B12 Opioid reduction policy

Purpose

This policy details a protocol for tapering or withdrawal of opioid medication.

Example policy

[insert practice name]

Date effective:

Review date:

TAPERING OR DISCONTINUING OPIOIDS

- If benefits do not outweigh harms of continued opioid therapy, this practice policy supports GPs to work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
- Continued pain management, including optimised non-opioid regimens and interventional approaches, should be offered for patients undergoing tapering of opioids.
- Where there is no evidence of substance use disorder, tapers can be initiated using the patient's usual long-term opioid treatment medication.
- Where there is evidence of substance use disorder, doctors are reminded of their obligations under state or territory legislation, and advised that referral to clinics experienced in substance use disorder or to GPs specifically trained in this area is required.

Details

Depression, high pain scores and high opioid doses are key predictors of opioid tapering dropout or relapse. Addressing these factors through pharmacologic and psychological support might improve outcomes, although there is no research yet to validate this hypothesis.

Withdrawal symptom management using a2-adrenergic agonists (eg clonidine) is well supported by the literature. These drugs reduce sympathetic activity and therefore reduce symptoms of withdrawal.

Where there is no evidence of substance use disorder

If weaning is required after a short period of opioid therapy, such as after failure to achieve the goals of an opioid trial, or after a negotiated treatment phase for acute pain, then a faster rate of weaning is generally appropriate. One option is a stepwise reduction of the daily opioid dose each week by 10–25% of the starting dose.

If weaning is required in response to significant adverse effects or opioid misuse, then daily stepwise reduction may be more appropriate. Alternatively, immediate opioid cessation and pharmacological treatment of withdrawal symptoms can be considered.

Otherwise, a decrease of 10% of the original dose every five to seven days until 30% of the original dose is reached, followed by a weekly decrease by 10% of the remaining dose, rarely precipitates withdrawal symptoms and facilitates adherence.

Where there are complex patient comorbidities

Discontinuing opioid therapy is often hindered by patients' psychiatric comorbidities and poor coping skills, as well as the lack of formal guidelines for the prescribers. Depression, high pain scores and high opioid doses are key predictors of opioid tapering dropout or relapse.

If a previous attempt at opioid weaning has proven unsuccessful, then the rate of tapering can be slowed. This can be achieved by reducing the size of the dose reduction each month and/or by increasing the time spent at each dose level (eg two or three months between reductions).

Where there is evidence of substance use disorder

Doctors are advised to adhere to the legislative requirements of each state or territory regarding opioid therapy for patients with a substance use disorder (SUD).

Doctors should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioural therapies) for patients with opioid use disorder. Doctors are advised that referral to clinics experienced in SUD or to GPs specifically trained in this area is required.