

5 steps to tapering opioids for patients with chronic non-cancer pain

The decision to taper opioids can be daunting for both patients and prescribers. Careful planning, close, patient-centred engagement and realistic goals help lay the groundwork for success. NPS MedicineWise has developed an opioid tapering algorithm to help GPs step through the process of preparing a successful tapering plan with their patients who have chronic non-cancer pain.

Key points

- ▶ Opioid analgesia attenuates with time, while the likelihood of harm persists or increases over time and with increasing doses.
- ▶ Recent evidence suggests that tapering opioids can improve chronic pain, function and quality of life.
- ▶ GPs are encouraged to work with patients to develop a tapering plan when opioid harm outweighs benefit.
- ▶ GPs can download the NPS MedicineWise opioid tapering algorithm to support tapering decisions.

Why consider tapering?

We know the analgesic effects of opioids attenuate over time due to physiological tolerance, physical dependence or opioid-induced hyperalgesia.¹⁻⁵

We also know the risk of harm from opioids increases with escalating doses,^{6,7} and that around 80% of people with chronic non-cancer pain who take opioids long term will experience at least one adverse effect.¹

Experts agree that opioids should not be started without a clear plan for stopping them.⁴ For some patients however, the primary benefit of continuing opioids becomes the avoidance of unpleasant withdrawal symptoms.⁴ These can include nausea, abdominal cramps, piloerection, dilated pupils, agitation, tachycardia, anhedonia and hyperalgesia.²

What's the evidence?

Patients are often uncertain about the benefits of tapering opioids and may fear opioid withdrawal or uncontrolled pain without them.⁸

However, tapering opioids may not necessarily worsen pain. In fact, a recent systematic review suggests that tapering opioids for patients with chronic pain does not lead to increased pain, but can lead to decreased (or the same) pain once tapering is completed.⁹

Another systematic review¹⁰ suggests that tapering opioids can improve pain, functioning and quality of life. In this review, several studies evaluated strategies for effective reduction of long-term (> 3 months) opioids.^{10,11} These were:

- ▶ tapering opioids with input from patients
- ▶ an emphasis on non-pharmacological and self-management strategies such as cognitive behavioural therapy (CBT) or mindfulness meditation

- ▶ multidisciplinary care through interdisciplinary pain programs
- ▶ slow dose reductions (over 22 weeks in 1 study)
- ▶ regular follow up (at least weekly in some studies).

While current Australian guidelines recommend regular follow-up visits during opioid tapering,¹² it is important to acknowledge that weekly visits may not be feasible for patients or practices.

Having considered potential reasons for tapering and the most recent evidence, let's look at the 5 steps to opioid tapering.

Step 1. Explore the patient's expectations

When exploring a patient's readiness to reduce their opioid dose, the prescriber's goal should be to enable behaviour change by listening to and reflecting back the patient's concerns and expectations. This could be as simple as asking what they like and dislike about opioid treatment.¹¹

Open-ended questions, like the ones listed below, create an opportunity for each patient to weigh their choices and explore what change might look like.¹³

- ▶ What do you know about the long-term use of opioids?
- ▶ What do you think are the upsides and downsides of continuing to take opioids?
- ▶ How do you see yourself in a few weeks or months' time if you were able to reduce or stop the opioids?
- ▶ What worries you about reducing your opioid dose?
- ▶ What do you want to be able to do day-to-day that you can't do right now?

A thorough patient-centred assessment can incorporate the '5As' framework of chronic pain management with questions that include:⁷

- ▶ **Analgesia:** How do you rate the pain? How much relief are opioids providing?
- ▶ **Activity:** Are you achieving your functional goals?
- ▶ **Adverse effects:** Are you experiencing any harms or side-effects from opioids such as constipation, drowsiness, sexual dysfunction or falls?
- ▶ **Affect:** Have you been experiencing any mood changes eg, depression or low mood?
- ▶ **Aberrant behaviour:** Have you been taking the opioids as prescribed? Have you increased your dose lately or have you used opioids to treat other symptoms eg, anxiety?

Empower the patient

Open dialogue, collaboration and trust are especially important when the effectiveness (or otherwise) of the patient's current opioid treatment is being explored. It helps to have set clear expectations from the beginning of treatment about the expected length of treatment, the opioid dosing thresholds, how effectiveness is to be measured and what an exit strategy (discontinuing opioids) will entail.¹⁴

If the patient knows that tapering is part of opioid treatment, they will be more likely to be willing participants in opioid tapering. The overall goal when talking about tapering is to help the patient feel they are opting into the decision to reduce their opioids, rather than the decision is being imposed on them.

[Download the NPS MedicineWise resource: Lowering your opioid dose](#)

Provide reassurance

Patients need to know that their GP is not going to stop their prescription and then leave them to manage the process themselves. Ideally a tapering schedule should be supervised by the patient's regular GP to maintain continuity of care. It's important to reassure the patient that guidelines recommend gradual opioid tapering with regular reviews of progress, supported by an agreed pain management plan.¹⁵

Reassurance is key to effective GP-patient communication at this stage of the discussion.⁸

[Download the NPS MedicineWise resource: Starting a conversation about opioid tapering with your patients](#)

Step 2. Review pain management plans

Effective pain management planning allows the patient to set specific meaningful and realistic goals that emphasise active self-management.^{1,16} Self-management strategies can include:^{1,17}

- ▶ cognitive behavioural therapy (CBT) techniques such as setting realistic goals, pacing activities and challenging unhelpful thoughts
- ▶ acceptance and mindfulness-based interventions
- ▶ physical therapies that aim to gradually improve function despite persisting pain.

[Read the MedicineWise News: If not opioids, then what?](#)

Where possible, pain management planning should involve

collaboration between primary care, specialists and allied health professionals.

The efficacy of a coordinated, multidisciplinary pain management approach has been shown to reduce pain severity and improve mood.¹⁸

Where multidisciplinary support is not available, GPs are encouraged to leverage their networks eg, coordinate medication management reviews with a local pharmacist and encourage patients to explore online or local community pain management programs.

To increase chances of success, undertake opioid tapering with motivated patients¹¹ and slowly reduce opioid doses with their input.^{8,11}

Step 3. Develop a tapering plan

If the patient agrees to reducing their opioids, a tapering plan can be developed with the patient's individual circumstances, goals and preferences in mind. Tapering takes time and its effects and pathway can be difficult to predict for each patient. There is no clear evidence on the most effective tapering rate.³ Preferably, the rate should be slow enough to minimise symptoms and signs of opioid withdrawal.

The NPS Medicinewise tapering algorithm provides a step-wise approach to tapering.

[Download the Opioid tapering algorithm](#)

[Read an accessible text version of this algorithm](#)

Tapering rates

Fast taper

If tapering is required after a shorter period of opioid treatment ie, less than 3 months, or if treatment goals of an opioid trial have not been achieved, then a faster rate of tapering is recommended,⁷ that is, reducing the daily opioid dose each week by 10%–25% of the dose you are starting the taper from.

However, if tapering is required in response to significant adverse effects, daily stepwise reduction may be more appropriate.⁷

Slow taper

In situations where longer term opioid treatment has been maintained (often for many years) without meaningful improvement in pain and function, the recommended approach is slow tapering and stopping completely if possible.

One practical strategy is to reduce the daily opioid dose each month by 10%–25% of the dose you are starting the taper from. Reducing the dose by 10%–25% each month may allow cessation in 3–9 months.⁷

Where the formulation is not easily reduced eg, transdermal formulations, and cannot be stopped without risking withdrawal symptoms, changing to a new opioid may need to be considered.

Consider specialist advice when changing opioid treatment.

Monitor regularly

Regular monitoring is essential during the tapering process. Tapering does not always follow a linear path and the patient's progress and challenges may determine whether to slow the tapering rate, maintain or pause the taper.

During each review it's important to review the patient's goals, emphasise the benefits of tapering and assess the risk of side effects or harm. Of course, if more frequent reviews are expected, the associated time and cost will need to be discussed with the patient.

Establish success criterion

Tapering may be considered successful as long as the patient is making progress³ eg, if agreed goals are being met. Success will often depend on how realistic the patient's pain management goals are while they are coming off opioids. It is generally recommended that to be useful, goals should not only be personally relevant but specific, achievable and measurable.¹⁹

Equally, it may be useful for prescribers and patients to discuss the real possibility of tapering challenges without couching these in terms of 'failure'.

If the patient encounters challenges with tapering, consider re-evaluating the tapering plan or seeking specialist advice. If a patient is having difficulty with tapering because of withdrawal symptoms the rate of taper may need to be slowed down to help reduce and manage these symptoms.

Building on each patient's support network is crucial for successful opioid tapering. This includes involving friends, family, carers and pain support groups.⁸

Tapering takes time and patience

Opioid tapering is a marathon not a sprint. It is important to acknowledge that complete cessation of opioids may not be feasible or appropriate for all patients. An opioid taper can always be stopped and resumed at a later date if the patient is experiencing challenges.

An alternative approach to tapering in these patients is to reduce to the lowest effective dose where the benefits of treatment outweigh the risk of harm, as any dose reduction may be beneficial.^{3,7,15}

Step 4. Expect some withdrawal symptoms

Acute withdrawal symptoms are more likely to occur with rapid tapers or sudden large decreases in dose. A gradual approach to tapering with regular appointments for follow-up can help to reduce the risk of withdrawal symptoms.²⁰

If the patient is having difficulty managing withdrawal symptoms, eg, nausea, diarrhoea, muscle pain and myoclonus, these can be managed with alpha₂ adrenergic agonists (eg, clonidine).¹² This class of medicine helps to reduce withdrawal symptoms by reducing sympathetic

activity.¹² Alpha₂ adrenergic agonists are used widely in the treatment of withdrawal symptoms in opioid use disorder (OUD)²¹ and there is anecdotal evidence for their use when tapering long-term opioids.²²

Guidelines recommend 0.1–0.2 mg of clonidine every 6 hours, and/or simple supportive therapy until the opioid taper is complete.¹² Side effects of clonidine include drowsiness, dizziness, feeling tired or irritable, dry mouth, loss of appetite, constipation, dry eyes, insomnia and nightmares.²³

Opioid withdrawal symptoms can include:^{2,3,12,22}

- ▶ sweating
- ▶ runny nose
- ▶ nausea
- ▶ diarrhoea
- ▶ abdominal cramps
- ▶ piloerection
- ▶ dilated pupils
- ▶ agitation
- ▶ tachycardia
- ▶ anxiety
- ▶ insomnia
- ▶ opioid cravings

Increased pain and hyperalgesia

Although improvements in pain and functioning are the ultimate goal of tapering, short-term withdrawal can lead to transitory increases in pain and hyperalgesia.²⁰

GPs should inform patients of the likelihood of a temporary increase in pain or an increased sensitivity to pain, reassuring them that these symptoms should improve over 1–2 weeks.^{12,22}

Withdrawal symptoms and their severity vary among patients. For patients on long-term opioid therapy who have developed opioid dependence, extended withdrawal symptoms can last for weeks or months.²⁴

Step 5. If in doubt, seek support

Consider seeking multidisciplinary advice or support for patients who are having difficulty with tapering. Tapering is challenging, and patients will often want to give up when they experience challenges.

Key predictors of opioid tapering dropout are depression, high pain scores, high opioid doses and OUD.^{12,22} Patients who are at high risk for dropout will need additional support.

Support could include pain specialists, drug and alcohol services, mental health teams and physiotherapists – many of whom have valuable experience managing patients living with chronic non-cancer pain.

Where these services are not readily available, consider contacting interstate specialist services for advice. Most Primary Health Networks (PHNs) have information about specialist services in local and regional areas.

Conclusion

Overall, weighing up the risks and benefits of opioid treatment and considering opioid tapering is challenging for both patients and prescribers.

Key factors in successful tapering include introducing the concept of tapering early in opioid treatment, supported by evidence and guidelines, and having an open dialogue with patients about their concerns and goals.

Working with patients to set functional and social goals helps to establish criteria for success based on the achievement of these goals. And finally, developing a clear plan for tapering with regular frequent reviews and realistic expectations provides a solid foundation for managing chronic non-cancer pain without opioids.

Useful resources for health professionals

- ▶ [NPS MedicineWise opioid tapering algorithm](#)
- ▶ [NPS MedicineWise Starting a conversation about opioid tapering with patients](#)
- ▶ [Australian Counselling Association](#) – find a counsellor in your local area
- ▶ [Australian Prevention Partnership Centre](#) – a chronic disease research group who have compiled a comprehensive list of local chronic pain initiatives

across Australia

- ▶ [Faculty of Pain Medicine Opioid Calculator](#)
- ▶ [Primary Health Network \(PHN\) locator](#)
- ▶ [Pain management network](#) – Provides information for patients, families and health professionals on management of chronic pain. Includes online information developed for Aboriginal and Torres Strait Islander patients – [Our Mob](#)

Useful links for your patient

- ▶ [NPS MedicineWise, Pain: what is going on?](#)
- ▶ [NPS MedicineWise, Lowering your opioid dose](#)
- ▶ [NPS MedicineWise, Chronic pain explained](#)
- ▶ [NPS MedicineWise, Opioid medicines and chronic non-cancer pain](#)
- ▶ [NPS MedicineWise MedicineWise app](#)
- ▶ [Painaustralia](#) – Provides a list of support groups and helplines for people experiencing chronic pain.
- ▶ [Pain management network](#) – Provides information for patients and families about developing skills and knowledge needed to help self manage chronic pain. Includes online information developed for Aboriginal and Torres Strait Islander patients – [Our Mob](#)

Further reading

NPS MedicineWise News: [If not opioids – then what?](#)

Australian Prescriber: [Prescribing wellness: comprehensive pain management outside specialist services](#)

References

1. Analgesic Expert Group. Therapeutic Guidelines: Analgesic. Version 6. West Melbourne: Therapeutic Guidelines Ltd. 2012. <https://tgldcdp.tg.org.au/topicTeaser?guidelinePage=Analgesic&etgAccess=true> (accessed 10 January 2019).
2. Ballantyne JC. The brain on opioids. *Pain* 2018;159 Suppl 1:S24-S30. <https://www.ncbi.nlm.nih.gov/pubmed/30113944>.
3. Dowell D, Haegerich TM, Chou R. CDC Guideline for prescribing opioids for chronic pain – United States, 2016. *MMWR Recomm Rep* 2016;65:1-49. <https://www.ncbi.nlm.nih.gov/pubmed/26987082>.
4. Juurlink DN. Rethinking “doing well” on chronic opioid therapy. *CMAJ* 2017;189:E1222-E3. <https://www.ncbi.nlm.nih.gov/pubmed/28970259>.
5. Arout CA, Edens E, Petrakis IL, et al. Targeting Opioid-Induced Hyperalgesia in Clinical Treatment: Neurobiological Considerations. *CNS Drugs* 2015;29:465-86. <https://www.ncbi.nlm.nih.gov/pubmed/26142224>.
6. Chou R, Turner JA, Devine EB, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop. *Ann Intern Med* 2015;162:276-86. <https://www.ncbi.nlm.nih.gov/pubmed/25581257>.
7. Faculty of Pain Medicine. Australian and New Zealand College of Anaesthetists. Recommendations regarding the use of opioid analgesics in patients with chronic non-cancer pain. PM01 2015. Melbourne: ANZCA, 2015. <http://fpm.anzca.edu.au/documents/pm1-2010> (accessed 14 March 2019).
8. Matthias MS, Johnson NL, Shields CG, et al. “I’m Not Gonna Pull the Rug out From Under You”: Patient-provider communication about opioid tapering. *J Pain* 2017;18:1365-73. <https://www.ncbi.nlm.nih.gov/pubmed/28690000>.
9. Fishbain DA, Pulikal A. Does opioid tapering in chronic pain patients result in improved pain or same pain vs increased pain at taper completion? A structured evidence-based systematic review. *Pain Med* 2018. <https://www.ncbi.nlm.nih.gov/pubmed/30597076>.
10. Frank JW, Lovejoy TI, Becker WC, et al. Patient outcomes in dose reduction or discontinuation of long-term opioid therapy: A systematic review. *Ann Intern Med* 2017;167:181-91. <https://www.ncbi.nlm.nih.gov/pubmed/28715848>.
11. Dowell D, Haegerich TM. Changing the conversation about opioid tapering. *Ann Intern Med* 2017;167:208-9. <https://www.ncbi.nlm.nih.gov/pubmed/28715842>.
12. Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management. East Melbourne: RACGP, 2017. <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-c2> (accessed 19 March 2019).
13. Crawley A, Murphy L, Regier L, et al. Tapering opioids using motivational interviewing. *Can Fam Physician* 2018;64:584-7. <https://www.ncbi.nlm.nih.gov/pubmed/30108077>.
14. Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part A: Clinical governance framework. East Melbourne: RACGP, 2015. <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> (accessed 10 January 2019).
15. NSW Therapeutic Advisory Group Inc. Preventing and managing problems with opioid prescribing for chronic non-cancer pain. Sydney: NSW TAG, 2015. <http://www.nswtag.org.au/wp-content/uploads/2017/07/pain-guidance-july-2015.pdf> (accessed 8 January 2019).
16. Nicholas MK, Blyth FM. Are self-management strategies effective in chronic pain treatment? *Pain Manag* 2016;6:75-88. <https://www.ncbi.nlm.nih.gov/pubmed/26678703>.
17. Australian Medicines Handbook. Chronic pain. Adelaide: AMH Pty Ltd, 2019. <https://amhonline.amh.net.au/> (accessed 10 January 2019).
18. Pain Management Best Practices Inter-Agency Task Force. Draft report on pain management best practices: updates, gaps, inconsistencies and recommendations. Washington DC, USA: US Department of Health and Human Services, 2018. <https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html?language=en#note-42> (accessed 18 March 2019).
19. Nicholas MK, Molloy AR, Brooker C. Using opioids with persisting noncancer pain: a biopsychosocial perspective. *Clin J Pain* 2006;22:137-46. <https://www.ncbi.nlm.nih.gov/pubmed/16428947>.
20. Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part C1: Opioids. East Melbourne: RACGP, 2017. <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-c1> (accessed 19 December 2017).
21. Gowing L, Farrell MF, Ali R, et al. Alpha₂-adrenergic agonists for the management of opioid withdrawal. *Cochrane Database Syst Rev* 2014;CD002024. <https://www.ncbi.nlm.nih.gov/pubmed/24683051>.
22. Berna C, Kulich RJ, Rathmell JP. Tapering long-term opioid therapy in chronic noncancer pain: evidence and recommendations for everyday practice. *Mayo Clin Proc* 2015;90:828-42. <https://www.ncbi.nlm.nih.gov/pubmed/26046416>.
23. Australian Medicines Handbook. Clonidine. AMH, 2020. <https://amhonline.amh.net.au/chapters/cardiovascular-drugs/antihypertensives/other-antihypertensives/clonidine-cardiovascular#clonidine-cardiovascular-adverse> (accessed).
24. Manhapra A, Arias AJ, Ballantyne JC. The conundrum of opioid tapering in long-term opioid therapy for chronic pain: A commentary. *Subst Abuse* 2018;39:152-61. <https://www.ncbi.nlm.nih.gov/pubmed/28929914>.

nps.org.au

Level 7/418A Elizabeth Street Surry Hills NSW 2010
PO Box 1147 Strawberry Hills NSW 2012
☎ 02 8217 8700 📠 02 9211 7578 @info@nps.org.au

Independent, not-for-profit and evidence based, NPS MedicineWise enables better decisions about medicines, medical tests and other health technologies. We receive funding from the Australian Government Department of Health. ABN 61 082 034 393
© 2020 NPS MedicineWise

Disclaimer: Reasonable care is taken to provide accurate information at the time of creation. This information is not intended as a substitute for medical advice and should not be exclusively relied on to manage or diagnose a medical condition. NPS MedicineWise disclaims all liability (including for negligence) for any loss, damage or injury resulting from reliance on or use of this information. Read our full disclaimer.