*Opioid reduction policy template*

Purpose:

To set a guideline for tapering or withdrawal of opioid medication.

For more information, please refer to the RACGPs [Prescribing drugs of dependence in general practice – Part A](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prescribing-drugs-of-dependence/prescribing-drugs-of-dependence-part-a).

[Insert practice name] opioid reduction policy

*Current as of: [insert date of last revision]*

*Version no: [insert version number]*

*Review date: [insert date]*

TAPERING OR DISCONTINUING OPIOIDS

Not all patients benefit from opioids, and general practitioners frequently face the challenge of reducing the opioid dose or discontinuing the opioid altogether.

Reasons to discontinue opioids or refer for addiction management include:79

* severe pain despite an adequate trial of several different opioids
* no improvement in function and pain
* opioid related complications (eg sleep apnoea, falls)
* as a component of ‘structured opioid therapy’ for addicted patients with a pain condition who do not access
* opioids from other sources or alter the route of delivery
* patient exhibits drug-seeking behaviours or diversion
* if in the general practitioners judgement, the health risks outweigh the benefits.

From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues.

* Precautions for opioid tapering
* Pregnancy – Acute withdrawal can cause premature labour and spontaneous abortion.
* Unstable medical and psychiatric conditions – While opioid withdrawal does not have serious medical consequences, it can cause considerable anxiety and insomnia that might exacerbate severe, acute medical or psychiatric conditions. Consider specialist review.
* Opioid addiction – Outpatient tapering is unlikely to be successful if the patient regularly accesses opioids from
* other doctors or the street; methadone or buprenorphine treatment is advised.
* Concurrent medications – Avoid sedative-hypnotic drugs, especially benzodiazepines, during the taper.
* Opioid tapering protocol
* Before initiation
  + Emphasise that the goal of tapering is to make the patient feel better (ie to reduce pain intensity and to improve mood and function).
  + Have a detailed treatment agreement.
  + Be prepared to provide frequent follow-up visits and supportive counselling.
  + Physical rehabilitation is an important factor that should be integrated into the opioid reduction program, with adequate attention and management of other psychological issues.
* Type of opioid, schedule, dispensing interval
  + Use controlled-release morphine if feasible.
  + Prescribe scheduled doses (not as needed).
  + Prescribe at frequent dispensing intervals (daily, alternate days, or weekly, depending on patient’s control over opioid use); do not refill the prescription if the patient runs out.
  + Keep daily schedule the same for as long as possible (eg 3 times daily).
* Rate of taper
* Seek advice from a local drug and alcohol clinical advisory service or pain unit.
* Can vary from 10% of the total daily dose every day to 5% every 1–4 weeks.
* Slower tapers are recommended for patients who are anxious about tapering, those who might be
* psychologically dependent on opioids and those who have cardiorespiratory conditions.
* Faster tapers may be used if the patient is experiencing serious adverse effects such as obvious sedation.
* Once one-third of the original dose is reached, slow the taper to half of the previous rate.
* Hold or increase the dose if the patient experiences severe withdrawal symptoms or worsening of pain or mood.
* Switching to morphine
* Consider switching patients to morphine if the patient is addicted to oxycodone or hydromorphone.
* A person addicted to opioids should be referred to an addiction specialist or a general practitioner with relevant training for management.
* Ongoing prescription of morphine to addicted patients requires an authority. Most jurisdictions will not grant an authority unless it is for treatment with methadone liquid or sublingual buprenorphine (film).
* Calculate the equivalent dose of morphine.
* Start the patient on half this dose (tolerance to one opioid is not fully transferred to another opioid).
* Adjust dose up or down as necessary to relieve withdrawal symptoms without inducing sedation.
* Monitoring during taper
* See the patient frequently; at each visit, ask about the benefits of taper (eg improved pain, mood, alertness).
* If a patient is not successfully reducing, or there is an escalation in dose beyond prescription, involve other
* practitioners.
* Doses may need to be dispensed daily by pharmacy to assist wean process.
* Use urine drug testing to ensure compliance.
* Completion of taper
* Taper can usually be completed in between 2–3 weeks and 3–4 months.
* Patients who are unable to complete the taper may be maintained at a lower opioid dose if they are compliant with the treatment agreement.

A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6–8 weeks).

If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.

* Symptoms of an abstinence syndrome, such as nausea, diarrhoea, muscle pain and myoclonus can be managed with clonidine 0.1–0.2 mg orally every 6 hours or clonidine transdermal patch 0.1 mg/d (Catapres TTS-1) weekly during the taper while monitoring often for significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
* Symptoms of mild opioid withdrawal may persist for 6 months after opioids have been discontinued. Rapid reoccurrence of tolerance can occur from months to years after prior chronic use.
* Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptic for neuropathic pain.
* Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
* Referral for counselling or other support during this period is recommended if there are significant behavioural issues.
* Referral to a pain specialist or public health dependency centre should be made for complicated withdrawal symptoms.

There are no foolproof methods for preventing behavioural issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioural problems if an opioid taper becomes necessary.

An Opioid Taper Plan Calculator is available and makes it easier for prescribers to calculate safe and effective taper plans for patients who would benefit from lower opioid doses. Washington State Medicaid developed it in collaboration with the University of Washington pain management experts. It can be accessed at www.hca.wa.gov/medicaid/pharmacy/pages/index.aspx and then click on Medical Opioid Taper Plan Schedule.

**Recognising and managing behavioural issues during opioid tapering**

Opioid tapers can be done safely and do not pose significant health risks to the patient. Special care needs to be taken by the prescriber to preserve the therapeutic relationship at this time. Otherwise, taper can precipitate doctor shopping, illicit drug use or other behaviours that pose a risk to patient safety. Extremely challenging behavioural issues may emerge during an opioid taper.75

Behavioural challenges frequently arise when a prescriber is tapering the opioid dose and a patient places great value on the opioid they are receiving. In this setting, some patients may feel overwhelmed or desperate and will try to convince the prescriber to abandon the opioid taper.

Challenges may include:

* a focus on the right to pain relief (‘You don’t believe I have real pain’)
* arguments about poor quality of pain care with threats to complain to administrators or licensing boards
* attributing their deteriorating psychological state, including suicidal thoughts, to opioid withdrawal.

Disclaimer

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