Typical Opioid withdrawal symptoms include:
- Dysphoric mood
- Nausea or vomiting
- Muscle aches
- Lacrimation or rhinorrhoea
- Pupil dilation, piloerection, or sweating
- Diarrhoea
- Yawning
- Fever
- Insomnia

Opioid withdrawal is uncomfortable, but differs from alcohol or anxiolytic withdrawal, because serious complications such as seizures or DTs do not typically occur and are not life threatening.

Below are two different Morphine Reduction Schedules to use as a guide. The rate of reduction is a clinical decision, determined by the risks associated with the ongoing prescribing of opioids. Risks include the use of other substances of abuse/dependence such as opioids, amphetamines/BZP, benzodiazepines, zopiclone and alcohol on top of prescribed opioids, a past history of substance dependence, presenting drug affected, or evidence of current intravenous substance use.

If there are significant concerns about diversion with clients on liberal dispensing arrangements, then the prescriber must be aware of the potential risks of overdose and death, should dispensing be changed to consuming on premises daily. We do not recommend this if they have previously had more liberal dispensing arrangements.

We would recommend that any patients who are prescribed opioids, have urine drug screens to confirm the presence of this, as well as screening for other substances of abuse/dependence.

**If risks are significantly elevated, the prescriber may wish to cease prescribing opioids without a reduction regime, and utilise opioid withdrawal medications.

**

**Outpatient Reduction (Fast)**

<table>
<thead>
<tr>
<th>Dose of Morphine</th>
<th>Dose reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>240mg +</td>
<td>40mg per week</td>
</tr>
<tr>
<td>120-240mg</td>
<td>30mg per week</td>
</tr>
<tr>
<td>40-120mg</td>
<td>20mg per week</td>
</tr>
<tr>
<td>40mg or less</td>
<td>10mg per week</td>
</tr>
</tbody>
</table>

**Outpatient Reduction (Slow)**

<table>
<thead>
<tr>
<th>Dose of Morphine</th>
<th>Dose Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>300mg +</td>
<td>20mg per week</td>
</tr>
<tr>
<td>160-300mg</td>
<td>15mg per week</td>
</tr>
<tr>
<td>60-160mg</td>
<td>10mg per week</td>
</tr>
<tr>
<td>20-60mg</td>
<td>4mg per week</td>
</tr>
<tr>
<td>20mg or less</td>
<td>1mg per week</td>
</tr>
</tbody>
</table>
Opioid Withdrawal Medications

For Agitation:
Chlorpromazine 10-50mg Max 200mg/24hours
OR
Quetiapine 25-50mg, Max 200mg/24 hours

For Diarrhoea
Loperamide 2mg, 1-2 capsules, maximum 8 caps/24 hours

For nausea/vomiting
Metoclopramide 10mg tds, Max 30mg/24 hours
OR
Prochlorperazine 3mg, max 3 doses in 24 hours

For GI Cramps/Spasms
Hyoscine 10-20mg, 4 daily, Max 80mg/24hours

For Sedation
Promethazine 25-50mg nocte Max 50mg at night
OR
Quetiapine 50mg nocte

Clonidine patches-TTS 1 (Transdermal for 7 days)

Should you have any queries in relation to the withdrawal of Opioid medications, please do not hesitate to contact one of the Community Alcohol and Drug Services medical staff.

Recognizing and Managing Behavioural Issues during Opioid Weaning Opioid tapers can be done safely and do not pose significant health risks to the patient. In contrast, extremely challenging behavioural issues may emerge during an opioid taper. Behavioural challenges frequently arise in the setting of a prescriber who is tapering the opioid dose and a patient who places great value on the opioid he/she is receiving. In this setting, some patients will use a wide range of interpersonal strategies to derail the opioid taper.

These may include:
- Guilt provocation ("You are indifferent to my suffering")
- Threats of various kinds
- Exaggeration of their actual suffering in order to disrupt the progress of a scheduled taper

There are no fool-proof methods for preventing behavioural issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioural problems if an opioid taper becomes necessary.