean that you will abandon them, and that you will continue to support them to take up more efficient strategies they can use in the longer term. The transition from opioid analgesic treatment to supported self-management and other pain management strategies is strongly supported by scientific evidence.

Successful opioid analgesic tapering can take time with multiple facilitators, most importantly the patient. Tapering is supported by policy and regulation, clinician expertise including holding therapeutic boundaries with empathy and patient empowerment, opportunity and motivation. Opioid analgesic tapering is more likely to succeed when there is a shared decision between the prescriber and patient. In particular, be clear when the patient has made an active decision to taper their opioid analgesic, and document and agree on the tapering plan. Also, recognise there is variability in the level of opioid analgesic tapering and discomfort patients can or will accept that will guide the approach.

Some resources to support GPs in opioid analgesic tapering discussions with patients

Communication techniques for tapering conversations (University of Sydney, Aug 2020): https://imh.org.au/research/back-pain-and-musculoskeletal-conditions/research-projects-in-improving-clinical-care/

NPS MedicineWise: www.nps.org.au/professionals/opioids-chronic-pain/starting-a-conversation and www.nps.org.au/cpd/activities/real-time-prescription-monitoring-safe-script

Internal Medicine Society of Australia/ NZ: https://www.imsanz.org.au/sb_cache/associationnews/id/643/f/PSA%20Opioid%20Medicine%20Fact%20Sheet%20_FINAL.pdf

www.researchgate.net/publication/51070630_The_Behaviour_Change_Wheel_a_new_method_for_characterising_and_designing_behaviour_change_interventions

Opioid analgesic tapering protocols

Whether a faster or gradual opioid analgesic tapering is best will depend on the level of patient engagement, and how the patient progresses during tapering (e.g. withdrawal symptoms). In general, switching between different opioid analgesics during tapering may be unsettling to the patient. However, switching from opioid analgesics, such as oxycodone to buprenorphine (a partial agonist), may be appropriate for those patients who may be at risk of overdose through seeking illicit opioids during tapering. Pain management services are usually willing to provide telephone advice to prescribers to support replacement of poorly performing treatments such as opioid analgesics with better or safer alternatives for particular patients. In general:

- At every consultation, give the patient a written opioid analgesic tapering plan. With the patient's agreement, communicate the plans with the patient's nominated pharmacy to reinforce the plan.

Prescribe only enough of the opioid analgesic until the agreed review date and emphasise that "bridging" prescriptions will not be provided.

- Consider implementing a staged supply arrangement with the patient's nominated pharmacy.
- In the case of unequal split daily dosing, have the patient participate in deciding which opioid analgesic doses are reduced first.

Gradual taper

- Rationalise the patient's regimen to a single modified release opioid analgesic. However, in patients on higher doses of an immediate release opioid analgesic, taper on the same product.
- When stabilised, the opioid analgesic dose should be reduced slowly by 5 to 20% oMEDD **each month**. Note that some symptoms of withdrawal and transient rebound pain may last several weeks.
- In the case of persisting or recurrent withdrawal symptoms, consider reverting to the previous lowest tolerated dose. Then slow the process by recommencing weaning after 6 to 12 weeks at lower weaning rate (e.g. by 5 to 10% oMEDD every 2 to 3 months).

Faster taper

- If tapering after a short (< 3 month) period of opioid analgesic treatment or opioid analgesic trial, reduce dose by 10 to 25% oMEDD **every week**.
- If significant adverse events or significant risk of harm is likely if current opioid analgesic dose is maintained, reduce dose by 10 to 25% oMEDD **daily** (this may require hospital admission).

Specialist services should be considered for some patients. This includes patients where opioid analgesic withdrawal management with short-term clonidine may be required to limit opioid tolerance and hyperalgesia.

Some resources to support GPs in choosing tapering protocols

NPS MedicineWise: www.nps.org.au/news/5-steps-to-tapering-opioids

NSW Therapeutic Advisory Group: http://www.nswtag.org.au/wp-content/uploads/2018/06/1.8-Deprescribing-Guide-for-Regular-Long-Term-Opioid-Analgesic-Use-in-Older-Adults.pdf

NSW Government guidelines on deprescribing in general practice: http://www.aci.health.nsw.gov.au/chronic-pain/health-professionals

Note, an Australian Clinical Practice guideline is under development with an anticipated completion date of 2022: www.clinicalguidelines.gov.au/register/development-evidence-based-opioid-deprescribing-guidelines

End points for opioid analgesic tapering

The end point for opioid analgesic tapering will depend on the overall aim for the particular patient. The timing and rate of opioid analgesic reduction should always be negotiated. In some cases, it may be appropriate to taper to the lowest tolerated opioid analgesic dose rather than de-prescribing, as some patients will report reduced function and increased distress and pain with opioid analgesic de-prescribing.

In other patients it is appropriate to cease opioid analgesics altogether. These patients may continue non-pharmacological pain management approaches and use other analgesics, such as NSAIDs, if tolerated, and not contraindicated. It is vital that patients are closely monitored and supported during opioid analgesic tapering to increase the chance of success.

Other points

- **Only prescribe enough opioid analgesic** during the tapering period until you can see the patient again. Set up a series of regular appointments with the patient and stage dispensing from the patients pharmacy.
- The opioid analgesic tapering plan should **take into account the available formulations** for the chosen opioid analgesic, and ensure the patient understands the percentage reduction that is practical at each stage. If opioid analgesics are prescribed twice a day, agree with the patient which dose is reduced first. If three times a day, it might be the midday dose. When weaning controlled release oxycodone there is no formulation for less than 10mg, but the oxycodone/naloxone combination can usually be substituted.
- **Other support for the patient** may be needed throughout opioid analgesic tapering, including:
  - agreement on the goals of therapy, and access to self-management services and helplines
  - information on adverse effects of opioid analgesics and of withdrawal symptoms, and acknowledgement that the patient has been alerted to these
  - setting an opioid analgesic treatment agreement with the patient, including conditions such as the patient using only a single pharmacy, single prescriber (or a nominated second prescriber from the same practice if the patient's main GP is not available), staged supply, regular review, real time prescription monitoring services (where available) and Urine Drug Screen check, and agreement to engage with specialist services
  - for those patients who may not fully cooperate during the taper, "nudge" approaches may be appropriate
  - take home naloxone should be used to support all high and co-morbid use of opioids (see www.health.gov.au/initiatives-and-programs/take-home-naloxone-pilot; www.penington.org.au/wp-content/uploads/2019/04/COPE-overdoseresponse-nyxoid.pdf)
- For some patients, if on the advice of an addiction medicine specialist opioid use disorder is the primary problem, conversion to opioid substitution treatment (for example, buprenorphine) may be appropriate. This can be undertaken either in outpatient or inpatient settings.
- **Opioid analgesic tapering requires special care with pregnant patients** on high doses, and should be carried out in conjunction with an obstetrician/neonatologist as it is important to avoid precipitating withdrawal—perinatal risk or risk of miscarriage or premature labour.

Assessing dependence and options for opioid substitution programs

www.racp.edu.au/docs/default-source/news-and-events/covid-19/interim-guidance-delivery-of-medication-assisted-treatment-of-opiod-dependence-covid-19.pdf?sfvrsn=e36eeb1a_4

www.health.nsw.gov.au/aod/Publications/nsw-clinical-guidelines-opioid.pdf

www2.health.vic.gov.au/public-health/drugs-and-poisons/pharmacotherapy/pharmacotherapy-training

www.health.qld.gov.au/__data/assets/pdf_file/0022/444613/qotp-clinical-guidelines.pdf

www.mhc.wa.gov.au/media/1614/wa-clinical-policies-and-procedures-for-the-use-of-methadone.pdf

www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+programs+and+practice+guidelines/substance+misuse+and+dependence/drug+and+alcohol+programs/gp+program+medication+assisted+treatment+for+opioid+dependence

www.dhhs.tas.gov.au/__data/assets/pdf_file/0018/112527/2012_TOPP_Document.pdf

www.health.act.gov.au/services-and-programs/alcohol-and-drug-services/opioid-maintenance-treatment

Opioid analgesic tapering is a personal experience and should be guided by the prescriber as agreed with the patient. Additional information on support services is available from the **National Pain Services Directory** which is an online directory to provide people living with chronic pain—and their health practitioners—with a comprehensive list of available services to help manage their conditions: www.painaustralia.org.au/getting-help/pain-directory.

The table below describes approaches to opioid tapering for those requiring different levels of support. If it emerges that the primary problem is opioid use disorder then a change of approach is required and advice from an addiction medicine specialist considered. This may be required if significant aberrant behaviour emerges, risk of overdose through polysubstance abuse or emergence of serious cravings during taper.

Opioid tapering guide (for those prescribed opioids for pain)

Patient characteristics		
Low prescribing support	Moderate prescribing support	High prescribing support
No misuse of opioid medication **No polydrug use** **Patient agrees or volunteers** with opioid analgesic tapering and takes as prescribed Stable mental and physical health.	**Harmful use** with infrequent misuse of opioid medication; no intoxicated presentation Use of atypical opioids (buprenorphine, tapentadol, tramadol) **Polypharmacy** but not high risk; no intoxicated presentations Patient contemplative or disagrees with opioid analgesic tapering after feedback on hazardous use Maladaptive pain cognitions and/or limited pain coping skills Unstable mental or physical health	**High dose** (over 100 mg oMEDD daily) **Harmful use**, with frequent misuse of opioid analgesic medication **Significant aberrant behaviour** (e.g. doctor shopping, forging script/street drug, use for sleep/anxiety, diversion) **High risk polydrug use** (e.g. sedatives) with intoxicated presentation Patient disagrees with opioid analgesic tapering despite feedback on harmful use Unstable social conditions and unstable prescriber engagement Serious unstable mental (e.g. risk of harm to self or others health) or physical health concern, that requires specialist input
Potential tapering intervention for pain		
Low prescribing support	Moderate prescribing support	High prescribing support
Determine whether opioid analgesic tapering is appropriate Psychoeducation Gradual opioid analgesic tapering under medical supervision	Brief intervention Gradual opioid analgesic tapering under medical supervision Or Containment if unable to further reduce, until specialist review, e.g. weekly staged supply	Brief intervention, behaviour management Containment until specialist review, e.g. daily supervised dosing Or Partial opioid analgesic tapering to safer dose in conjunction with referral to specialist services

Consider rotation to atypical opioid Pain self-management program	Harm reduction strategy Referral for pain clinic and pain self-management program	Harm reduction strategy Specialist referral for urgent review, e.g. drug and alcohol and/or pain management clinic and/or psychiatry

Some opioid tapering resources

www.racgp.org.au/getmedia/33c608d7-e336-41ea-920f-fa171eb02885/Opioid-reduction-policy-template.docx.aspx.

Racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Drugs%20of%20dependence/Prescribing-drugs-of-dependence-in-general-practice-Part-A.pdf

www.nps.org.au/professionals/opioids-chronic-pain#resources

NSW Ministry of Health

www.aci.health.nsw.gov.au/chronic-pain/health-professionals/quick-steps-to-manage-chronic-pain-in-primary-care/how_to_de-prescribe_and_wean_opioids_in_general_practice

www.nswtag.org.au/wp-content/uploads/2018/06/1.8-Deprescribing-Guide-for-Regular-Long-Term-Opioid-Analgesic-Use-in-Older-Adults.pdf

QLD Health

www.health.qld.gov.au/__data/assets/pdf_file/0021/444432/quick-clinical-guide.pdf

https://insight.qld.edu.au/shop/withdrawal-management-quick-reference-guide-opioids

https://insight.qld.edu.au/training/opioid-related-case-studies/detail

Primary Health Tasmania

www.primaryhealthtas.com.au/wp-content/uploads/2018/09/A-Guide-to-Deprescribing-Opioids.pdf

South Australia

http://nceta.flinders.edu.au/files/8315/4959/9031/Responding_to_pharmaceutical_opioid_related_problems.pdf

https://reachforthefacts.com.au/for-prescribers/

Victoria

www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript/training

www.turningpoint.org.au/

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