FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Faculty of Pain Medicine (FPM) position statement: Opioid optimisation. Concerns over opioid reduction practices.

The Faculty of Pain Medicine (FPM) has received reports from doctors and patients that forced reduction of opioids is taking place in some parts of the UK in patients who have been taking opioids for pain for long periods of time with reported benefit. At its worst, this may involve no more than written notification that opioids are to be withdrawn by the prescriber as a one-size-fits-all policy decision.

We strongly advise against this unsafe practice – it is also contrary to current NHS and NICE Guidelines[1,2] which clearly state that "*Prescribing and deprescribing decisions should be made jointly with the patient*" and "*Dependence forming medicines (DFMs) should never be stopped abruptly unless they have been taken for only a short time*".

There is compelling evidence that such action may lead to psychological destabilisation, self-harm and death[3,4]. Rapid reduction is usually appropriate for those taking opioids in response to a resolving physical trauma such as pain after surgery who have been recently started on opioids. It is both inappropriate and dangerous to adopt this approach more generally in patients who are living and coping with chronic pain.

The FPM is further aware that medico-legal, fitness to practice and coroner's cases have scrutinised the decision-making process around opioid prescribing and most recently opioid reduction in both primary and secondary care. Adverse criticism is also to be expected with inappropriate, unsafe practice associated with rapid de-escalation/cessation of opioids in this manner[5,6].

When healthcare professionals are engaged in opioid optimisation*, the FPM preferred term, it is imperative that they are aware of the guiding principles and act accordingly, placing patient safety first.

The FPM has produced publications to guide best practice in opioid prescribing including Opioids Aware [4] which defines the principles that should be applied. In summary, these involve:

1. **Individualised risk assessment on the benefits and harms of opioids.** The benefits and harms of opioids must be considered on an individual basis. There is strong population-based evidence of the harms of opioids taken long-term for chronic pain. There is a paucity of quality studies on the effectiveness of opioids (positive and negative) in the long term but clinical experience, and the position of the FPM, is that opioids can be helpful in carefully selected patients in the long term where the benefits outweigh the

harms. However, doses should be kept low as the risk of harm increases as dose increases.

2. **A comprehensive biopsychosocial assessment of pain**. The aim of this assessment is to enable a broad approach to management: medical, physical and psychological as well as supported self-management.

3. **Decisions to reduce opioids to be undertaken within a comprehensive shared decision-making framework**. A range of tools or strategies should be used to enable engagement[4,5,6]. Supportive treatment may then involve one-to-one consultation, self-management programmes, motivational behavioural strategies, cognitive behavioural therapy, mindfulness and education to support the self-management of pain as well as the rational use of other pain medication besides opioids. Reduction as a policy without a comprehensive, functional and available support system cannot be considered good medical practice.

4. **Psychological assessment of risk with reduction**. This is required in all cases though not necessarily by an expert psychologist. With high-risk patients, feedback from an expert psychologist is necessary to contribute to prescriber decisions regarding safe rates of opioid reduction.

5. **Appropriate management of patient non-engagement**. The FPM have published in depth on this[4,5]. The usual clinical approach is to strive further for shared decision making by detailed explanation and careful management of patient concerns, and to avoid unilateral opioid reduction. The healthcare professional must have demonstrably exhausted all available avenues of patient engagement to consider opioid reduction in this extremely difficult circumstance[6]. Infrequently, unilateral opioid reduction is desirable. GMC guidance requires all doctors to work in the best interests of patient care and safety[7]. However, this situation is challenging for both the patient and healthcare provider and should only be reserved as an absolute last resort. All demonstrable steps must be undertaken with detailed documentation of all decision-making, respecting that opioid maintenance may at times be safer for some patients as a harm minimisation strategy. Close support is essential in this process and is best undertaken as part of an expert multidisciplinary team.

In summary, the opioid optimisation process requires meticulous individualised assessments and decision making, detailed documentation with regular and timely monitoring, assessment and review.

Specialist pain management units can provide expertise and clinical support in dealing with the most complex patients while recognising that much of this work is undertaken in community care by experienced general practitioners, dedicated pharmacists and other professionals. The principles of care outlined above are nevertheless the same.

**Medicines optimisation looks at the value which medicines deliver, making sure they are clinically-effective and cost-effective. It is about ensuring people get the right choice of*

medicines, at the right time, and are engaged in the process by their clinical team. (https://www.england.nhs.uk/medicines-2/medicines-optimisation/)

References

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