NHS
Kent and Medway
Clinical Commissioning Group

Opioid Tapering Resource Pack

Document history:

Version	Date	Main Changes/Comments
1	December 2021	Adapted from the original 'Opioid Tapering Resource Pack' approved by East Kent Prescribing Group in 2020. Additions made largely from the PrescQIPP bulletin 218 and Opioids Aware website from comments received from DVH, EKUFT, KCHFT and MTW.
1.1	February 2022	Link to EK chronic pain guidance removed. Addition of fentanyl tapering guidance as an appendix instead of a link. Broken links repaired.
1.2	March 2023	Links to opioid calculator added. Wording in template letter amended to reference clinician rather than GP.

Approved by: JPC, KMMOC and Clinical Cabinet
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Opioid Tapering Resource Pack

This resource pack is designed to provide simple structured guidance and resources related to opioid tapering in adults with chronic non-cancer pain

Acknowledgement

We gratefully acknowledge the West Suffolk CCG Medicines Management Team and West Suffolk Integrated Pain Management Service for the production of the original version of this resource.

Indications for opioid tapering and/or discontinuation

- Patient request
- > 120 mg oral morphine equivalent per day[1] (see p6 for calculator)
- Opioid not providing useful pain relief[1]
- Opioid trial goals not met
- Medical complications
- Overdose risk increased
- Opioids used to regulate mood
- Underlying painful condition resolves[1] or stable for ≥3 months
- Side effects intolerable or impairs function[1]
- Patient receives a definitive pain relieving intervention[1]
- Strong evidence that the patient is diverting their medication[2]
- Non-adherence to treatment plan
- If pain not reduced by at least 30% (or other pre-agreed objective), opioids should be considered as not effective and discontinued even if no other treatment available.[3]

Precautions: pregnancy, unstable psychiatric & medical conditions & opioid addiction

STEP 1

ASSESS RISK (Consider use of opioid risk tool)

Patient factors

- Depression, anxiety & history mental health[1]
- History of alcohol or substance abuse[1]
- Additional recreational drug use
- History of overdose[1]
- 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[1]

Further information: Indicators for dependence

Lower risk ← → **Higher risk**

Manage within Primary Care

Consider seeking specialist advice or refer to local specialist pain services

Consider referral of more complex cases to the local Pain Management Services via the Single Point of Access for optimisation of non-pharmacological pain management strategies and /or education & support for opioid tapering

STEP 2

Preparation & Prescription, Discuss with patient:

- Risks and benefits of opioid tapering[1]
- Agreed opioid tapering goals & plan and review appts[1]
- Not to miss or delay doses
- ↑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
- Review any physical or mental health co-morbidities
- Patient to be given one 'designated prescriber' and advised to engage with one regular pharmacy.

- Optimise non-opioid management of pain
- **Taper opioids first if co-prescribed benzodiazepines**
- Where possible simplify multiple opioid formulations to one type of modified release preparation and a matching immediate release preparation for occasional breakthrough
- Try to avoid liquid opioid preparations when reducing.[1]
- Keep daily dosing interval the same for as long as possible twice daily
- Fentanyl Patch Tapering Guidance: see Appendix 1
- Consider a controlled drug treatment agreement
- Where there is a high risk of accidental overdose (aberrant use, multiple sedating drugs, cardiac/respiratory/renal impairment) consider provision of home naloxone rescue pack

STEP 3

Rate of taper, Discuss with patient:

- Total daily opioid dose should be reduced gradually when patients have been prescribed a strong opioid longer than two weeks[1]
- A decrease by 10% of the original dose every 1 to 2 weeks 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 expec

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 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

PLEASE TURN OVERLEAF FOR STEP 4

OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN

Guidance for adults in primary care [1-5]

CONTINUED FROM STEPS 1, 2 & 3 OVERLEAF

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. Ask about bowel habit and consider laxatives where appropriate.
- Same prescriber to ideally review patient (telephone or face to face) prior to decreasing each dose. Use clinical judgement to consider when it may be necessary to pause the dose reduction. Consider agreeing a maximum number of times the reduction can be paused due to patients personal circumstances.

Successful tapering

Please note:
A small proportion of people, may obtain good pain relief that increases their function with opioids in the long term if: the dose can be kept low, use is intermittent and providing the dose is metabolically safe for the patient. However, it is difficult to identify these patients at the start of treatment.[1]

Escalation of pain or worsening of mood
Discuss with patient:

- You will work closely with them to manage their pain and mood
- The importance of using non-drug related pain management strategies:
  - Live Well with Pain Clinician Resources for supporting self-management
  - My Live Well with Pain – Resources for patients

- 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:
  - Specialist Pain Management Services
  - Wellbeing Services
- Consider use of adjuvant pharmacological agents

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 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 local Pain Management Services via the Single Point of Access or local Addiction Services. See also Painkiller Addiction Information Network
- 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

RESOURCES

Opioids Aware Website: http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

PAIN SERVICES EAST & WEST KENT

Multidisciplinary Pain services in **East Kent** are run jointly by East Kent Hospitals University Foundation Trust and Kent Community Health NHS Foundation Trust
Multidisciplinary Pain services in **West Kent** are run jointly by Maidstone and Tunbridge Wells Trust and Kent Community Health NHS Foundation Trust
There is a Single Point of Access for referrals. All referrals should take place via ERS/RAS. Chronic Pain Referral Criteria on KCHFT website.

Clinical advice only required:
East Kent Pain Management Service: kcht.chronicpainreferralpoint@nhs.net or simply refer ERS marking "Advice"
West Kent Integrated Pain Management Service: Please make use of Kinesis or refer on ERS marking "Advice"

Referrals to **Medway Pain Services**:[8]
Medway Pain Services will accept adults (18 years and over) with chronic pain (over three months) that is refractory to standard analgesia.
Access to this service can be via GP, consultant or Clinical Assessment Service referral.

Dartford and Gravesham NHS Trust offer a chronic pain service. Referrals for this may be done through Musculoskeletal Clinical Assessment and Treatment Service (MCAT's) and GP's either via choose and book or by direct referral.

References:

1. Reducing opioid prescribing in chronic pain. PrescQIPP bulletin 218. February 2019
2. Opioids Aware: http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
3. Reducing opioid prescribing in chronic pain 218. PrescQIPP briefing
4. http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b12.html
5. https://www2.health.vic.gov.au/public-health/drugs-and-poisons/medical-practitioners/specific-schedule-8-poisons-requirements/safer-use-of-opioids
6. http://www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext
7. https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pd
8. Medway NHS Foundation Trust Website. Available at: https://www.medway.nhs.uk/services/pain-medicine.htm

OPIOID PRESCRIBING REVIEW GUIDANCE

Protocol for informed evaluation of long term opioid prescribing in non-cancer chronic pain ≥ 3 months duration in adults in primary care

If opioid therapy is required for longer than 12 months a clinical review of the case and support for continuation of opioid prescribing by a second GP is highly recommended

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? (>120 mg in 24 hours of oral morphine equivalent/day unless on the advice of the local specialist pain services)		
c) Is the patient substantially free from adverse side effects of opioid therapy including harm associated with long term use? Opioids Aware – Long term harms of opioids		
d) Is there continued absence of inappropriate dose escalation, aberrant behaviours, misuse or abuse of opioids?		
e) Has a reduction in opioid therapy been trialed?		
3. ADDITIONAL TREATMENT		
a) Are non-pharmacological strategies optimised or has a referral to local specialist pain services been considered? Live Well with Pain Clinician Resources for supporting self-management		
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? Has the patient been provided with / Taking Opioids for Pain, and Driving and Pain leaflets?		
c) 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	Reduce opioid dose	Reduce and cease opioids
Pursue alternate therapies	Suggest specialist review	

Adapted from: RACGP One Year Review of Opioid Prescribing

Opioids Aware: Opioid Prescribing Checklist

TEMPLATE PATIENT LETTER

Invitation for opioid review

Please enclose copies of the following leaflets when the letter is sent to patients:

1) Taking Opioids for Pain
2) Driving and Pain - Information for Patients

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 leaflet 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 at the practice.

At this appointment, the clinician 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 treatment options with you.

Please make an opioid review appointment with [insert name of nominated clinician].

OPIOID TAPERING RESOURCES

Opioid Calculator

Opioid Calculator FPM ANZCA (available to download as an app)

- Introduction to opioid calculator
- Opioid calculator web version

NB: this should only be used to calculate the total oral morphine equivalent daily dose and not to support opioid rotation or switching from one opioid to another

Assessment Tools

Opioids Aware: Assessment of long-term pain

Pain scales in different languages

Opioid Risk Assessment Tool

PHQ 9 Depression Assessment Tool

GAD 7 Generalised Anxiety Disorder Assessment Tool

CAGE Questionnaire Alcohol Use Disorders Identification Test (AUDIT) Screening Questionnaire

Severity of Alcohol Dependence Questionnaire (SADQ-C)

Patient Information Leaflets

Opioids aware - Taking Opioids for Pain

Driving and Pain

Opioid Tapering

Patient Websites

My Live Well with Pain – Resources for patients

Kent Community Health NHS Foundation Trust Community Chronic Pain Service

Posters to use in Practice

Opioids: the downside – waiting room posters

Pain is like an iceberg - poster

Resources for Health Care Professionals

Live Well with Pain Clinician Resources (for supporting self-management)

Opioids Aware

- Dose Equivalent Tables and Changing Opioids
- Opioids for Long Term Pain
- Side Effects
- Long Term Harm
- Diagnosis of dependence, identification and risk populations
- Treatment and prevention of dependence
- Tapering and Stopping
- Checklist for Prescribers

Prescribed Opioid Addiction Resources

Painkiller Addiction Information Network (P.A.I.N)

Withdrawal Scales

Subjective Opiate Withdrawal Scale (SOWS)

Clinical Opiate Withdrawal Scale (COWS)

Objective Opiate Withdrawal Scale (OOWS)

Appendix 1.

FENTANYL PATCHES TAPERING GUIDANCE

It is not recommended to convert fentanyl to another opioid as conversions are unreliable and may result in overdose.

Taper down fentanyl patches by 12-25microgram/hour every 2-4 weeks.

Consider providing a small supply of immediate release morphine sulphate in the form of 10mg tablets (preferred formulation, note that tablets are scored, half=5mg). If clinically indicated morphine sulphate liquid 10mg/5ml to be taken ONLY in the event of severe breakthrough pain or withdrawal symptoms. Take care to not exceed a maximum of 4 doses per 24h or a total of 20 mg morphine per 24h; otherwise this will negate the reduction programme.

Advise lowest effective dose for the shortest period of time. It is usually in the first 3 days of each reduction that a patient potentially may require more breakthrough doses than later on.

Caution: Elderly may require very small doses only

Note that the price per dose is identical. The tablet is preferred because it ensures precise dosing and is portable.

When the patient's dose of transdermal fentanyl is 12microgram/hour, discontinue the patch and only use immediate release morphine sulfate.

Titrate down morphine sulfate to intermittent use for the management of flare ups.

Caution:
Following fentanyl patch removal it takes approximately ≥17 hours for serum concentrations of fentanyl to decrease by 50% or more

References:

1. Fentanyl Patches Tapering Guidance. West Suffolk Clinical Commissioning Group. Available from: https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2018/04/2826-NHSWSCCG-Fentanyl-Patches-Tapering-Guidance.pdf