

Reducing opioid prescribing in chronic pain

This bulletin discusses the processes and resources available to support opioid reduction (including discussion of advice from The Faculty of Pain Medicine of the Royal College of Anaesthetists (FPM) and The US Centers for Disease Control and Prevention (CDC)); supporting resources include an audit, searches and tapering schedules. This bulletin should be used in conjunction with bulletin 149 on non-neuropathic pain, which includes further resources (e.g. patient information leaflet and patient opioid agreement letter).

<https://www.prescqipp.info/resources/category/149-non-neuropathic-pain>

Recommendations

- There is little evidence that opioids are helpful for long term pain. A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent, but it is difficult to identify these people at the start of treatment.¹
- Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term.²
- The risk of harm increases above 120mg oral morphine daily or equivalent. Above this dose the risk of harm and mortality increases substantially but there is no increased benefit.^{1,2}
- There needs to be an agreed outcome of opioid reduction, with an explanation of the benefits of stopping an opioid.²
- If pain has not been reduced by at least 30% (or other pre-agreed objective), then opioids should be considered as not effective and discontinued, even if no other treatment is available.^{1,2}
- Switching from one opioid to another should only be recommended or supervised by a healthcare practitioner with adequate competence and sufficient experience. If uncertain, ask for advice from a more experienced practitioner. Opioid rotation or switching may be considered if a patient obtains pain relief with one opioid and is suffering severe adverse effects.²
- Conversion factors are an approximate guide only because comprehensive data are lacking and there is significant inter-individual variation. An individualised approach is necessary.²
- A detailed assessment of the emotional influences on the person's pain experience is essential for people with chronic pain who also have refractory and disabling symptoms, particularly if they are on high opioid doses.¹
- Patients and carers should be involved in decision making, with plans made for follow up.²
- Total daily opioid dose should be reduced gradually when patients have been prescribed a strong opioid for longer than two weeks.²
- The total daily opioid dose can be reduced by 10% of the original dose weekly or every two weeks.²
- Whilst reducing the opioid, the patient needs to be monitored for pain, level of function, and signs of withdrawal.²
- Recognise patients with drug seeking behaviour (see appendix 2). For patients with drug seeking behaviour, both opioid dependent and non-opioid dependent (e.g. pregabalin and gabapentin); refer to specialist support for assessment and support (i.e. addiction services, in line with local commissioning policies). Ensure multi-disciplinary support.²

- Patients should be reviewed at least every two weeks when reducing their opioid.
- The initial consultation should be face-to-face to explain why the opioid is being reduced, e.g. risk of mortality/harm and the lack of evidence in chronic pain.²
- Subsequent consultations should be every one to two weeks to discuss how the patient is doing and therefore agree on the next reduction. It may be possible to do these as telephone consultations, depending on individual patient circumstances/preferences.
- Do not use liquid opioid preparations when reducing; round to the nearest available strength of solid dosage form. Liquid opioid preparations are rapidly absorbed and metabolised, which can lead to tolerance and addiction.³

Background

It is reported that the current rate of annual cost growth in opioid prescriptions is approximately £26,000 per 100,000 population.⁴ The Care Quality Commission Controlled Drugs Report compared 2016 prescribing data with 2015 prescribing data and found there were increases in the volume of items prescribed for: oxycodone (7.8%), morphine sulphate (6.1%), buprenorphine (3.9%), and fentanyl (1.4%). There was a decrease in volume of items prescribed for tramadol (2.8%) and methadone (1.5%) compared with 2015.⁵

There are growing concerns that patients are being moved up the opioid ladder towards potent opioids inappropriately and without considering other drug and non-drug aspects of care. The potential social and medical harms of opioids have been significantly underestimated.⁴

The BMA have undertaken a project to discuss collaborative actions that can be taken in the light of UK prescribing patterns. Their actions focus on three key policy calls:⁶

- Creation of a national helpline for prescribed drug dependence.
- Increase in the provision of specialist support services.
- Revised guidance for doctors on safe prescribing, management and withdrawal of prescription drugs.

The BMA board of science has produced two briefing papers which explore ways of supporting improvements in analgesic use in these settings. These papers were produced with support and guidance from the Faculty of Pain Medicine of the Royal College of Anaesthetists.

The summary of recommendations include:

- Consideration should be given to the range of support that is required for doctors and patients during the process of assessment, trial and review of opioid treatment for chronic pain. This should include support for stopping opioid treatment that is not working.
- Sufficient investment and resources for primary care, including longer consultation times, are required to support improvements in analgesic prescribing for patients with chronic pain.
- All relevant commissioning and provider organisations (including CCGs in England, health boards in Scotland and Wales, and the Health and Social Care Board in Northern Ireland) should ensure that multidisciplinary pain management services are available for patients in their area and that these are commissioned according to available guidance. These organisations should also work to ensure timely access to pain management programmes, to support early intervention and comprehensive rehabilitation for patients with chronic pain.
- All healthcare providers that are responsible for the management of patients with chronic pain should be familiar with the range of non-pharmacological interventions that may be effective for the management of chronic pain - including physical and psychological therapies. Healthcare professionals should also be aware of the local availability of these services.⁷

Appendix 1 lists resources that may be useful for commissioning services.

Clinicians should only consider opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.^{2,8} Patients should be well informed of side effects and addiction risk. A detailed assessment of the emotional influences on the person's pain experience is essential for people with chronic pain who also have refractory and disabling symptoms, particularly if they are on high opioid doses.¹ Refer to the PrescQIPP bulletin on non-neuropathic pain for full details and resources (including opioid contracts and patient information leaflets).

Duration of therapy and review

The Faculty of Pain Medicine (FPM) states that:

1. Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term.
2. Patients who may benefit from opioids in the long term will demonstrate a favourable response within 2-4 weeks.
3. Short-term efficacy does not guarantee long term efficacy.
4. Data regarding improvement in quality of life with long term opioid use are inconclusive.

There is no good evidence of dose-response with opioids, beyond doses used in clinical trials, usually up to 120mg/day morphine equivalent. There is no evidence for efficacy of high dose opioids in long term pain. Increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm.²

Changing opioids

Opioid rotation or switching may be considered if a patient obtains pain relief with one opioid and is suffering severe adverse effects. Switching from one opioid to another should only be recommended or supervised by a healthcare practitioner with adequate competence and sufficient experience. If uncertain, ask for advice from a more experienced practitioner.²

- When converting from one opioid to another, the initial dose depends on the relative potency of the two drugs and route of administration.²
- Conversion factors are an approximate guide only because comprehensive data are lacking and there is significant inter-individual variation.² Various resources to guide conversion are available and differ in equivalence. An individualised approach is essential. Tables 1 and 2 provide conversion rates and further links to opioid calculators are stated.
- In most cases, when switching between different opioids, the calculated dose-equivalent must be reduced to ensure safety. The starting point for dose reduction from the calculated equi-analgesic dose is around 25-50%.²
- A dose reduction of at least 50% is recommended when switching at high doses (e.g. oral morphine or equivalent doses of 500mg/24 hours or more), in elderly or frail patients, or because of intolerable undesirable effects.²
- The half-life and time to onset of action of the two drugs needs to be considered when converting so that the patient does not experience breakthrough pain or receive too much opioid during the conversion period.²
- Once the conversion has occurred, the dose of new opioid should be titrated carefully according to individual response and the patient monitored closely for side effects and efficacy, especially when switching at high doses.²

Tapering

It is important to taper or stop the opioid regimen if:

- The medication is not providing useful pain relief.
- The dose of opioid is above 120mg oral morphine equivalent/24 hours, because harms of treatment outweigh benefits above this dose.
- The underlying painful condition resolves.
- The patient receives a definitive pain-relieving intervention (e.g. joint replacement).
- The patient develops intolerable side effects.
- There is strong evidence that the patient is diverting his/her medications to others.²

Withdrawal symptoms (e.g. sweating, yawning and abdominal cramps, restlessness, anxiety) occur if an opioid is stopped/dose reduced abruptly.²

By improving the way opioids are prescribed through clinical practice guidelines, patients can have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.⁸

Because of potential changes in the balance of benefits and risks of opioid therapy over time, clinicians should regularly reassess all patients receiving long term opioid therapy, including patients who are new to the clinician but on long term opioid therapy, at least every three months.⁸

Patients who are exposed to greater risk of opioid use disorder or overdose, e.g. patients with:

- Depression or other mental health conditions,
- A history of substance use disorder,
- A history of overdose, or
- Taking other central nervous system depressants with opioids more frequently than every three months.⁸

If clinically meaningful improvements in pain and function are not sustained or have greater risks as defined above, clinicians should work with the patient to reduce opioid dosage or to discontinue opioids when possible. Clinicians should consider consulting a pain specialist as needed to assist with pain management.⁸

A recent article in the BMJ highlighted that pain specialists feel there should be an annual review of pain in the same way that asthma is reviewed.⁹

Stopping opioids in collaboration with specialist services

Patients who are failing to derive benefit from large doses of opioids (greater than oral morphine equivalent of around 300mg/day) may need support from specialist services in order to reduce medication.

This must include detailed exploration of emotional and mental health history (including addiction – see section below). Opioid tapering/cessation when patients are taking high doses is more likely to succeed if patients' emotional and mental health needs are identified and an appropriate plan for support established.²

Evidence for tapering opioids

A systematic review investigated the effect on patient outcomes of strategies to reduce or discontinue long term opioid therapy in people with chronic pain (12,546 participants aged 18 years or older). Chronic pain was defined as pain lasting more than three months. Whilst the studies included in the review were generally low quality there was some evidence that several types of intervention may be effective at reducing or discontinuing long term opioid therapy and that pain, function and quality of life may actually improve with opioid dose reduction.¹⁰ Expert opinion

stated that these findings are consistent with existing guidance,^{1,2} which encourages the use of self-management plans to empower and involve people in the management of their condition and using the knowledge, skill and clinical expertise of several health and social care practitioners to create an individualised management plan for each person. The authors suggested several potential mechanisms for the reported improved outcomes after opioid dose reduction:

- Most interventions were designed to support patients to develop other strategies for managing their pain that may have provided more benefit than long term opioid therapy.
- Opioid dose reduction may alleviate adverse effects of long term opioid therapy that can negatively affect function and quality of life, such as constipation, fatigue, poor sleep and depressed mood.
- Resolution of opioid induced hyperalgesia, a paradoxical response in which people receiving opioid therapy become more sensitive to painful stimuli.
- Reverse causation - people successfully reduced opioids because pain severity decreased.¹⁰

Preparation for dose reduction

The decision to taper/stop an established opioid regimen needs to be discussed carefully with the patient including:²

- An explanation of the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long term harms and improvement in ability to engage in self-management strategies).
- Agreeing outcomes of opioid tapering - let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.⁸ Patients can be supported by telling them things like “I know you can do this” or “I’ll stick by you through this”.
- Deciding which patients may need admission for opioid taper/cessation informed by existing opioid dose.
- Reviewing any physical co-morbidities.
- Reviewing any mental health co-morbidities including significant emotional trauma.
- Encouraging the patient to monitor pain levels during tapering – consider using pain questionnaires as listed in appendix 1, bulletin 149 Non-neuropathic pain: <https://www.prescipp.info/our-resources/bulletins/bulletin-149-non-neuropathic-pain/>
- Symptoms and signs of opioid withdrawal. Explain that these may include for example drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhoea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection.
- Choice of opioid reduction scheme and documented agreed tapering schedule – see attachment 2 on dosage reduction.
- Incremental taper of existing drug.
- Conversion to methadone or buprenorphine.
- Defining the role of drug and alcohol services to support dose reduction.
- Close collaboration between the patient, his or her carers and all members of the patient’s health care team.² Primary care clinicians should collaborate with mental health providers and with other specialists as needed to optimise non-opioid pain management, as well as psychosocial support for anxiety related to the taper.⁸
- Arrangements for follow-up including agreed prescribing responsibilities.²

The FPM states that the dose of drug can be tapered by 10% weekly or every two weeks. The CDC clinical evidence review did not find high-quality studies comparing the effectiveness of different tapering protocols for use when opioid dosage is reduced or opioids are discontinued (tapers reducing weekly dosage by 10%–50% of the original dosage have been recommended by other clinical guidelines and a rapid taper over 2–3 weeks has been recommended in the case of a severe adverse event such as overdose).⁸

Experts noted that tapers slower than 10% per week (e.g. 10% per month) also might be appropriate and better tolerated than more rapid tapers, particularly when patients have been taking opioids for longer durations (for years).⁸

When opioids are reduced or discontinued, a taper slow enough to minimise symptoms and signs of opioid withdrawal should be used.

- CDC (like FPM) also states that a decrease of 10% of the original dose per week is a reasonable starting point.⁸
- Experts agreed that tapering plans may be individualised based on patient goals and concerns. Experts noted that at times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed once patients reach low dosages.⁸
- Tapers may be considered successful as long as the patient is making progress.⁸
- Once the smallest available dose is reached, the interval between doses can be extended.⁸
- Opioids may be stopped when taken less frequently than once a day.⁸

Consultations

- Patients should be reviewed at least every two weeks when reducing their opioid.
 - » Initial consultation: Face-to-face to explain why the opioid is being reduced e.g. risk of mortality/harm and the lack of evidence in chronic pain. The FPM has produced information leaflets (downloadable) on pain, things to think about when considering opioid therapy and answers to frequently asked questions about opioids. <https://www.rcoa.ac.uk/node/21133> Patient information leaflets and prescription agreements on opioid harmful effects are available as attachment 3 in the non-neuropathic pain bulletin. <https://www.prescqipp.info/resources/category/149-non-neuropathic-pain> Ensure continuity of care with the same healthcare professionals where possible.
 - » Subsequent consultations: Every one to two weeks to discuss how the patient is doing and therefore agree on the next reduction. It may be possible to do these as telephone consultations, depending on individual patient circumstances/preferences.^{2,8}

See attachment 2 on dosage reduction.

It may sometimes be necessary to convert to oral morphine and then reduce the dose. Conversions are as follows in table 1 on the next page.

Table 1: Opioid equivalence to morphine

Drug	Dose - Faculty of Pain Medicine ²	Dose - BNF prescribing in palliative care ¹¹	Dose - SIGN ¹²
Morphine equivalent	10mg	10mg	10mg
Oral codeine	100mg	100mg	100mg
Oral dihydrocodeine	100mg	100mg	Not stated
Oral tramadol	67mg	100mg	50mg
Oral tapentadol	25mg	Not stated	Not stated
Oral oxycodone	5mg	6.6mg*	5mg

*SPC for oxycodone states ratio of 1:2

Table 2a: Transdermal opioids – approximate equivalence of buprenorphine patches with oral morphine²

Oral morphine mg/day	12	24	48	84	126	168
Transdermal buprenorphine mcg/hr (change every 7 days)	5	10	20			
Transdermal buprenorphine mcg/hr (change twice weekly-apply every 72hours or 96 hours)				35	52.5	70

For further conversion data see <https://www.rcoa.ac.uk/node/21126>

Table 2b: Transdermal opioids – approximate equivalence of fentanyl patches with oral morphine²

Fentanyl patch dose (microgram/hour)	Oral morphine dose (mg/day)
12	45
25	90
37.5	135
50	180
75	270
100	360
300	1120

Further links for dose conversion:

http://www.palliatedrugs.com/download/090714_opioid_conversions.pdf

<http://opioidcalculator.practicalpainmanagement.com/>

Please note that this is an American website which contains American drug names, products only available in the US and veterinary products.

Table 3 lists Morphine preparations which may aid reducing opioids by 10% weekly. Whilst Zomorph® is the most cost-effective morphine preparation, it may be necessary to use MST® if 5mg or 15mg is required.

Table 3: Morphine preparations

	Zomorph® (Twice daily at 12 hourly intervals)	Morphgesic® (Twice daily at 12 hourly intervals)	MST® (Twice daily at 12 hourly intervals)
5mg			X
10mg	X	X	X
15mg			X
30mg	X	X	X
60mg	X	X	X
100mg	X	X	X
200mg	X	X	X

Pharmacotherapy to assist with opioid withdrawal in opioid dependent patients

Indicators that suggest the possibility of dependence should be explored in patients on a long term opioid prescription. These are listed in Appendix 2.

The decision to maintain a patient on an opioid dose versus detoxify can be influenced by factors that include: patient choice, a patient's motivation, past drug and alcohol dependence, psychiatric and physical history, length of time on opioids, quality of life and social support.²

Opioid withdrawal for an individual patient may involve a meeting of multiple healthcare professionals involved in the case.² The patient should be provided with as much information as possible so that they can make an informed choice. It may be important to record that the patient has the capacity (within the meaning of the Mental Capacity Act 2005) to make a decision.²

Addiction services should provide advice, assessment and support to other parties involved in the care of this patient group and, where appropriate, take over prescribing of opioids either looking towards detoxification or maintenance. In complicated patients, it may be appropriate for these services to become the lead agency depending on local arrangements.²

Pharmacotherapy (through specialist services) may include:

- Methadone and buprenorphine used as substitution therapy in opioid dependence. Substitute medication should be commenced with a short period of stabilisation, followed by either a withdrawal regimen or by maintenance treatment.¹¹
- Lofexidine may alleviate some of the physical symptoms of opioid withdrawal by attenuating the increase in adrenergic neurotransmission that occurs during opioid withdrawal. Lofexidine can be prescribed as an adjuvant to opioid substitution therapy, initiated either at the same time as the opioid substitute or during withdrawal of the opioid substitute.¹¹
- Clonidine (unlicensed) may lessen anxiety, sweats and chills.¹³
- Diazepam for agitation.¹¹

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- Loperamide 2mg may reduce diarrhoea.¹¹
- Mebeverine for abdominal cramps.¹¹
- Metoclopramide or prochlorperazine for nausea and vomiting.¹¹
- Paracetamol and NSAIDs for muscular pains and headaches.¹¹
- Topical rubefaciants to relieve muscle pain.¹¹

Further resources that will help with drug seeking behaviour:

- PrescQIPP Opioid aware webinar series <https://www.prescqipp.info/our-resources/webkits/pain/opioid-aware-webinars/>
- Information on opioids for patients <https://www.rcoa.ac.uk/node/21133>
- Recognising overuse/misuse/dependence/addiction and plans to address <https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/clinical-use-of-opioids/identification-and-treatment>
- Dealing with drug seeking behaviour (webinar) <https://vimeo.com/187991515/b6374f1254>
- Top tips in two minutes: Managing requests for potentially addictive/divertible drugs including newly registering/temporarily registering patients <https://www.herefordshireccg.nhs.uk/your-services/medicines-optimisation/strategy-and-overarching-guidance/689-top-tips-in-2-minutes-managing-drug-seeking-behaviour-november-2016/file>
- Recognising presence of drug/alcohol/mental health problems and measures to ensure patient safety <https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing/assessment>
- Advice given regarding driving/operating machinery <https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/best-professional-practice/opioids-and-driving>
- Advice to the patient with respect to safety, side effects, value of prescribing opioids for chronic pain: Understanding pain in less than 5 minutes, and what to do about it (YouTube) https://www.youtube.com/watch?v=C_3phB93rvI
- Hazards of combining opioids and commonly prescribed non-opioid pain killers (such as gabapentin and pregabalin) <http://www.bristol.ac.uk/news/2017/may/heroinpainkillers.html>
- RCGP Certificate in the Management of Drug Misuse <http://elearning.rcgp.org.uk/course/info.php?popup=0&id=130>
- Drug misuse and dependence: UK guidelines on clinical management <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

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Appendix 1: Resources to aid commissioning processes

- Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain hosted by the Faculty of Pain Medicine <https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware>
- Core Standards for Pain Management Services in the UK, Faculty of Pain <https://www.rcoa.ac.uk/system/files/CSPMS-UK-2015-v2-white.pdf>
- The hidden suffering of chronic pain, The Chronic Pain Policy Coalition <http://www.policyconnect.org.uk/cppc/research/hidden-suffering-chronic-pain-booklet-parliamentarians>
- Pain Management Services: Planning for the future: Guiding clinicians in their engagement with commissioners, Royal College of General Practitioners <https://www.rcoa.ac.uk/system/files/FPM-Pain-Management-Services.pdf>
- National Pain Audit Final Report 2010-2012 (England and Wales) https://www.britishpainsociety.org/static/uploads/resources/files/members_articles_npa_2012_1.pdf
- Guidance on the management of pain in older people (2013), British Geriatrics Society https://www.britishpainsociety.org/static/uploads/resources/files/members_articles_npa_2012_1.pdf
- Role of addiction specialist doctors in drug and alcohol services <https://www.gov.uk/government/publications/role-of-addiction-specialist-doctors-in-drug-and-alcohol-services>

Appendix 2: Indicators that suggest the possibility of dependence that should be explored with those on a long term opioid prescription

<http://www.roac.ac.uk/faculty-of-pain-medicine/opioids-aware/clinical-use-of-opioids/identification-and-treatment>

- Long term prescribing of opioids for non-cancer conditions.
- Current or past psychiatric illness or profound emotional trauma.
- Reports of concern by family members or carers about opioid use.
- Concerns expressed by a pharmacist or other healthcare professionals about long term opioid use.
- Insistence that only opioid treatment will alleviate pain and refusal to explore other avenues of treatment.
- Refusal to attend or failure to attend appointments to review opioid prescription.
- Resisting referral for specialist addiction assessment.
- The repeated seeking of prescriptions for opioids with no review by a clinician.
- Repeatedly losing medications or prescriptions.
- Taking doses larger than those prescribed or increasing dosage without consulting the clinician; often coupled with seeking early replacement prescriptions. Associated with continued requests for dose escalations.
- Seeking opioids from different doctors and other prescribers. This can take place within GP practices, often identifying locum doctors or doctors unfamiliar with their case. This may be associated with attempting unscheduled visits.
- Obtaining medication from multiple different providers, NHS and private GPs, repeatedly and rapidly deregistering and registering with GPs, seeking treatment for the same condition from both specialists and GP; or seeking treatment from multiple specialists. This may be coupled with a refusal to agree to writing to the main primary care provider.
- Obtaining medications from the internet or from family members or friends.
- Resisting referrals to acute specialists about complex physical conditions or failing to attend specialist appointments.
- Appearing sedated in clinic appointments.
- Misusing alcohol or using illicit or over the counter, internet or other prescribed drugs or a past history of alcohol or other drug dependence.
- Deteriorating social functioning including at work and at home.
- Resisting or refusing drug screening.
- Signs or symptoms of injecting opioids or snorting oral formulations.

Additional PrescQIPP resources



Briefing



Audit, patient information leaflet

Available here: <https://www.prescqipp.info/our-resources/bulletins/bulletin-218-reducing-opioid-prescribing-in-chronic-pain/>

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