Reducing opioid prescribing in chronic pain

This bulletin discusses the processes and resources available to support opioid reduction.

Key recommendations

- In England, Wales, and Northern Ireland - do not initiate opioids to manage chronic primary pain in people aged 16 years and over. In Scotland opioids should be considered for short or medium term treatment of chronic non-cancer pain, if other therapies have been insufficient, and the benefits outweigh the risks of serious harm.
- As there is little evidence that opioids are helpful for long term chronic non-cancer pain, review all opioids prescribed for chronic non-cancer pain. Use a shared decision-making approach to taper and stop the opioid if it is no longer providing useful pain relief or benefit or the risks of adverse effects outweigh the benefits of treatment.
- Prioritise a review for people prescribed high dose opioids above 120mg oral morphine equivalent daily (above 90mg in Scotland), use a shared decision-making approach to reduce and/or stop the opioid. The risk of harm increases substantially at doses above oral morphine equivalent of 120mg per day, and there is no increased benefit.
- Opioid treatment should be reviewed at least six monthly to ensure that the benefits of the medicine continue to outweigh the potential harms and to check whether the dose needs adjusting. Consider tapering the dose at regular intervals e.g. 6-12 monthly, to assess benefit or potential side effects and to minimise risk of harm. Consider increasing the frequency of reviews during dose adjustment.
- During the review, look for any signs that the person is developing problems associated with dependence (see appendix 1 of the bulletin).
- Discuss with the patient non-medicine treatments for chronic pain, such as TENS machine, acupuncture, advice about activity and increasing physical fitness and psychological treatments such as Cognitive Behaviour Therapy, Acceptance and Commitment Therapy (ACT) and meditation techniques such as mindfulness.
- If a person has pain that remains severe despite opioid treatment it means the opioid is not working and should be stopped, even if no other treatment is available.
- When discussing tapering or stopping an opioid explain the benefits the person can expect from reducing the dose and aim to reach an agreement using a shared decision-making approach.
- Suggest a slow, stepwise rate of reduction proportionate to the existing dose, to prevent withdrawal symptoms. The Faculty of Pain Medicine states that the dose of drug can be tapered by 10% weekly or every two weeks. However, the rate of reduction may need to be slower so should be adapted to suit the individual's needs based on how the withdrawal symptoms are tolerated.
- In England, review and implement the five actions listed for Integrated Care Systems to optimise personalised care for adults prescribed medicines associated with dependence and withdrawal symptoms.

Tapering or stopping opioids

Withdrawal symptoms (e.g. sweating, abdominal cramps, and anxiety) occur if an opioid is stopped or the dose is reduced abruptly.[1] The Faculty of Pain Medicine states that the dose of drug can be tapered by 10% weekly or every two weeks.[1] However, the rate of reduction may need to be slower so should be adapted to suit the individual's needs.[2] Patients should be reviewed at least every two weeks when reducing their opioid.

Cost and savings

£224million is spent annually on the prescribing of opioid medication in England, Wales, Isle of Man and Scotland. If reviewing opioid prescribing for chronic non-cancer pain and reducing and/or stopping treatment resulted in a 10% reduction this would lead to savings of **£18.7million in England, £1.2million in Wales, £34,914 in the Isle of Man and £2.5million in Scotland. This equates to £31,195 per 100,000 patients.** Data relates to NHSBSA (May-Jul23) and Public Health Scotland (Feb-Apr23). Additionally inadequate management of side effects and consequences of opioid treatment (falls, fractures and acute confusional state) may contribute to unplanned hospital admissions and contribute to the overall costs associated with opioid treatment.[1]

References

1. Faculty of Pain Medicine of the Royal College of Anaesthetists. Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. https://fpm.ac.uk/opioids-aware
2. NICE. Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. NICE guideline [NG215]. April 2022. https://www.nice.org.uk/guidance/ng215

Additional resources available	Bulletin	https://www.prescqipp.info/our-resources/bulletins/bulletin-336-/reducing-opioid-prescribing-in-chronic-pain/
	Tools	
	Data pack	https://data.prescqipp.info/#/views/B336_Reducingopioidprescribinginchronicpain/FrontPage?:iid=1

Support with any queries or comments related to the content of this document is available through the PrescQIPP help centre https://help.prescqipp.info

This document represents the view of PrescQIPP CIC at the time of publication, which was arrived at after careful consideration of the referenced evidence, and in accordance with PrescQIPP's quality assurance framework.

The use and application of this guidance does not override the individual responsibility of health and social care professionals to make decisions appropriate to local need and the circumstances of individual patients (in consultation with the patient and/or guardian or carer). Terms and conditions

PrescQIPP
Funded by the NHS for the NHS