Opioid Management Plan Bundle

Date ____________________

This document describes a plan for the management of opioid analgesics agreed between:

Clinician ___________________________ Job title ________________________ and

Patient

The aim of this **document bundle** is for patients and clinicians to have a clear understanding of the possible benefits and the potential pitfalls of long-term opioid usage. Patients starting an Opioid Management Plan should be given the entire bundle. Only the last part - **Treatment Agreement** - should be saved for GP and hospital records. There are **4 parts**:

Opioids for Pain Management – Patient Information is a patient information leaflet describing what opioid analgesics are, when they are used, realistic expectations of benefit and details of the significant risks associated with long term use.

Opioid Management - Prescriber Information is advice primarily designed to educate prescribers but is also appropriate to give to patients.

Weaning Opioids – Advice for patients. There is a sister document: "Weaning Opioids – Advice to GP's" also available.

Opioid Management Plan - Treatment Agreement. This is signed by the patient and prescriber. It outlines terms and conditions to be satisfied for opioid treatment to continue. The clinician provides a brief clinical summary plus details of present analgesic use and suggestions for the future. If new drugs are started it will describe dose ranges that should not be exceeded. It will also give advice on when to try reducing the dose and how to achieve discontinuation if possible.

The completed **management plan** should be given / sent to the patient.
Copies of the completed **Treatment Agreement** section should be kept in the GP patient records, and sent to The Pain Clinic, RCHT. From here, the **treatment agreement** will be scanned and uploaded to MAXIMS.

Opioids for Pain Management – Patient Information

What are opioids?

Opioids are a family of strong pain killers, which includes morphine, diamorphine (heroin), fentanyl, codeine, tramadol and others. They are not suitable for all types of pain. The aim of opioid treatment is to reduce the pain so that you can do more of your daily activities, not to take away the pain completely. They should not be used in isolation but with other pain relieving medications and in combination with other activities such as exercise and distraction. Opioids should be taken with the close guidance of a healthcare professional. Care must be taken to use only the prescribed dose and to keep these medications away from children.

How effective are opioids for pain relief?

Acute (recent onset) pain: Opioids work well for acute pain such as post-operative pain or cancer related pain in combination with other analgesics because it is mainly due to tissue damage. We would expect acute pain to settle within 3 months.

Chronic (long term) pain: - not very effective. Chronic pain isn't usually due to tissue damage, and it is rare to completely relieve it with medications. The aim of treatment is to reduce pain enough to allow you to get on with your life. On average opioids will only help about 1 in 5 people and even then pain levels are generally only reduced by about 30%. This is why we give a trial of treatment and only continue the drug if there is clear benefit.

Are there any side effects?

Opioids have many unwanted side effects. The most common include, but are not limited to: dizziness, sickness, sleepiness, confusion, itching, alteration in mood, reduced sexual drive, weight gain, opioid-induced hyperalgesia (increased pain), opioid-induced bowel dysfunction which includes; narcotic bowel syndrome, nausea, vomiting, abdominal pain and constipation. Too much can lead to reduced breathing, unconsciousness and death. There is a full list of known side effects described in the information leaflet that comes with your medication. Besides pain relief, opioids may have other effects such as euphoria (feeling good/high for a while) or dissociation (emotional numbing). These are followed by a period of "coming down" and worsening pain as the drug levels fall. If this low is managed by increasing the dose of opioid, then escalation, tolerance and increased dependence will follow.

Can I still drive?

The law in the UK currently allows you to drive if you are taking prescribed opioid medicines and are taking them according to the prescription. You should not drive if you have changed your dose or if you feel that your judgment is impaired. You are responsible for making sure you are fit to drive.

Can I drink alcohol?

Alcohol and opioids together cause sleepiness and poor concentration. Avoid alcohol completely when you first start on opioids, when your dose has just been increased or if you drive or operate machinery. When you get on a steady dose of opioid, you may be able to tolerate modest amounts of alcohol.

Are opioids addictive?

Physical dependence and/or tolerance can occur with the use of opioid medications.

Tolerance is an inevitable physiological process defined by the gradual loss of effect over time as your body gets used to the drug.

Dependence means that you may experience withdrawal symptoms if the drug is suddenly stopped; therefore the drug is gradually reduced to prevent this. This is a physiological process, which can be very uncomfortable but is not life threatening. Most people develop dependence if using opioids continuously for more than a few weeks.

Addiction is a form of psychological dependence with extreme patterns of behaviour associated with obtaining and consuming the drug. If it is felt that this is happening, the opioid will be gradually withdrawn.

Abuse is a term that means that the drug is not being used in a responsible way. If this is suspected, the prescribed opioid will be gradually withdrawn.

What is an opioid management plan?

This is a plan of care regarding the prescription of opioid analgesics. It provides patients with information to allow an informed decision regarding commencement or continuation of the drugs and stipulates goals, sets out realistic expectations and responsibilities for both patients and clinicians to minimise risk. Your GP will be responsible for on-going prescribing of your opioids and they will be responsible for ensuring the terms of this agreement are being met.
Where a patient management plan is used, this leaflet forms the patient information section of that plan

What if I decide to stop taking opioids?

Stopping opioids may lead to withdrawal symptoms, which are not dangerous but can be very unpleasant. Reduce the dose gradually. Ask your GP for advice, or for a copy of the leaflet *weaning opioids – advice for patients*

Further information for patients

- British Pain Society
  https://www.britishpainsociety.org/

- Opioids aware section “information for patients”
  https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

- Self-management strategies can be found at
  http://www.paintoolkit.org/tools

- Patient information on Narcotic Bowel Syndrome:
  https://www.med.unc.edu/gi/faculty-staff-website/patient-education/patient-education/8KNarcoticBowelSyndrome.pdf

- Drug driving
  https://www.gov.uk/drug-driving-law

Opioid Management - Prescriber Information

Treating chronic pain is complex and challenging - only 5% of sufferers are pain free at 5 years. Chronic pain does not emanate from tissue damage alone (if at all) but is also a product of altered CNS architecture, thoughts, emotions, understanding of the meaning of pain, previous experience of pain and a representation of their current distress.

Strong opioids are dangerous drugs that are often prescribed and monitored poorly, resulting in preventable sickness, unnecessary long term prescribing and occasionally deaths.

The **"opioids aware" section of the Faculty of Pain Medicine website** gives well designed advice for prescribers and for patients. Here are their golden rules regarding opioids in non-cancer pain:

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is very *little evidence that they are helpful for long term pain*

2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is *intermittent*. However it is difficult to identify these people at the point of opioid initiation

3. The risk of harm increases substantially and there is no increased benefit at doses above an oral morphine equivalent of 120mg / day

4. If a patient is using opioids but is still in pain, *the opioids are not effective* and should be discontinued, even if no other treatment is available

5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on a high opioid doses , a very detailed assessment of the many emotional influence on their pain is essential [usually via the pain clinic]

- Usually GPs will provide long-term prescriptions for these medications as long as they improve symptoms and function
- We suggest that this agreement is placed in a noticeable position in the electronic patient record
- Medication reviews should be regular to optimise doses and to intermittently taper and sometimes cease the drugs to inform on the need for continued therapy
- Remember the pain team has information on analgesics, pain interventions, neuropathic prescribing and referral information on the Referral Management Service website / pain management

Weaning opioids – Advice for patients

If pain remains severe despite taking opioids, it is probable that the opioids are not helping at all and you would feel better and avoid the associated risks if you reduced or stopped them. Read the leaflet that comes with the medication (or consult the internet) for the long list of negative effects of taking opioids.

We now know that when long-term opioids are used to treat long-term pain, there can be benefit for the first few weeks of treatment, but this benefit then tails off. For the majority, opioids provide little or no pain relief in the long term, and lead to an overall reduction in their quality of life.

Most people that have been on opioids for more than a few days will experience side effects when they reduce the dose. Side effects vary in their intensity and unpleasantness. Side effects generally reduce after 3 days and are mostly gone after a week.

What are the symptoms of opioid withdrawal?

Pain is often the first. This may be general muscle and joint pain or an increase in the patient's painful condition. Many people take these "withdrawal pains" as a sign that the opioids had been working and need to be continued (or even increased) – they are not. It can be tough getting through this time but it's worth it.

Other side effects of withdrawal are rather like severe flu, and may include
Sweats, chills, "goose flesh"
Abdominal cramps, diarrhoea
Anxiety, insomnia, fatigue, malaise

Not everyone experiences these symptoms, but you are more likely to if you stop your opioids suddenly or reduce the dose very quickly. If you do experience severe symptoms you may need to reduce the dose more slowly. Some people occasionally need medication to control the effects of opioid withdrawal.

But my opioids were recommended and prescribed by a doctor!

The evidence regarding the use of long-term opioids has changed in recent years. It has become clear that in the past, doctors over-estimated the effectiveness of opioids, and under-estimated the problems associated with their use.

How can opioids be withdrawn?

The most suitable withdrawal schedule varies widely, depending on the individual, their circumstances, the drug dose and how long the drugs have been taken. Try the suggestion below, and adapt it as required.

Work out a reduction dose – the amount by which your daily dose will be reduced. A suggestion is approximately 10% of your current daily total opioid dose. It may be necessary to first change your opioid(s) to a drug or a schedule that allows this reduction, then to reduce using the new drug. Your doctor can help you with this. The pain clinic can advise. The reduction figure of 10% is only a rough guide – it may not be possible or practical to do this as tablets only come in certain sizes.

Reduce your daily intake by the reduction dose. If you possibly can, maintain this lower dose for 2 weeks. If after that time your symptoms are no worse than when you were on the higher dose, then you are ready to make your next reduction.

Reduce by the reduction dose again. Repeat the process ten times and your wean is complete.

You may find that withdrawal symptoms become more prominent as you near the end of the wean. This is normal, and is not a sign that the wean shouldn't continue. Make the dose reduction smaller, and keep going if you can.

What if withdrawal effects are intolerable?

First, try reducing in smaller steps, or prolong the period between reductions. Consider non-medical strategies – distraction and self-reward can be very effective. If this proves inadequate, your doctor might have some medication that lessens the side effects
There are organisations that help patients that are struggling to wean opioids or other medications – see your GP for details.
(some information is outlined in the document "Weaning Opioids – advice to GP's")

I've weaned, and I've still got pain. Now what?

Once you have been off opioids for a few weeks, or at least on a lower dose, consider two questions:
Has my quality of life gone up or down as a result of the wean? Why?
Has my pain increased, decreased or remained the same?
If you are not happy with the end result of weaning, speak to your doctor about your experience to discuss what to do now. Suggestions include:
Consider taking short-acting opioids instead. These should be taken only to treat exacerbations (worsening) of your pain, or before doing activity that you can't manage without them. Evidence suggests that the less often opioids are used, the more effective they are. They should not be taken more than once or twice a day.
Consider alternative pain relief. Sometimes a referral to another practitioner, such as a physiotherapist or pain clinician, might be appropriate.
Occasionally it might be appropriate to reinstate your opioids. This is rare – the majority of people feel and function better after weaning. If you and your GP do decide to go back to opioids, do so gradually in order to stave off the inevitable tolerance and reduction in benefit.

"I can't manage to wean these medications unaided"

Ask your GP about sources of help available in your area. Some are listed on this document's sister leaflet "Weaning opioids – Advice for GP's".
Type "weaning opiates" into a search engine to peruse sources available on the internet.

Information sources

http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Opioid Management Plan: Treatment agreement

Patient Details

Patient Declaration

In signing this agreement, the patient is agrees to the following conditions regarding his / her treatment and the prescribing of an opioid medication:

1. I have read and understood the information in the document "Opioid Management Plan", including sections on *patient information, prescriber information* and *weaning.*

2. My GP is responsible for prescribing a safe and effective dose of the opioid medication. My GP will control my dose, perhaps with advice from one or more hospital specialist in a condition relevant to my pain ("relevant specialist"). I will not use an opioid medication other than at the dose prescribed and I will discuss any changes in my dose with my GP.

3. Any evidence of unsafe use such as: drug hoarding, acquisition of any opioid medication or other pain medication from other sources (which includes emergency departments), uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the agreement and withdrawal of opioids.

4. I am responsible for the security of my opioid medication at home. Lost, misplaced or stolen medication or prescriptions for opioid medicines may not be replaced. In the event that opioid medication is stolen, this must be reported to the police.

5. I will only obtain my opioid medication from my GP or another doctor specifically authorised by them, or a relevant specialist. I understand that no early prescriptions will be provided.

6. I have read the patient information on this agreement regarding opioid analgesia and I will tell my GP or specialist if I experience on-going/intolerable side effects.

7. As possible dependence is important in the management of my pain, I have informed the clinician signing this contract of any present or past dependence on alcohol or drugs that I may have had, and of any illegal activity related to any drugs (including prescription medications) in which I may have been involved.

8. I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.

9. I understand that if my level of activity has not improved, I do not show a significant reduction in my pain, or if I fail to comply with any of the conditions listed above my opioid prescription may be changed or stopped.

Opioid Management Plan:– Treatment agreement

Patient Details

Clinicians prescribing an opioid should have plans regarding future provision of the drug. This section allows the clinician to clarify these plans with the patient. Sections may be omitted at the prescriber's discretion.

Healthcare Professional to complete - Sections may be omitted as appropriate.

Condition(s) being managed with opioids:

Opioids being taken prior to the implementation of this agreement:

New opioids being commenced as this agreement is being implemented:
THIS IS FOR A TRIAL PERIOD DURING WHICH THE PRESCRIBER WILL NEED GOOD EVIDENCE OF IMPROVEMENT IN FUNCTION TO EMBARK ON LONG TERM TREATMENT.
(Suggest weak opioid eg codeine or tramadol, not Sustained-Release, or oramorph max 30mg / 24hrs. "As required" (prn) use generally preferable to by-the-clock.)

Period before next mandatory review:
(For new trials or dose adjustments, suggest 4-6 weeks. For long-term prescription, 6 – 12 months)

At the end of the trial period the patient should be reviewed and if function is improved, opioids may be considered in the longer term. Make a longer term plan, including regular (maximum 6 month) reviews. Consider intermittent dose reductions or drug holidays so as to demonstrate that ongoing prescriptions are clinically appropriate and beneficial.

Plan for weaning opioids, if applicable
(If the opioids are not to be weaned to zero, include an acceptable range for the on-going dose of opioids)

Is there a maximum opiate dose above which opioids are not to be escalated in the management of the condition being treated?
(Patients with non-cancer pain should not usually be supplied more that 120mg oral morphine per day, or equivalent. *Most patients should receive much less* – a ceiling of 60mg per day is generally sensible. Trials of escalation should be reviewed after 4-6 weeks and reversed unless clear improvement in function and/or quality-of-life is perceived.)

Patient and Prescriber Declaration
We have read and understood the information leaflets *Opioids for pain management – Patient information*, *opioid management – prescriber information* and *Weaning Opioids – Advice for patients*
We understand the information in the leaflets, and in this Treatment Agreement
We agree that my opioid medication will be provided as laid out in these documents.

Patient's signature: __________________________ Date:

Patient's name: __________________________

Medical practitioner's signature: ________________________ Date:

Medical practitioner's name & role: ________________________

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