Evidence-based Clinical Practice Guideline for Deprescribing Opioid Analgesics

Public Consultation Submission Summary

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The full guideline and supporting documents are available at:
www.opioiddeprescribingguideline.com.au

Table of Contents

SUMMARY OF PUBLIC CONSULTATION PROCESS 4
PUBLIC CONSULTATION PROCESS 4
ORGANISATIONS APPROACHED FOR PUBLIC CONSULTATION 4
OVERVIEW OF SUBMISSIONS RECEIVED 5

List of Tables

TABLE 2: SUBMISSIONS RECEIVED DURING PUBLIC CONSULTATION AND CORRESPONDING RESPONSES 7

Summary of Public Consultation Process

Public consultation process

A national public consultation was undertaken from 2nd February 2022 to 3rd April 2022. The purpose of this consultation was to receive feedback on the draft Guideline and supporting documents from key organisations, individuals and groups who may be affected by the guidelines, or who have an interest in the guideline content. Targeted individuals, organisations and Government Departments were notified of the public consultation through electronic-mail (e-mail) and followed-up with email reminders if required. Links to a Public Consultation submission template were also made available via the Opioid Deprescribing Guideline website. In addition, Guideline Development Group members further disseminated notice of the public consultation amongst their networks. The core guideline development group also met with some stakeholders via teleconference or videoconference to discuss their written public consultation feedback in further detail.

Organisations approached for public consultation

- Allied Health Professions Australia (AHPA)
- Arthritis Australia
- Australasian College for Emergency Medicine (ACEM)
- Australian and New Zealand College of Anaesthetists (ANZCA) and Faculty of Pain Medicine
- Australian Association of Consultant Pharmacy (AACP)
- Australian Commission on Safety and Quality in Health Care - The Medication Safety Oversight Committee and the Health Services Medication Expert Advisory Group
- Australian Deprescribing Network (ADeN)
- Australian Dental Association (ADA)
- Australian Medical Association (AMA)
- Australian Pain Society (APS)
- Australian Physiotherapy Association (APA)
- Chronic Pain Australia
- Consumers Health Forum (CHF)
- Dementia Australia
- Federation of Ethnic Communities Councils of Australia (FECCA)
- Musculoskeletal Australia
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Prescribing Service MedicineWise (NPS)
- NSW Agency for Clinical Innovation (ACI)
- Pain Australia
- Palliative Care Australia (PCA)

- Pharmaceutical Benefits Advisory Committee (PBAC)
- Pharmaceutical Society of Australia (PSA)
- Pharmacy Guild of Australia
- Primary Healthcare Networks (PHNs)
- Royal Australasian College of Physicians (RACP)
- Rural Doctors Association of Australia (RDAA)
- Scriptwise
- Society of Hospital Pharmacists of Australia (SHPA)
- State and Federal Departments of Health
- The Agency for Clinical Innovation (ACI)
- The Australian College of Nurse Practitioners (ACNP)
- The Australian College of Rural and Remote Medicine (ACRRM)
- The Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT)
- The Director-General, Chief Executive or Secretary of State, Territory and Commonwealth Departments of Health
- The Royal Australian & New Zealand College of Psychiatrists (RANZCP)
- The Royal Australian College of General Practitioners (RACGP)
- Therapeutic Goods Administration (TGA)

Overview of submissions received

In total, we received 40 responses over the sixty days of public consultation. Of those, 15 were from individuals (37.5%), and 21 were from organisations (52.5%) and 4 were from Government Departments (10%). Individual responses have been deidentified, stating the individuals occupation / role for context. Responses were received from the following organisations:

- Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT)
- Australian College of Nurse Practitioners (ACNP) & Drug & Alcohol Nurses of Australasia (DANA) (joint response)
- Australian Commission on Safety and Quality in Health Care - Clinical Pharmacy Unit
- Australian Deprescribing Network (ADeN)
- Australian Pain Management Association (AMPA)
- Australian Pain Society (APS)
- Australian Physiotherapy Association (APA) - Pain Special Interest Group
- Chronic Pain Australia
- Dementia Australia
- Faculty of Pain Medicine (FPM), Australian and New Zealand College of Anaesthetists (ANZCA)

- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Painaustralia
- Palliative Care Australia (PCA)
- Pharmaceutical Society of Australia (PSA)
- Royal Australasian College of Physicians (RACP) –The Chapter of Addiction Medicine (AChAM) and The Australasian Faculty of Public Health Medicine (AFPHM)
- Seqirus
- Society of Hospital Pharmacists (SHPA)
- The Agency for Clinical Innovation (ACI)
- The Australian Psychological Society (APS)
- The Royal Australian & New Zealand College of Psychiatrists (RANZCP)
- The Royal Australian College of General Practitioners (RACGP)

Responses were received from the following Government Organisations:

- Northern Territory Department of Health
- QScript Management Unit – Queensland Health
- Victorian Department of Health
- Western Australian Department of Health

Table 1: Submissions Received During Public Consultation and Corresponding Responses

No.	Type of Responder	Topic/Section	Feedback received	Actions taken by the guideline team
1	Individual Alcohol and Drug Program Senior Specialist	Overall	I have had a chance to read this document today and have the following comments to make: The document is comprehensive, and personally speaking, I agree strongly with <u>all</u> opinions/recommendations expressed in it. I have been an Addiction Medicine Physician for the last 37 years, and have no issue whatsoever with any of the recommendations in the document. The document is honest – brutally so – and that is both a strength and a feature I welcome and respect highly. Throughout the document, there is a frank honesty about the weakness of much of the evidence – that point is made numerous times. The document is lengthy and too wordy – as such it risks becoming a "shelf" document, like so many others on my and other Doctors shelves. There for reference but never read. It is too long to be a useful document to the average GP – and yet that is your intended audience. The document needs to be considerably edited and shortened to be readable and useable as a quick reference document to the intended audience (GP's). Yes – it contains an executive summary, but regardless I would like to see it reduced to no more than about 8-10 pages with a list of recommendations, and then an overall comment stating that many (or all!) of the recommendations contained in the document are based on low evidence.	Thank you for your feedback. We agree with the suggestion of developing additional guideline resources to ensure that the guideline is acceptable and useful for end-users. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources. We are currently collaborating with end-users to develop these resources and will test their usability in clinical practice.

			Summary: The document as it stands is excellent, honest and comprehensive. As a reference paper it needs no changes. If it is to be utilised by GP's as a guideline, as should be your intention, it needs to be shortened and edited down into some sort of short glossy GP based guideline. Sorry to be critical in any way, but I would like to see this excellent, well researched paper modified into a usable document for GP's (who are the main opioid prescribers.) All the best – well done	
2	Organisation Dementia Australia	Pages 24 & 91	We strongly supports the reference to the need for supported decision making where possible when deprescribing for a person with 'impaired decision-making' (p 24). We also endorses the observations in relation to the complexities of pain assessment and management - and the prescribing and deprescribing of opioids for people with cognitive impairment and dementia in this context (p 91). We note that sections dealing with other specific populations are equally brief, however, we believe that a more detailed discussion of the need for robust pain assessment and management (the use of Painchek and other technologies for instance) is warranted to contextualise the deprescribing of opioids for people living with dementia.	Noted. We have adapted the 'Population Considerations' section regarding individuals with cognitive impairment as suggested and have included additional links to relevant resources.
3	Organisation Pharmaceutical Society of Australia	Guideline section – Opioid related harm risk minimisation strategies: Naloxone – Page 88	The 'health information resources on naloxone' hyperlink, links to a page that references the PSA Naloxone Guidance Document – the link to this document is broken. This may be because this resource has been recently revised and updated. The correct link is Non-prescription medicine treatment guideline: Naloxone for opioid overdose (psa.org.au) . Apart from that we thought the guideline is well written and structured with clear recommendations.	Noted. Our guideline development group does not have control over external hyperlinks. We have instead directly linked to the PSA document in this section of the guideline.

4	Government Department QScript Management Unit – Queensland Health	Legal and Ethical Considerations – p87	As highlighted in Recommendation 6, in Australia, for persons who are known or suspected to be drug dependent, Schedule 8 medications cannot be prescribed without a permit or an appropriate approval from the relevant state or territory health department's pharmaceutical services unit. Every state and territory in Australia has a Drug and Alcohol Specialist Advisory Service that GPs can contact for advice. Resources such as 'Laws and Regulation' in the Royal Australian College of General Practitioners Prescribing drugs of dependence in general practice, Part A – Clinical governance framework108 provides further information. The above paragraph contains the section 'persons who are known or suspected to be drug dependent, Schedule 8 medications cannot be prescribed without a permit or an appropriate approval'. This is incorrect from a Queensland perspective due to recent legislative changes. Also states and territories have varying names for the regulatory services with only a few being pharmaceutical services. Perhaps it is more appropriate to refer to these as state and territory medicines regulatory areas. Furthermore, the RACGP article is now out of date, and contains broken links to most state and territories health departments.	Noted. We have updated this section (and the section connected to Recommendation 6) to reflect this.
		Prescription Drug Monitoring Programs (PDMP) – p88	Most state and territories have recently or will be amending legislation to allow for real-time prescription monitoring. I am not sure that the following statement is correct; Every state and territory in Australia has a Drug and Alcohol Specialist Advisory Service that GPs can contact for advice. Queensland has a limited Alcohol and Drugs Clinical Advisory Service provided by its Metro North Hospital and Health Service.	Noted. Thank you for clarifying and providing this additional information. This has been reflected in the guideline section on Prescription Drug Monitoring Programs.

			The summary here is very high and does not reflect the current status of PDMPs in Australia. In Australia, all states and territories have committed to implemented PDMPS in cooperation with the Australian Government who have established a National Data Exchange. At present Victoria, Tasmania, Queensland, South Australia, Australian Capital Territory have implemented real-time prescription monitoring programs. Please also note the Australian PDMPs will allow access to a range of medicines other than opioids, such as benzodiazepines. Australian PDMPs are also accessible to prescribers other than medical practitioners, such as nurse practitioners, dentists, and others. Furthermore all Australian PDMPs are also accessible to pharmacists. PDMPs are public health initiative but are also regulatory mechanisms. The element of PDMPs is essential to the understanding of their operation. The supporting legislative basis allows for the collection and sharing of relevant information. And the regulatory structure sets the controls around the activities of health practitioners, prescribers and dispensers, in relation the medicines captured by the regulatory scheme.	
5	Individual Pharmacist	Overall	I received your request for feedback about the Opioid Deprescribing document. It is an excellent document. One deficiency is that there is no mention at all of paediatric and adolescent patients. At the end they mention other unique patient groups such as CALD. I doubt there is any literature concerning deprescribing in the paediatric and adolescents (although I haven't searched) which may contribute to them being overlooked. Never-the-less there are times when we have to address the issue, particularly if GPs have initiated opioids for acute or chronic pain management. I feel these kids at least need to be	The guideline scope focussed on adults (individuals aged 18 years and over). This guideline did not examine evidence for paediatric or adolescent populations, however, we agree with the comment and have flagged this as an area for further research in the guideline section entitled 'Gaps

			acknowledged/recognised and referred to specialist services or advice sought from them.	in knowledge and future research'.
6	Individual Pharmacist	Overall	The recommendations made in this guideline are evidence-based and address a key gap in clinical practice. I found the structure of information following each recommendation (practice points, rationale, evidence summary) intuitive and the links provided allow clinicians to easily access relevant resources.	Noted.
		Page 54	Consider adding a brief definition of what a 'co-intervention' may involve. I note it is discussed below under 'Research Evidence Summary', but readers may not find that immediately clear unless they refer to Table 5.	Noted. A definition of 'co-intervention' has been provided in the glossary and in the 'Rationale' for Recommendation 11.
		Page 72	There does not appear to be a reference for the 'Buprenorphine' co-intervention. Consider replacing 'Ketamine assisted dose reduction' with simply 'Ketamine' as, to my understanding, the other co-interventions are also used to assist with dose reduction.	Noted. Reference has been added. Noted. The text has been modified as suggested.
7	Individual Clinical Psychologist	Overall	I have seen the Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics come through my networks. This is a very important document, and it is great to see this work being progressed. When reviewing the guideline development group members, I noticed that there is no clinical psychology representation. Given the importance of a biopsychosocial approach to pain management, and role of psychological treatments in managing pain and also supporting voluntary opioid dose reduction, I wondered if you had considered psychologist involvement in guideline development? I have forwarded your request for feedback to the Australian Psychological Society in case this is helpful.	We recognise that there is a lack of clinical psychology representation within the guideline development group. We acknowledge that our guideline development group has limitations and for future updates of the guideline, we will endeavour to broaden clinical psychology involvement. We value the public consultation feedback from expert individuals and organisations in the field of clinical psychology.

				Thank you for your suggestion and for liaising with the Australian Psychological Society (APS) regarding providing a public consultation response. APS's response is included in the public consultation feedback summary.
8	Individual Anaesthetist		Great document with so many useful references. I wonder if a flow chart or practical guide with links to resources might be useful for GPs. Link to plan for those suitable for GP /link to services for those in need of possible opioid substitution services? Is there a service to help GPs start the deprescribing pathway with patients and support in case of hiccoughs? A handbook / internet education site/ video like the explain pain one for patients and their families to understand the dangers of long term opioids and the idea that they no longer act as pain relievers and the benefits of careful weaning including regaining of self?	Noted. We agree with the suggestion of developing additional guideline resources to ensure that the document is acceptable and useful for end-users. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid in implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources to address some of the identified challenges in this feedback response. We are currently collaborating with end-users to develop

				these resources and test their usability in clinical practice. We value the additional suggestions of potential resources / tools to develop such as videos. In terms of services for those in need of possible opioid substitution services, we have provided additional guidance under Recommendation 6.
9	Organisation The Australian Pain Management Association (APMA)	Overall	The Australian Pain Management Association (APMA) welcomes the development of evidence based clinical guidelines into opioid deprescribing and the opportunity to make a submission under public consultation on behalf of our community members. The Australian Pain Management Association Limited (APMA) was established in 2009 as an association incorporated to address the need for community services and representation for the estimated 3.4 millions of Australians living with pain. APMA provides collective advocacy, information and practical support for people living with persistent pain and their families. We aim to enhance the well-being of all Australians living with persistent pain through guided pain management. This is reflected in the goals of the National Pain Strategy which APMA actively supports. As a peak consumer body representing Australians affected by persistent pain, we are well placed to make this submission and represent our community members, most of whom have relied on opioids to manage their pain at different stages in their health journey. The anonymous survey was open for a period of 20 days, commencing 3 March 2022. 111 respondents completed the survey,	Noted. Thank you for providing feedback on behalf of your members. This feedback has been included in the guideline section entitled “Stakeholder Values and Preferences”. We agree that further implementation support is required. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources. We are currently collaborating with end-users to develop these

			including 70 individuals who would be willing to provide information about their experiences. APMA supports the concept to develop clinical guidelines for deprescribing opioid analgesics, however consideration for the integration of the guidelines, specifically for General Practitioners and tapering, needs to be carefully considered and widely consulted. We also note that community members advise that their GPs regularly tell them that they perceive the legislation regarding opioid prescribing is policing their practices and they are concerned with deregistration. Our community members feel General Practitioners need more support regarding persistent pain and opioid management.	resources and will test their usability in clinical practice.
10	Organisation Australian Commission on Safety and Quality in Health Care - Clinical Pharmacy Unit	Recommendation 1/p23	On page 23 it says that the guidelines do not provide advice to health care practitioners with regards to prescribing or initiating opioids. However, Recommendation 1 clearly states to mention deprescribing or institute a plan for stopping when initiating opioids. This contradicts the statement on page 23. Might be better to rephrase the wording of the p23 statement.	Noted. We note that recommendation 1 does not provide advice with regards to prescribing or initiating opioids. Rather, it suggests when opioids are initiated, that a deprescribing plan should be implemented. The wording of the statement on page 23 has been modified to clarify and now reads “This guideline does not provide advice to healthcare professionals on when or how to prescribe or initiate opioid therapies. It does not provide comprehensive advice about pain management and healthcare professionals should refer to relevant clinical

				practice guidelines for further advice on this topic.”
		P24	The opening statement is excellent and articulated well	Noted.
		P33	Under the table it states ‘we searched 5 databases’ – yet 6 are listed	Noted. This has been modified to reflect the five databases searched.
		P91	There is a section for the special population group of older people and persons with cognitive impairment. In the sentence that starts with ‘some older adults’ could you consider changing that to ‘many older adults’. Dementia affects one in four adults by the time they reach 80 years– and rates get higher as people age so it should be ‘many’ as opposed to ‘some’. The sentence: ‘As such, the risks and benefits for opioid use should be carefully considered for each person’ is non-specific and essentially valid for all population groups. Many older people, especially those with significant cognitive impairment and more advanced dementia, receive funded aged care either at home or in residential care. For those receiving aged care, it is important to involve formal carers and nursing staff, and informal carers (e.g. relatives and significant others) in overall pain management and when considering deprescribing as these people will know the older person, their preferences and how signs of pain may be manifested.	Noted. This section has been updated as suggested.
		Overall	Well done – well researched, comprehensive and clearly written	Noted.
11	Government Department Northern Territory Department of Health	1.Consensus Recommendation We suggest developing and implementing a deprescribing plan for persons being prescribed opioids at the point of opioid initiation.	Supported	Noted.

		2.Conditional Recommendation for (very low certainty evidence) We suggest initiating deprescribing for persons taking opioids for chronic non-cancer pain, if (any of the following): a) there is a lack of overall and clinically meaningful improvement from baseline in function, quality of life or pain, b) there is a lack of progress towards meeting agreed therapeutic goals, OR c) the person is experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains.	In principle support. Support the need for further research.	Noted.
		3.Consensus Recommendation We suggest initiating deprescribing for persons taking	Supported	Noted.

		opioids for chronic cancer-survivor pain if, (any of the following): a) there is a lack of overall and clinically meaningful improvement from baseline in function, quality of life or pain, b) there is a lack of progress towards meeting agreed therapeutic goals, OR c) the person is experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains.		
		4.Consensus Recommendation We suggest considering deprescribing for individuals taking opioids for chronic pain with one or more of the following clinical characteristics: a) Sleep-disordered	Supported	Noted.

		breathing or sleep apnoea b) Chronic obstructive pulmonary disease (COPD) c) Concomitant use of medicines or substances with sedating effects e.g. benzodiazepines, alcohol, gabapentinoids, antipsychotics and sedating antidepressants d) Prescribed doses greater than 60-100mg oral morphine equivalent daily dose (OMEDD).		
		5.Consensus Recommendation We suggest avoiding deprescribing for persons taking opioids for pain or dyspnoea who are nearing the end-of-life.	Supported	Noted.
		6. Conditional Recommendation against (moderate certainty evidence)	The wording of this conditional recommendation as being against is confusing as it is a double negative. Support the need for further research.	Noted. We note that a 'conditional recommendation against' may create some confusion, however this is in

		We suggest avoiding opioid deprescribing for persons taking opioids with a severe opioid use disorder and suggest that evidence-based care, such as transition to, or referral for, medication assisted treatment of opioid use disorder is provided.		accordance with the standard classification of recommendations throughout the document, as outlined in the executive summary and methods.
		7. Recommendation for (low certainty evidence) We recommend gradual tapering of opioids. Abrupt cessation of opioids without prior dose reduction may increase risks of harm.	In principle support. Support the need for further research.	Noted.
		8. Recommendation for (very low certainty evidence) In principle support. We recommend tailoring the deprescribing plan based on the person's clinical	In principle support. Support the need for further research.	Noted.

		characteristics, goals and preferences.		
		9. Consensus Recommendation We suggest conducting regular monitoring and review of a person taking opioids throughout the opioid deprescribing process. Response against agreed therapeutic goals contained in a deprescribing plan should be regularly assessed.	Supported. All states and territories now have a Real Time Prescription Monitoring system available to prescribers and pharmacists, which will be of great assistance to prescribers in planning and monitoring deprescribing of opioids.	Noted. We have extended the section on Real Time Prescription Monitoring systems to reflect this.
		10. Conditional Recommendation for (low certainty evidence) When available, we suggest the use of interdisciplinary or multidisciplinary care, or a multimodal approach which emphasises non-pharmacological and self-management	In principle support. Support the need for further research.	Noted.

		strategies to deprescribe opioids		
		11.Conditional Recommendation for (very low certainty evidence) We suggest the consideration of evidence-based co-interventions to support opioid deprescribing	In principle support. Support the need for further research.	Noted.
		Overall	Comment on de-prescribing not specific to a recommendation. 1. The document has deliberately omitted the management of patients who are on long acting opioids (Buprenorphine and methadone / implants/depot) and patients who present to hospital with non-cancer pain, and the pathway for such patients. These are 'high risk patient' and using the elucidated de-prescription guidelines in the hand of a non-specialist (Pain and AOD) could be potentially counterproductive. These sub-groups require special mention. 2. Regarding remote communities, there are several logistical and management issues of de-prescribing (out of hospital) due to timely access to pharmacy (support), language and cultural barriers and also limited medical input with continuing care. This could make some groups vulnerable to getting safe and effective management and follow up. 3. To assist with these may require link to education videos (animation) in the few major languages of central Australia and	Noted. We note these populations were outside the guideline scope. Recommendation 6 recommends against deprescribing for persons with opioid use disorders. Primary care was the guideline target setting, however Recommendations relating to persons with chronic non-cancer pain may be applicable across a range of settings. We agree that there are additional challenges related to implementation for rural and remote communities. We also recognise there is a need to develop specific resources for special population groups

			remote communities or with subtitles to enable compliance to verbal/written agreements.	which are culturally and linguistically appropriate. We are planning to work with relevant organisations to develop this further as part of our implementation strategy.
12	Organisation Australian Physiotherapy Association (APA) - Pain Special Interest Group of the	Overall	This is a fantastic document, which will be useful for a wide range of professionals. The APA Pain Group would be very happy to affirm the contents of these guidelines and to promote these to members.	Noted.
		Plain English and Executive Summary	A small point we would ask for consideration. The document stipulates clearly that it does not attempt to provide clinical advice around use of non-opioid treatments (pharmacologically or non-pharmacologically). However, Guidelines 1 and 10 affirm (especially Guideline 10) the importance of multi-modal treatment approaches as having the strongest evidence for reducing opioids. Therefore, surely this advice should be included in the Plain English and Executive Summary sections. To reduce GPs starting opioids and to assist them have an alternative to opioids (ie facilitate deprescribing), affirm to them the better options ie multidisciplinary care (which can be done through Primary Care).	Noted. We have incorporated this in the Plain English Summary. Recommendation 11 which relates to this, is included in the Executive Summary.
13	Organisation Palliative Care Australia (PCA)	Recommendation 5, Page 44	I had been forwarded your paper on Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics. It is a very comprehensive paper. I was also pleased to see the references to avoiding deprescribing for persons taking opioids for pain or dyspnoea who are nearing the end of life (Recommendation 5, Page 44). We also note you have a reference (no 102) to the Palliative Care Australia : Learn More About Pain Management.	Noted. We have incorporated suggested references / links in relation to Recommendation 5.

			I just wanted to draw your attention to two other key resources that you can find on our website. The first is a Position Statement on Sustainable Access to Prescription Opioids for use in Palliative Care PalliativeCare-Opioid-Position-Final.pdf (published May 2019) which provides an evidence-based summary of the PCA position on opioids for palliative care patients. The Position Statement was endorsed by 12 other peak health bodies: • Australian College of Nurses (ACN) • Australian College of Nurse Practitioners (ACNP) • Australian College of Rural and Remote Medicine (ACCRM) • Australian Healthcare and Hospital Association (AHHA) • Australian and New Zealand Society of Palliative Medicine (ANZSPM) • Australian Pain Society (APS) • Pain Australia • Paediatric Palliative Care Australia and New Zealand (PAPCANZ) • Palliative Care Nurses Association (PCNA) • The Pharmacy Guild of Australia • Royal Australasian College of Physicians (RACP), and • Society of Hospital Pharmacists of Australia (SHPA). You may find some helpful material to reference in this Position Statement as you are finalising your Guideline. The other reference on our website that you may find helpful is: Facts about morphine and other opioid medicines in palliative care - Palliative Care Australia. This is on the resources part of our website which might be accessed by patients, carers and health professionals.	

			If you would like to discuss any of this further or need clarification on any of the links, please just let me know. All the best to you in finalising this important piece of work.	
14	Organisation Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (ANZCA)	Overall	This is an outstanding comprehensive effort, especially as it is constrained by the paucity of evidence available.	Noted.
		P 37 and ref 69	This statement should be referenced as "Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists: Position statement… etc"	Noted. This has been updated.
		P 46 DSM-IV opioid dependence criteria	It would be worthwhile listing those criteria as a footnote. You may also consider listing the nine DSM-5 criteria for opioid use disorder.	Noted. We have hyperlinked the term 'opioid use disorder' to the Guideline Glossary for ease of reference.
		P 70 "physiological interventions"	With respect, the interventions as listed are physical, not physiological. They may have physiological consequences but so do behavioural and cognitive interventions.	Noted. Terminology has been updated to reflect this suggestion.
15	Organisation Australian Deprescribing Network (ADeN)	Overall	On looking through all documents I see the development of these guidelines has been meticulous – IOM standard so well done – and I don't have anything to add except to say dissemination and implementation is where the rubber hits the road and very few clinicians will have time to read a 94-page guideline. I see a one-page algorithm is intended which is good – may be worthwhile embedding the preferred tapering regimens in this if you can. The other thought (and you may already have this in mind) is that MJA often publishes summarised versions of new guidelines that have wide application to general practice; Australian Family Physician does the same and is widely read by GPs. You may also want to consider IMJ which is read by physicians. I hope the finished products get wide publicity and ADeN executive would be more than happy to endorse the guideline and post it on our website.	Noted. We agree with the suggestion of developing additional guideline resources to ensure that the guideline is acceptable and useful for end-users. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid in implementation. This will include both an algorithm for use by healthcare

				professionals, as well as consumer resources. We are currently collaborating with end-users to develop these resources and test their usability in clinical practice.
16	Individual Psychiatrist	Overall	I wanted to send this document and the attachments even though I understand it is past the Public consultation period of Sunday 3rd April 2022. I was busy with my responsibilities at work and preparing to send my response to 2022 CDC Pain Guidelines that you have expertly and eloquently commented on. I concur with your three concerns and endorse the idea of formulating de-prescribing strategy for opioids used for pain management. I was able to insert these reports. 1. Chronic Nonmalignant Pain has three parts including the 2022 CDC guidelines, NIH Neuropathic pain: a practical guide for the Clinician, A Clinical Guide to Neuropathic Pain [These have very great graphics and illustrations c. Bradley Galer and Robert Dworkin. 2000 Edition- They offer this sage advice- and you at CDC are trying to provide this-:" To treat Chronic nonmalignant nociceptive pain, you have to first understand Pain. Chap1, Page3." 2. Chr. Pain tools, 3. Chr. Pain Daily Habits, 4. Chr. Pain- Naltrexone- New hope for Treating Chr. Pain, 5.Chr. Pain- Questions about Cannabis effectiveness. 6. Chr. Pain -Mind Body Stress reduction. 7.Chr. Pain From AFP very useful patient information. 8. CMEB- Declaratory statement on use of controlled Substances for treatment of Pain- I was a member of the group of the CT Medical Examining Board who formulated these guidelines. There are many related additional posts on my	Noted. Thank you for providing the additional resources for our reference.

			professional website: https://www.velandymanoharmd.com/ about pain, stress, inflammation, immune mechanisms.	
17	Organisation The Australian Pain Society (APS)	Overall	The Australian Pain Society (APS) wishes to congratulate the guideline development group for this excellent, clinically relevant and comprehensive research paper. The APS especially endorses the messages that pain management treatment and opioid (and other drug) deprescribing for persons with non-cancer pain needs to take a realistic, patient-centred with shared decision making, multidisciplinary approach and must not be forced. We agree that deprescribing can be conducted at any time in the persons care, with indications for deprescribing ideally outlined when originally commenced. General practitioners (GPs) and other primary care providers are key to the safe and appropriate use of opioid, and adjuvant drugs. Whilst the persons level of pain may or not be changed, improved functional ability and quality of life may be improved. It is pleasing to see that stakeholder values, challenges and stigma are all addressed in this draft guideline. Overall, the guideline provides a good universal guideline to opioid deprescribing. This is a multitarget and multimodal intervention worth further study, and further assessment of the safety and efficacy of the recommendations.	Noted. We have incorporated the suggestion to further assess the safety and efficacy of the recommendations into the guideline section entitled "Gaps in knowledge and future research".
		Guiding Principles Page 25	The role of allied health professions, especially psychologists need to be emphasised here	Noted. We have modified the text to include psychologists.
		Evidence retrieval and synthesis Page 32-33	The term "atypical opioids" has been used to describe buprenorphine, tapentadol and tramadol. Should this term be used in search criteria?	Noted. We did not use this term in the search criteria, however we have provided

			The use of these medications is often promoted and considered by some prescribers to be “safer” and “less addictive”.	additional information in the ‘Clinical considerations’ section about ‘atypical opioids’.
		Recommendation 3 Page 41	The final dot point related to cancer-survivor populations related to the assessment of new or worsening pain needs to be emphasized.	Noted. This has been moved in the list of practice points, and is now listed as the first practice point, for emphasis.
		Recommendation 7 Page 47	The inclusion of the opioid deprescribing guide is excellent.	Noted.
		Recommendation 9 Page 51	The Abbey Pain Scale is included as an example of tools to be used for patients unable to communicate their pain and needs. The Pain Assessment in Advanced Dementia (PAINAD) scale is used in the acute hospital setting given it provides a score of 0-10, which is used commonly in general practice. Its inclusion may be easier in primary care given it is a similar score to verbal numerical rating scales of 0-10, as also used in the PEG pain intensity scale.	Noted. This scale has been incorporated into the practice points for Recommendation 9.
		Recommendation 10 Page 53	How current is the National Pain Services Directory? The research evidence summary reads as being contradictory to the conditional recommendation	The National Pain Services Directory website suggests “The information is provided 'as is' with no guarantee of completeness, accuracy, timeliness or of the results obtained from the use of this information.” Noted. Although the evidence is low certainty, Interdisciplinary, multidisciplinary and multimodal care which emphasised non-pharmacologic and self-management strategies

				showed the greatest evidence for effective opioid deprescribing.
		Summary of Findings Pages P55-60	The overall level of certainty for this recommendation is low or consensus. Therefore, is there sufficient evidence to call this an evidence based clinical practice guideline? In a systematic review or meta-analysis, usually the conclusion would suggest that there is insufficient evidence to make evidence-based recommendation. For example, systematic review of 12 RCT by Mathieson et al in 2019 concluded that patient centred intervention showed no effect on opioid use and there is insufficient evidence to recommend any one particular method to deprescribe opioid medication for chronic non-cancer pain. How do we illicit behaviour change and reduce variability in practice based on the current evidence? How do we educate patients regarding the benefit, pain and function with deprescribing, with low certainty of evidence? Perhaps further guidance on the utility of the low-level evidence recommendation in the clinical setting would be useful.	Noted. The term 'evidence-based' relates to the robust process of guideline development which was grounded in and driven by evidence, rather than the certainty of evidence for particular recommendations. The evidence-based development process included a systematic retrieval and analysis of evidence and use of GRADE methodology to determine the certainty of evidence. The certainty of the evidence informing each recommendation has been transparently reported. In the absence of RCTs, we used lower levels of evidence including expert opinions to form low or consensus-based recommendations. We agree that when guidelines have recommendations with a low certainty of evidence, they may be more difficult to implement in practice. This is the case with many areas of

				research. We have identified priorities for recommendation implementation in the 'Dissemination and Implementation' plan and have identified areas for future research which are required to guide future practice.
		Opioid Use Disorders Page 49, 52, 60	We acknowledge that the scope of this document and target audience is not primarily persons with opioid use disorder who are prescribed opioids for opioid substitution. These persons also have comorbid pain problems and are best managed under specialist services. It is also acknowledged that accessibility to, the availability of suitably qualified clinicians and patient engagement in these specialised services can vary significantly. Advice for GPs about what to do when the clinician's risk / benefit analysis differs to the individual's assessment of risk and when and how to transition these persons to drug and alcohol services would be helpful. Further example, should the GP continue to prescribe (after gaining permission from regulatory bodies), should they try to deprescribe whilst waiting to attend the specialised unit and suggestions on what action to take if the person declines treatment with specialised drug and alcohol services would also be of assistance to GPs.	Noted. As stated, the target audience did not include individuals with opioid use disorders who are prescribed opioids for opioid substitution therapy. Recommendations relating to management of individuals with opioid use disorders is largely out of scope of this guideline. However, we acknowledge that "the boundary between chronic pain and opioid use disorder management is complex, with a continuum of presentations". GPs may require additional advice whilst awaiting access to specialist care/services and there may be a need to put measures into place in the interim to increase patient safety. As such, we have provided a direct reference to the National guidelines for medication-assisted treatment

				of opioid dependence which includes information on 'Recommended regimens for patients transferring from prescribed pharmaceutical opioid preparations'.
		Recommendation 5 (Consensus) Page 65	The APS strongly agrees with avoiding deprescribing for person taking opioids for pain and dyspnoea who are near the end of life. The addition of a definition of "chronic cancer survivor pain", as mentioned on page 41, would be helpful to clarify the difference between treating active cancer pain (where deprescribing is not indicated) and when cancer appears to have been successfully treated but pain has persisted due to the treatment given. When does cancer pain transition to chronic cancer survivor pain?	Noted. The definition for chronic cancer survivor (A person with a history of cancer who is beyond the acute diagnosis and treatment phase) and pain are included in the glossary.
		Clinical considerations Page 83	Excellent inclusion of links on how to conduct opioid tapering conversations and the Words-Matter fact sheet on using non-stigmatizing language; useful suggestions regarding withdrawal symptom management.	Noted.
18	Organisation The Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT)	Overall	The Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT) is the leading professional body in Australasia for clinical pharmacology policy and practice and its members' expertise encompasses experimental and clinical pharmacology and toxicology, including drug development, toxicology, clinical trial and regulatory issues, pharmacovigilance and quality use of medicines. The Clinical Pharmacology Special Interest Group of ASCEPT appreciates the opportunity to comment on the Evidence-Based Clinical Practice Guidelines for Deprescribing Opioid Analgesics. Feedback: • The term "user" often has connotations of illicit use.	Noted. We have minimised the use of the term 'user' throughout the revised document. We have expanded the section in 'Clinical Considerations' to explore differences between different opioids (e.g. typical vs atypical opioids). Although we see value in the suggestion to detail a defined period of time when assessing

			• The risk of harm associated with the use of opioids, in addition to factors mentioned in the guideline, may also depend on type of opioid, and dose. • In regard to Recommendation 2 and lack of improvement/progress, it is suggested that "after a defined period of time" is incorporated. • In regard to baseline function, it is suggested that this be more specifically defined. • In regard to Recommendation 4, level of severity of clinical characteristics (sleep disordered breathing, sleep apnoea, COPD) could be considered. • Also in regard to Recommendation 4, and concomitant use of medicines/substances with sedating effects, discussion with patients regarding relative clinical utility of and potential deprescribing of these agents could be considered.	improvement / progress, this recommendation is evidence-based, and we did not have evidence to inform recommending a particular time frame. We have clarified in the 'Practice Points' for Recommendation 2 and 3, that baseline function (and improvements / declines) can be informed by both the person taking opioids and their healthcare professional(s), which may be aided by the use of validated tools (as presented in Recommendation 9). Severity of clinical characteristics was considered for recommendation 4, however the evidence did not clearly distinguish risk based on a specific severity rating. Noted. Deprescribing of other medicines is outside the scope of this guideline, however we have flagged this in the practice point which states: "Optimisation of medical management of comorbidities

				and the overall medication regimen is required. This may involve reducing or stopping other substances such as benzodiazepines or alcohol in addition to, or instead of, opioid deprescribing."
19	Individual responses compiled by Organisation Agency for Clinical Innovation: Respondent 1 Anaesthetist	Consensus recommendation 2 ("who")	This is a fantastic piece of work and I hope it gets well used. There is some evidence that patients presenting for surgery who are opioid dependent can achieve better outcomes (less likely to develop/maintain prolonged post op opioid use) if opioids are weaned pre op. You might want to refer to that group of patients. Levy N, Quinlan J, El-Boghdadly K et al (2021) An international multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients. Anaesthesia 76(4): 520-36.	Noted. This has now been acknowledged in the guideline and flagged as a gap in knowledge / area for future research.
	Individual responses compiled by Organisation Agency for Clinical Innovation: Respondent 2 Emergency Care Physician	Consensus recommendation page 23 'We suggest developing and implementing a deprescribing plan for persons being prescribed opioids at the point of opioid initiation'.	Appropriate prescribing principles should be followed when consideration the use of opioid analgesia in the Emergency Department. Some of the components include patient information and shared decision making, acute pain assessment, risk assessment, pathway of care, monitoring and management opioid analgesic adverse effects, and documentation. Review of therapy has both Emergency Department and non-Emergency Department components depending on patient disposition and involve both the patient and other services such as in-patient teams or primary care services. Providing patients with both prescribing plans and deprescribing plans may result in confusion for some patients regarding analgesia plans and potentially sub-optimal pain control, particularly in the outpatient setting. Clear instructions on analgesic use, potential	Noted. The scope of the guideline is primarily for use in Primary Care, however we acknowledge that opioids are commonly prescribed in hospitals and Emergency Departments. Regardless of setting, a deprescribing plan should be developed at the point of prescribing (whether it is part of the prescribing plan or a distinct plan), in accordance with Recommendation 1.

			adverse events and instructions to follow up with the patient's primary care provider may be of greater patient benefit in the Emergency Department setting.	This recommendation is supported by the content of the recently released Australian Commission on Safety and Quality in Health Care - Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (which has been referenced in Recommendation 1 Practice Points).
	Individual responses compiled by Organisation Agency for Clinical Innovation: Respondent 3 Pain Medicine Physician		Concern re another group developing guidelines for opioids. The word "Deprescribing" encourages a biomedical approach in contrast to a biopsychosocial one. Consumer input is needed on the word "Deprescribing" – strengthens the stigma surrounding people who are prescribed opioids. It has an implied emphasis on the prescriber, it focuses the attention on the drug rather than on the person involved. It simplifies the complexity needed to assist people prescribed long-term opioids, to successfully cease and remain off opioids indefinitely. Suggest we talk about "reducing reliance" on opioids. This implies that other non-pharmacological strategies are provided in conjunction with, and to enable, medication reduction.	Noted. Our guideline group has opted to continue using the term 'deprescribing' in this guideline as it is an acceptable term and is used across a range of medicines. We have conducted qualitative work with a range of people taking opioids prior to guideline development without concerns raised about the use of the term. 'Patient-centeredness is at the heart of 'deprescribing'. As we are particularly focused on the over prescribing of opioids and associated harms, the use of the term 'deprescribing' is appropriate.

				We recognise that the terminology “reducing reliance” has been used in the opioid deprescribing discussion, however we worry that this places the blame/responsibility on the person which may reinforce stigma. Further, it may imply that opioids are fully effective for people to be able to ‘rely’ on them, when they may not be providing important benefits. The term ‘deprescribing’ framed our guideline development and as such, we have opted to continue using this term.
	Individual responses compiled by Organisation Agency for Clinical Innovation: Respondent 4 Hunter New England Pain Service		Not sure if there are any published articles on this specifically in opioid deprescribing space but one of the major requests for support to GP’s, is around setting patient “boundaries” and reducing their opioid dose in the face of degrees of patient resistance but needing to be done with empathy due to safety concerns. The greater the risk of harm the more one might want to do this. Emergency Care Institute had also previously highlighted the need for emergency physicians to have some guidance and support in this area as well for when patients present to ED.	Noted. We have provided resources to assist health care professionals to have discussions around opioid deprescribing, using a shared-decision making model. The purpose of this guideline is for use in primary care specifically, however, may be of use of other health care professionals such as Emergency Care Physicians.

				We have provided reference to the recently released Australian Commission on Safety and Quality in Health Care - Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard, which may be directly relevant to Emergency Care.
	Individual responses compiled by Organisation Agency for Clinical Innovation: Respondent 5 Consumer		As a consumer, I share (Respondent 3's) concerns about the word deprescribing. 'Reducing reliance on opioids' is easier to understand and isn't as stigmatising.	We recognise that the term deprescribing is imperfect, however it has been deemed to be an appropriate term to use for this guideline (as outlined above in the response to Respondent 3). The main audience of this document is healthcare professionals and we will consider and test appropriate wording for any consumer directed materials that are developed.
20	Organisation Seqirus	Page 84 (Characteristics of opioids, Equivalent and equianalgesic opioid doses) "Transition from one opioid to another	Atypical opioids (buprenorphine, tapentadol, tramadol) are opioids which achieve analgesic effects by additional mechanisms or via alternate interactions with opioid receptors, as opposed to conventional opioids (codeine, fentanyl, hydromorphone, methadone, morphine, oxycodone, oxycodone with naloxone, pethidine) which achieve analgesia solely through mu agonism.[1-3] This is acknowledged by recent Australian Guidelines and resources	Noted. We have updated the guideline to include information about atypical opioids and explanatory statements in relation to equianalgesic conversions for the opioid calculator.

		may be required to facilitate deprescribing. Different opioids are not equianalgesic, however oral morphine equivalents of different opioids can be calculated. The Faculty of Pain Medicine of the Australian New Zealand College of Anaesthetists (ANZCA) has released an online opioid equianalgesic calculator (also available in table format) which may assist when transitioning between different opioids or developing a tailored opioid deprescribing plan." Page 18 (Recommendation 4) "Prescribed doses greater than 60-	including ANZCA/FPM Acute Pain Management: Scientific Evidence 5th edition and Therapeutic Guidelines - Pain and Analgesia. Consider inclusion of atypical/conventional pharmacology when describing opioid characteristics. This is relevant and important when interpreting oMEDD and in particular, from a patient safety perspective when switching/transitioning from conventional opioids to atypical opioids or vice versa. As equianalgesic doses of atypical opioids do not reflect equivalent opioid activity of conventional opioids, care must be taken to avoid potential opioid withdrawal or overdose when switch/transitioning.[3-6] In addition, consider inclusion of the following explanatory statements: - oMEDD/FPM ANZCA Opioid equianalgesic calculator: this tool calculates total oral morphine equivalent daily dose (oMEDD) based on equianalgesia.[4] The equianalgesic dose expressed as oMEDD does not reflect equivalent opioid activity of atypical opioids due to differences in pharmacology compared to conventional opioids.[4] - Not all opioids are easily converted to an equianalgesic dose. If transition from a conventional opioid to an atypical opioid such as tapentadol is considered, take an individualised approach and consider cross-tapering to avoid opioid withdrawal.[3,5,6] The calculated equianalgesic doses of tapentadol does not reflect equivalent opioid activity as efficacy is partly due to noradrenaline reuptake inhibition.[3,4-6] Regarding the statement "Prescribed doses greater than 60-100mg oral morphine equivalent daily dose (OMEDD)" consider whether a risk-based approach is appropriate to include, for example where	Noted. We have modified this recommendation and removed the dose threshold from the recommendation.

		100mg oral morphine equivalent daily dose (OMEDD)."	deprescribing of conventional opioids is recommended at an oMEDD = 60mg and deprescribing of atypical opioids (tapentadol, tramadol, buprenorphine) is recommended at an oMEDD = 100mg. Recent guidelines acknowledge the adverse event profile of opioids differs according to their pharmacology and potency. [2,3] The Therapeutic Guidelines, Pain and Analgesia have employed a similar approach where different, molecule specific oMEDD limits are utilised to guide when specialist consultation should be sought when prescribing for CNCP (see below extract from "The role of analgesics in chronic noncancer pain - Prescribing opioids for chronic noncancer pain"):[3] If a trial of morphine is appropriate for adults with chronic noncancer pain, use: morphine modified-release 5 to 10 mg orally, once or twice daily. Increase 10 mg every 3 days until adequate analgesic effect is achieved. Do not use 40 mg daily without specialist support. Older patients require lower doses a slower titration. If a trial of oxycodone is appropriate for adults with chronic noncancer pain, use oxycodone modified-release 5 mg orally, once or twice daily. Increase by 5 every 3 days until adequate analgesic effect is achieved. Do not use more th daily without specialist support. Older patients require lower doses and slov titration. If a trial of tapentadol is appropriate for adults with chronic noncancer pain, use [tapentadol modified-release 50 mg orally, once or twice daily. Increase by 5 every 3 days until adequate analgesic effect is achieved. Do not use more th mg daily without specialist support. Use lower doses and slower titration st in older patients. If a trial of tramadol is appropriate for adults with chronic noncancer pain, use: tramadol modified-release 50 mg orally, once or twice daily. Increase by 50 every 3 days until adequate analgesic effect is achieved. Do not use more th mg daily without specialist support. Use lower doses and slower titration st in older patients.	

			References 1. Raffa B et al. Curr Med Res Opin 2014; 30-12: 2579-2584. 2. Schug S et al. APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2020). Acute Pain Management: Scientific Evidence (5th edition), ANZCA & FPM, Melbourne. 3. eTG complete, Pain and Analgesia [digital]. Melbourne: Therapeutic Guidelines Limited; Dec 2020 4. ANZCA FPM Opioid calculator available at http://www.opioidcalculator.com.au/ (accessed March 2022) 5. PALEXIA SR Approved Product Information 6. PALEXIA IR Approved Product Information	
		Page 49 (Recommendation 8 - practice points) "We recommend tailoring the deprescribing plan based on the person's clinical characteristics, goals and preferences." • "Transition from one opioid to another may be required to	For Recommendation 8, consider the addition of practice points specifically addressing: - Patients who may be taking multiple analgesics and opioids, guidance on how to manage these patients including which agents to deprescribe first. The Therapeutic Guidelines, Pain and Analgesia provides the below guidance (extract from "Using analgesics to manage acute pain - tapering and stopping analgesics for acute pain"): An analgesic tapering and stopping plan is particularly important for patients prescribed opioids because lo the use of opioids for acute pain. Ideally, the opioid is stopped within a few days of reducing the dose [Not more than a couple of days, tapering opioids should start before discharge. The discharge opioid prescripti amount of opioid the patient has required 24 to 48 hours prior to leaving hospital. In general, taper and st oxycodone before tramadol and tapentadol; paracetamol and NSAIDs should be the last drugs discontinue analgesics commonly used for acute pain, see Table 1.6.	Noted. We have not included practice points on which opioid(s) to deprescribe first as we did not have evidence from our review to inform this. The provided reference is in relation to the management of acute pain and may not be applicable to all indications covered by this recommendation – which encourages an individualised deprescribing plan regardless of indication for opioid use. Noted. Considerations when transitioning between opioids

		facilitate deprescribing."	- Expand guidance on transition of one opioid to another to include when this is appropriate (and not appropriate) and how to do this safely. Consider inclusion of:
			  - If the opioid trial goals are not met, then a process of weaning should be commenced, rather than transition/switch. [1]
			  - If transition from a conventional opioid to an atypical opioid such as tapentadol is considered, a reminder to take an individualised approach and consider cross-tapering to avoid opioid withdrawal. [2-6] The calculated equianalgesic doses of tapentadol does not reflect equivalent opioid activity as efficacy is partly due to noradrenaline reuptake inhibition.[2-6]
			
			References
			1. Faculty of Pain Medicine, ANZCA. PS01(PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain 2020. Available at https://www.anzca.edu.au/getattachment/7d7d2619-6736-4d8e-876e-6f9b2b45c435/PS01(PM)-Statement-regarding-the-use-of-opioid-analgesics-in-patients-with-chronic-non-cancer-pain (accessed March 2022).
			2. eTG complete, Pain and Analgesia [digital]. Melbourne: Therapeutic Guidelines Limited; Dec 2020
			3. ANZCA FPM Opioid calculator available at http://www.opioidcalculator.com.au/ (accessed March 2022)
			4. PALEXIA SR Approved Product Information
			5. PALEXIA IR Approved Product Information
				and equianalgesic doses of convention and atypical opioids has been included in 'Clinical Considerations'. This has been linked in Recommendation 8's practice points.

		• Page 15 (Plain English Summary)	To support the prescribing of opioids in line with current indications and minimise potential confusion, consider inserting wording to	Noted and updated as suggested.

		"Opioid analgesics (opioids) are a group of medicines commonly used to treat the symptoms of moderate to severe pain." • Page 20 (Background) "Opioids, including buprenorphine, codeine, fentanyl, hydromorphone, methadone, morphine, oxycodone, oxycodone with naloxone, pethidine, tapentadol and tramadol, are commonly prescribed for the management of moderate to severe pain."	reflect there has been a change to indications (i.e. now severe pain rather than moderate-severe).[1] References https://www.tga.gov.au/hubs/prescription-opioids (accessed March 2022)	

21	Organisation National Aboriginal Community Controlled Health Organisation (NACCHO)	Plain English Summary	This is not in plain English and appears to be written for a very health literate/health professional audience. Words and phrases such as 'tissue', 'associated with, or resembling that associated with', 'sedation', 'respiratory depression', 'dependence' and the long list of opioid analgesics provided will not be broadly understood and will be alienating. 'Pain medicines' is more appropriate than 'analgesics', 'damage to a part of the body' would be more appropriate than 'tissue damage', 'drowsiness' more appropriate than 'sedation' as some examples.	Noted. The plain English summary has been updated accordingly. We have used the Health Literacy Editor, created by the Sydney Health Literacy Lab https://protect-au.mimecast.com/s/1WnNCZY1NqiMPNjvQczmPGi?domain=mail.eventsairmail.com to assist with re-wording.
		Overall	Well researched and well written document that is clear and easy to follow. However, suggest consideration needs to be given to how GPs will interact with the document – they will want the recommendations up front, and some understanding of how confident they should be in those recommendations, and will be less likely to be interested in the methodology and guideline development team (which could be in an appendix for instance). Perhaps separate resources are intended and this will be a reference document which would resolve this comment.	Noted. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid in implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources. We are currently / planning to collaborate with end-users to develop these resources and test their usability in clinical practice.
		Population considerations (Australian Aboriginal and Torres Strait Islander peoples)	No need for "Australian" in the subheading i.e. heading should read "Aboriginal and Torres Strait Islander peoples" Link to healthinfonet resources is a great inclusion.	Noted. This has been modified.

		Strength based approach	Please consider the following proposed re-wording to present the paragraph regarding Aboriginal and Torres Strait Islander peoples as a special population from a strength based position. It is important to focus on ways to optimise the care of Aboriginal and Torres Strait Islander populations in the context of opioid deprescribing and ensure that care is culturally suitable and tailored to the individual. Culturally appropriate care involves building on the strengths of Aboriginal and Torres Strait Islander peoples to determine their own health priorities, through protective factors such as strength of family, community and culture. Australian Aboriginal and Torres Strait Islander peoples Aboriginal and Torres Strait Islander peoples experience substantially higher rates of mortality and morbidity than the general population.231 The incidence of long-term opioid use in Aboriginal or Torres Strait Islander populations is 1.7–1.9 higher than non-Aboriginal and Torres Strait Islander populations, 232 increasing the risk of opioid-related harm. To address these inequities will require an understanding of the historical and ongoing social and emotional determinants of health. Healthcare professionals are required to consider language barriers and cultural differences, and how this may impact communication and treatment. It is important to discuss the recommendations within this guideline in a culturally suitable manner, with trusted Aboriginal and/or Torres Strait Islander Health Workers or Practitioners and trained interpreters if necessary. A range of resources that have been designed for clinical use are available at the Australian Indigenous HealthInfoNet website. 233	Noted. Thank you for taking the time to revise this section. We have updated as suggested.
		Resource dissemination	NACCHO would like to work with the authors to ensure these guidelines are implemented in practice through our extensive network. NACCHO is the national leadership body representing more than 140 Aboriginal Community Controlled Health Organisations (ACCHOs) across the country on Aboriginal health and wellbeing issues. NACCHO represents over 6,000 ACCHO staff – of which 3,500	Thank you. We would value the opportunity to work with NACCHO on guideline dissemination and implementation activities.

			are Aboriginal – and is the largest employer of Aboriginal and Torres Strait Islander people in Australia. ACCHOs have over 50 years of experience in the delivery of comprehensive primary health care. Services are delivered through fixed, outreach and mobile clinics operating in urban, rural and remote settings across Australia.	
		Areas requiring further research mentions Aboriginal and Torres Strait Islander peoples as a focus area.	Great to see this included. Could include an extra sentence that research should be led by Aboriginal and Torres Strait Islander peoples in a culturally appropriate model.	Noted. This has been added.
		Conditional Recommendation 10. for (Low certainty evidence) When available, we suggest the use of interdisciplinary or multidisciplinary care, or a multimodal approach which emphasises non-pharmacological and self-management strategies to deprescribe opioids.	Consider adding additional information in this section The integrated primary health care model adopted by ACCHOS is in keeping with the philosophy of Aboriginal community control and the holistic view of health. Addressing the ill health of Aboriginal people is best achieved by local Aboriginal people controlling health care delivery, this has demonstrated improved health outcomes. https://www.mja.com.au/journal/2014/200/11/aboriginal-community-controlled-health-services-leading-way-primary-care	Noted. This has been included as suggested.
22	Organisation Chronic Pain Australia	Overall	• Overall recommendation – Opioid deprescribing should be a joint decision with clinician and health consumer and not enforced. • Naloxone therapy should be prescribed and education provided to the patient when opioid deprescribing	Noted. We have attempted to emphasise the value of shared decision making when opioid deprescribing is being considered and enacted.

			commences. Patients are at highest risk of opioid toxicity when tapering opioids - it might be helpful for this to also discuss risk in deprescribing. • Naloxone also saves three lives per day - https://www.australianpharmacist.com.au/naloxone-pilot-prevents-three-deaths-daily/ • The recommendations are very black and white (which I understand is likely the aim of the recommendations) but a very challenging area for both health consumer and clinician. It would be helpful using other terms such as "rationalise" opioids - for example if taking multiple opioid agents recommend rationalising to one single agent, or aim for lowest possible OME, sometimes complete cessation is unrealistic. • I think there is a large cohort of Australian consumers who are missing a recommendation/ and very high risk of harm - These consumers are generally low socio economic, lifetime disability, unable to work, comorbid mental health and have a history of childhood abuse or neglect and are generally on the higher end of OME for chronic pain >100mg OME. The POINT study provides good evidence of this https://ndarc.med.unsw.edu.au/project/point-study-pain-and-opioids-treatment . The majority of these patients will not be successful in deprescribing and can become significantly distressed, or worse disengage from health care. It would be great to see a formal recommendation from this body of work which looks to provide formal recommendations on the options for management. Some articles from America are calling this "complex persistent dependence" doesn't fit the criteria for "SUD" - as consumers taking opioids as prescribed does not escalate or have aberrant behaviours. Their recommendation was trial	Noted. We have included the provided reference relating to Naloxone. Noted. We note that complete cessation is not always possible, realistic or the best course of action. The recommendations re intended to be clear and actionable. We have decided to not include the term “rationalise” in this guideline in an attempt to prevent confusion between terminologies. The definition of ‘deprescribing’ has been tweaked to clarify that cessation is not always the intention of deprescribing. Noted. We found insufficient evidence to determine which individual or tapering characteristics were associated with greater success of opioid deprescribing. We have called for future research into the outcomes of deprescribing for specific population groups in the guideline section ‘Gaps in knowledge and future research’.

			tapering and if not successful switch to suboxone stabilise and trial taper or continue therapy. Thank you for the hard work on a challenging practice.	The evidence synthesis included reviews which examined buprenorphine as an intervention for opioid deprescribing, however we did not find sufficient evidence to make a recommendation pertaining to suboxone stabilisation and trials of tapering. This may be partially due to the scope of the guideline, where we did not include opioid substitution therapy for people with opioid use disorders in our evidence synthesis. Further, we did not examine opioid rotation, unless the intention was dose reduction.
23	Organisation	Overall	The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide feedback on the draft Evidence-based Clinical Practice Guideline for Deprescribing Opioid Analgesics. We provide the following comments for consideration.	Noted.
		Consensus recommendation 4	We suggest considering deprescribing for individuals taking opioids for chronic pain with one or more of the following clinical characteristics. This recommendation states that prescribers should consider deprescribing when the morphine equivalent daily dose of 60-100mg is used. Given that this is a consensus recommendation, we recommend reviewing this and providing a relevant single dose of morphine instead of a range. A single target dose makes implementation in general practice easier, as it allows GPs to design	Noted. Taking into consideration the breadth of feedback relating to Recommendation 4 and the potential misinterpretation of a dose threshold, we have opted to remove the dose threshold from the Recommendation.

			an appropriate search strategy to identify suitable patients to target for deprescribing.	
		Consensus recommendation 5	We suggest avoiding deprescribing for persons taking opioids for pain or dyspnoea who are nearing end-of-life. There are specific circumstances where doctors should identify reasons to deprescribe (or reduce the dosage or change opioids) in near end-of-life care. These include: unwanted confusion, opioid hyperalgesia unmanageable constipation, dry mouth, sweating and itching organ deterioration that reduces clearance and makes a change of opioid advisable. This approach to deprescribing should be discussed with the patient as part of a care plan and monitored as their condition changes1. References 1. The Royal Australian College of General Practitioners. RACGP aged care clinical guide (Silver Book). 5th edn. East Melbourne, Vic: RACGP, 2019.	Noted. This additional information has been added to the practice points section of this recommendation.
		Table 5: Effectiveness of co-interventions for opioid deprescribing	This table provides information on the success rates of co-interventions utilised to facilitate opioid deprescribing, determined by the proportion of population who ceased opioids. However, this may not be a true indication of the success rates. It is not clear whether the values represent short- or long-term outcomes of deprescribing. It is also unclear if the implemented interventions were only effective in specific highly-selected populations. The RACGP recommends this information be clarified where possible in the table, as this important context may be otherwise missed.	Noted. Additional text has been provided to accompany Table 5 and explain the context of the reported data.
		Additional recommendations for consideration	Consider including an additional recommendation to advise whether short-acting or long-acting formulations are more likely to be associated with harms such as opioid use disorder, and whether dose tapering is more successful with long- or short-acting formulations.	Noted. We did not have sufficient evidence to inform an additional recommendation relating to the success of opioid deprescribing depending on opioid formulation.

		Other comments	We recommend including information on the success rates of opioid deprescribing at the start of the document.	Noted. In accordance with the guiding principles of this guideline, opioid deprescribing plans are ideally individualised according to the needs, values, preferences and goals of the person. Therefore, success may be defined differently for different individuals. There is insufficient evidence to determine which individual or tapering characteristics are associated with greater success of opioid deprescribing. Given the heterogeneity of studies examining opioid deprescribing and the limited reporting of deprescribing protocols and participant baseline characteristics, we were unable to assess the comparative effectiveness of different opioid tapering approaches. As context is integral to the success of opioid deprescribing, we have opted to not include blanket population data on the success rates of opioid deprescribing at the beginning of the document and instead have kept this

				information in table 5 with additional text which speaks to contextual factors impacting on the rate and nature of opioid cessation.
24	Organisation Australian College of Nurse Practitioners (ACNP) & Drug & Alcohol Nurses of Australasia (DANA) joint response	Overall	Thank you for the opportunity to provide a response to the Review of Evidence-Based Clinical Practice Guidelines for Deprescribing Opioid Analgesics. The Australian College of Nurse Practitioners (ACNP) is the national peak organisation for Nurse Practitioners, advancing nursing practice and consumer access to health care. A key focus for the role and scope of practice development for Nurse Practitioners is on unmet needs within the community and increasing access to health care. The Drug & Alcohol Nurses of Australasia (DANA) is the peak nursing organisation in Australasia for nurses and midwives with a professional interest in Alcohol, Tobacco and Other Drug (ATOD) issues. Overall, the Guidelines provide good guidance on tapering/deprescribing opioids; however, the document does not have utility in its current format. We suggest compiling a very abbreviated version for time-poor health professionals addressing key points of the 11 recommendations and relevant links to help prescribers commence the discussion with patients, set plans for deprescribing and monitor their patient's progress. The Guideline in its current format would be more useful as a reference document.	Noted. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid in implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources. We are currently planning / collaborating with end-users to develop these resources and test their usability in clinical practice.
		Guideline Development Group Composition	There is limited breadth of clinician input into the Guidelines – the majority of the 17 experts are identified as pharmacists/pharmacologists (most working in academia) with only a couple of medical practitioners, who identified a clinical	The guideline development group represented a broad range of clinicians, researchers, methodologists and a

			component in their role. This narrowed the scope of the Guidelines and accordingly there is limited attention made to options outside traditional general practice models of care. It appears there was a lack of nursing input for the Guidelines, demonstrated by the language used throughout. There appears to be poor understanding of the nursing role (especially of advanced practice nurses and nurse practitioners). The definition for 'Nurse Practitioners, Registered Nurses and Enrolled Nurses with Endorsement' in the Glossary is incorrect and confusing. It is unclear if there was any consultation with Nurse Practitioners or Advanced Practice Nurses for the Guidelines , especially the those working in primary health care, palliative care, pain management, ATOD, residential aged care etc.	consumer, in accordance with NHMRC guidance. We had representation from two Registered Nurses on the Guideline Development Group. We intentionally sought additional input from Nurse Practitioners through the public consultation process. We acknowledge that our guideline development group has limitations and for future updates of the guideline, we will endeavour to broaden nursing involvement. Definition for 'Nurse Practitioner' has been updated.
		Terminology	There needs to be inclusive terminology in the document to encompass all health professionals. Instead of using profession-specific language, we suggest the use of more general terms, such as the word prescriber (inclusive of GP, NP, Physician etc).	Noted. We have attempted to use Inclusive terminology (i.e. prescriber, healthcare professional) as suggested. However, we note the primary target audience of this guideline is General Practitioners and where appropriate, we have used this term.
		Glossary Pages 6-13:	Aberrant Prescription Opioid Behaviour, Inappropriate Medication and Diversion are pejorative terms and are not helpful language to be used in a Guideline that intends to support people at risk of or currently experiencing substance use disorders.	Noted. We have attempted to minimise the use of such language throughout the document, however some of the highlighted terms are used

				in the context of diagnostic criteria, other definitions, or studies included in the evidence synthesis, and have therefore been defined in the glossary. The definition for 'aberrant prescription opioid behaviour' has been modified and 'diversion' has been removed.
		Page 9:	Inappropriate Medication is not a widely used term and as such, is open to misinterpretation. Perhaps the term potentially inappropriate medications (PIM) could be used instead, or a clearer definition of the term added.	Noted. We have kept the term 'inappropriate medication' as it is a key component of the definition of deprescribing and is clearly defined in the glossary.
		Page 10	Add correct definitions for Nurse Practitioners, Registered Nurses and Enrolled Nurses.	Noted. No preferred definition was provided, however a distinct definition has been included for Nurse Practitioner, highlighting extended clinical roles such as diagnosis and prescribing.
		Page 10	Non-medical use of prescription opioids (NMUPO) should be added to the glossary and the Guidelines with a brief synopsis of this and the issues for prescribers to consider.	Noted. This term is not used in this guideline and as such, it has not been defined in the glossary.
		Page 25:	The statement needs to include Nurse practitioners: 'the multidisciplinary care team may comprise of GPs, pharmacists, residential aged care facility (RACF) staff, registered nurses, other specialist medical practitioners and allied health professionals.'	Noted. Modified as suggested.
		Page 88:	'Accessible health information resources on naloxone' No info on this link related to Naloxone.	Noted. Modified as suggested.

			Suggest instead linking to COPE – Overdose First Aid - Penington Institute as a useful site for information on Naloxone and it also provides examples of prescriptions.	
		Page 88: Prescription Drug Monitoring Programs:	Add links to each state/territory prescription drug monitoring program	Noted. Modified as suggested.
		Areas needing to be addressed further:	More emphasis on a Multi-Disciplinary Team approach to deprescribing and how to create a Team using local services. Include Home Medicine Review for patients being considered for deprescribing.	Noted. We have included this in the Principles of Deprescribing: "Deprescribing is ideally undertaken with the assistance of a multidisciplinary care team as various healthcare professionals may need to be consulted to determine the appropriateness of deprescribing or to ensure monitoring is conducted throughout the process." We acknowledge that interdisciplinary and multidisciplinary pain management services may be difficult to access or implement, particularly in rural or remote areas, among socially-disadvantaged communities, or in primary care settings where resources or access to specialist services are limited.

				Directives on how to create a team using local services is context specific and falls outside the scope of this guideline. Reference to Home Medicine Reviews has been included within the guideline.
		Page 91: 'Rurality'	More discussion required about needs and service delivery options in Rural and Remote areas Further considerations/information/recommendations for special populations, e.g. aged/elderly, pregnancy	Noted. There is significant variability in terms of needs and service delivery options in rural and remote areas. In future we will aim to assess barriers and facilitators to guideline implementation which will require assessment of service delivery in rural and remote areas. Considerations for specific population groups have been included in the guideline. It is unclear what "more discussion" is required.
		Recommendation 1	We suggest developing and implementing a deprescribing plan for persons being prescribed opioids at the point of opioid initiation. This needs further explanation. It would be unrealistic to expect this will happen every time an opioid is prescribed, unlikely to be followed by prescribers and not necessarily needed for a short course of opioids for acute pain.	Noted. Recommendation 1 supports the suggestion that "EVERY person being prescribed opioids is given information about safe use, safe storage and safe discarding of opioids,

			The only time we would suggest this be done at time of first opioid prescription would be for persons with a past history of opioid (or other drug) use disorder. Perhaps suggest a deprescribing plan should be implemented for persons being prescribed opioids for an acute pain episode greater than 2 weeks or if needing repeats. There may also need to be a different suggestion for when a deprescribing plan should be implemented for persons being prescribed opioids for persistent pain. An optimal suggestion is to expect EVERY person being prescribed opioids is given information about safe use, safe storage and safe discarding of opioids, benefits of non- opioid meds and helpful non-pharmacological strategies.	benefits of non- opioid meds and helpful non-pharmacological strategies." In the context of a deprescribing guideline, Recommendation 1 is appropriate. We acknowledge that the deprescribing plan may vary in depth/breadth depending on the individual and their circumstances. As highlighted in the guideline, "The plan may be adjusted to meet the ongoing needs of the person. A deprescribing plan is ideally a written document, but may be a verbal agreement between the person and the healthcare professional." For short term prescriptions, an expected duration of treatment or tapering / cessation plan may be sufficient. We agree with the statement "to expect EVERY person being prescribed opioids is given information about safe use, safe storage and safe discarding of opioids, benefits of non- opioid meds and helpful non-pharmacological

				strategies." This has been incorporated into Recommendation 1 Practice Points.
		Page 37	Link to CDC management guidelines does not work: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.html	Noted, this has been updated.
		Recommendation 2 and Recommendation 3	We suggest initiating deprescribing for persons taking opioids for chronic non-cancer pain, if (any of the following): a) there is a lack of overall and clinically meaningful improvement in function, quality of life, or pain, b) there is a lack of progress towards meeting agreed therapeutic goals, OR c) the person is experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains We suggest initiating deprescribing for persons taking opioids for chronic cancer-survivor pain if, (any of the following): a) there is a lack of overall and clinically meaningful improvement in function, quality of life or pain, b) there is a lack of progress towards meeting agreed therapeutic goals, OR c) the person is experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains. Recommendations 2 and 3 could be a single Recommendation. They are essentially the same.	These two recommendations are distinct due to the population group examined. As such one is an evidence-based recommendation and one is a consensus recommendation and therefore cannot be combined.
		Recommendation 4	We suggest considering deprescribing for persons taking opioids for chronic pain with one or more of the following clinical characteristics: e) Sleep-disordered breathing or sleep apnoea, f) Chronic obstructive pulmonary disease (COPD), Concomitant use of medicines or substances with sedating effects e.g. benzodiazepines, alcohol, gabapentinoids, antipsychotics and sedating antidepressants, h) Prescribed doses greater than 60-100mg oral morphine equivalent daily dose (OMEDD). The list needs relabelling a) to d) Add anti-epilepsy drugs to the last point on the list.	Noted. This recommendation has been modified. Options have been relabelled. Antiepileptic drugs are captured by the term 'substances with sedating effects'.

		Recommendation 5	We suggest avoiding deprescribing for persons taking opioids for pain or dyspnoea who are nearing the end-of-life. This needs to be Recommendation 1.	Noted. The order of recommendations is in accordance with the key clinical questions. We have kept the recommendation order as is.
		Recommendation 6	We suggest avoiding opioid deprescribing for persons taking opioids with a severe opioid use disorder and suggest that evidence-based care, such as transition to, or referral for, medication assisted treatment of opioid use disorder is provided. This needs to be worded differently; in addition, any opioid use disorder is a concern, not just those at severe levels. We consider this cohort of persons are often poorly managed or treated punitively and as a result risk switching into self-management with illicit drug use, NMUPO etc. 'strongly recommend a referral to prescriber skilled in opioid-use disorder, +/- AOD support services….'Define the acronym for "medication-assisted treatment of opioid dependence" (MATOD) in the Glossary. The national MATOD guidelines linked to in this Guideline are out of date. We recommend creating links to state policies on MATODs, as these are kept more current and reviewed more frequently. These also include newer therapies, such as long acting injectable buprenorphine treatments (LABA). Need to include ICD 11 criteria for substance use disorder Page 38: Rationale: If initiating opioid treatment, we suggest that the prescriber and person taking opioids should agree on the goals of therapy and the criteria for treatment success and/or failure. Need to add link to an Opioid Treatment Agreement. Page 45: Headspace link https://headspace.org.au/health-professionals/information-and- guidelines/understanding-	Noted. We have opted to keep the wording and classification of 'severe' in this recommendation as per the justification in the guideline. This recommendation contains a referral to specialist care where appropriate. Advice on opioid management outside deprescribing is outside the scope of this guideline. We acknowledge that GPs may require additional advice whilst awaiting access to specialist care/services and there may be a need to put measures into place in the interim to increase patient safety. As such, we have provided a direct reference to the National guidelines for medication-assisted treatment of opioid dependence which includes information on 'Recommended regimens for patients

			substance-abuse-for-health-professionals/ the link works, but when you click on 'assessment' 404 error occurs	transferring from prescribed pharmaceutical opioid preparations'. Noted. We have included both the ICD-11 definition of 'Opioid dependence' and the DSM-5 definition of 'Opioid Use Disorder' in this guideline. The acronym MATOD has not been used in this guideline. Noted. We do not have control over external links. The intended information is available on the link provided.
		Recommendation 7	We recommend gradual tapering of opioids. Abrupt cessation of opioids without prior dose reduction may increase risk of harm. This recommendation should be earlier on the list.	Noted. The order of recommendations is in accordance with the key clinical questions. We have first provided recommendations on 'when' to deprescribe, followed by 'how' to deprescribe.
		Recommendation 8 - 11	No specific feedback Thank you again for the opportunity to participate in this important review.	Noted.
25	Organisation The Royal Australian & New Zealand College	Target audience (Page 23)	There is opportunity to extend the target audience of the guideline, which is healthcare professionals involved in the care of persons prescribed opioids ("primarily GPs"), with the expertise of psychiatrists. Similarly, for the additional audience section of the guideline, 'those who may find the guideline useful'. Issues of pain	Noted. We have specifically mentioned psychiatrists in the 'Target audience'.

	of Psychiatrists (RANZCP)		and opioid dependence are pertinent to psychiatrists, with such expertise required to sufficiently manage comorbid mental health conditions. Psychiatrists can play a significant role in assisting with the de-prescribing process, offering targeted support for individuals as they manage the psychiatric impact of their pain and/or there the effects of their opioid medication (See Below – Population Considerations). The RANZCP recommends including guidance for health practitioners on referring to specialists such as psychiatrists, when developing or enacting a deprescribing plan. As the draft guidelines own recommendation 10 supports multidisciplinary care, guidance for health practitioners on how and when to best engage with these multiple disciplines would be a welcome addition.	Noted. We have modified the 'Deprescribing Plan' Section to included information about referrals to other healthcare professionals when developing and enacting a deprescribing plan. "A deprescribing plan should specify realistic and relevant goals of treatment, detail the intended process of dose reduction and identify potential supports that may be required throughout the deprescribing process. This may include involvement of other relevant healthcare professionals (e.g. psychiatrists, psychologists etc)."
		Recommendation 8: We recommend tailoring the deprescribing plan based on the person's clinical characteristics, goals and preferences (Page 49)	The RANZCP supports recommendation 8, providing guidance to tailoring the deprescribing plan based on the person's clinical characteristics, goals and preferences, and ultimately improving patient centred care (See Below – Engaging the Patient). Listed under recommendation 8, the following resources are welcome sources of information for clinicians to provide this crucial patient centred care: An opioid deprescribing conversation guide to provide guidance on communication techniques for opioid analgesic tapering conversations. (Safer management of opioids for chronic pain: Principles and language suggestions for talking with patients, and The Department of Human Services - Difficult conversations: Tapering Opioid Dose)	Noted. Mental health conditions have been added to the practice point as suggested.

			NPS MedicineWise's series of educational videos to support effective conversations about the use of opioids for the management of chronic non-cancer pain and opioid deprescribing The NPS MedicineWise tapering plan when developing a deprescribing plan. These resources are an effective inclusion for health practitioners to deliver structured conversations relating to the potential benefits and harms of deprescribing in the context of the person's values, goals and preferences. These support the recommendation to deliver on a mutually agreed deprescribing plan, centred around the patient's ongoing needs. There is opportunity to advance recommendation 8 by the specific reference to mental health conditions when referencing relevant comorbidities and concomitant medications that may influence the deprescribing approach (See Below - Population Considerations).	
		Recommendation 9: We suggest conducting regular monitoring and review of a person taking opioids throughout the opioid deprescribing process. Response against agreed therapeutic goals contained in a deprescribing plan should be regularly assessed (p.51)	The RANZCP concurs with guidance to document and plan continual patient follow up and assessment, assessing cognitive and functional status, behavioural and psychological symptoms, and how these have changed over the follow-up period. The inclusion of various questionnaires and withdrawal scales to assist practitioners to measure withdrawal and pain severity is a useful addition to the guideline. Such guidance on the many possible outcomes of the deprescribing process educates health practitioners as they conduct treatment. To further the guidelines in this sense, the RANZCP recommends including scales that include references to the mental health of the patient. Recommendation 9 states that if complicated withdrawal symptoms are experienced, discussions should begin with or referral to, a pain or addiction medicine specialist. This includes monitoring for suicidal thoughts, mental health issues and illicit opioid use. The RANZCP	Noted. Modified as suggested.

			recommends that in this instance, the guideline articulates a clear referral pathway for health practitioners towards the expertise of psychiatrists. This ensures that the emerging complexities in patient care are promptly met with treatment from the appropriate specialist.	
		Recommendation 10: When available, we recommend the use of interdisciplinary or multidisciplinary care which emphasises non-pharmacological and self-management strategies to deprescribe opioids. (Page 53)	The Clinical Practice Guideline is enhanced by recommendation 10, recommending the use of interdisciplinary or multidisciplinary care which emphasises non-pharmacological and self-management strategies to deprescribe opioids. Interdisciplinary or multidisciplinary care programmes provide multimodal treatment, with coordinated contributions by healthcare professionals from different disciplines. The RANZCP concurs that these models allow for the expertise of several healthcare professionals and community groups whom the person taking opioids can access (including the expertise of a psychiatrist) during the deprescribing process. The RANZCP also applauds the inclusion of non-drug interventions (cognitive behavioural therapy, physiotherapy and occupational therapy), as part of the recommended multidisciplinary model. Such recommendations allow for a more holistic model of care for deprescribing opioid analgesics, and the RANZCP highlights non-drug psychiatric treatments (psychotherapy) as another useful resource to healthcare practitioners in this regard. Recommendation 10 is also a beneficial inclusion to the guideline, due to the impact of interdisciplinary and multidisciplinary care on the health outcomes of Aboriginal and Torres Strait Islanders. Co-development processes allow for Aboriginal and Torres Strait Islander-controlled community organisations to play a key role in the integration of deprescribing services within communities. Consumer co-design and community partnership ensure equitable access to culturally appropriate care for Aboriginal and Torres Strait Islanders and other priority populations (CALD communities, LGBTIQ+ etc.).	Noted.

			The recommendation would benefit from further articulating patient flows and referral pathways within this multidisciplinary approach. The guideline would therefore offer clearer guidance to the health practitioner, allowing them to match the appropriate intervention along a unified pathway that is understood by all health practitioners. The RANZCP suggests that the draft guideline draws attention to psychiatric and psychological strategies of pain management, when recommending multidisciplinary care that emphasises non-pharmacological and self-management strategies to deprescribe opioids. Such strategies would be a welcome inclusion due to the close relationship between chronic pain and mental health (See Below - Population Considerations).	Noted. We acknowledge the benefit of inclusion of this information, however articulating patient flows and referral pathways for multidisciplinary care approaches is outside the scope of this guideline. When recommending multidisciplinary care that emphasises non-pharmacological and self-management strategies to deprescribe opioids, we have reported on all interventions examined in the evidence synthesis. Interventions were not directly compared against each-other and we have not recommended any intervention over another.
		Recommendation 11: We recommend the consideration of evidence-based co-interventions to support opioid deprescribing (Page 54)	Evidence-based interventions are critical to tailoring the de-prescribing process to best practice, putting consumers' informed decisions at the heart of the service. Guidance to assess the appropriateness of co- interventions for opioid deprescribing to be discussed between the healthcare professional and the person taking opioids is an effective addition to the guideline. This allows the clinician to effectivity consider the person's clinical status, preferences, values and costs, and facilitate effective deprescribing.	Noted. Modified as suggested: The appropriateness of co-interventions for opioid deprescribing must be discussed between the healthcare professional and the person taking opioids, taking into consideration the person's clinical status,

			The RANZCP stresses that lived experience should form part of the evidence base for evidence-based co-interventions. This will assist the clinician to achieving opioid reduction, as patients, their families and carers are sources of knowledge given that their lived experience contributes to understanding the patient. This is pertinent in the case of people with mental illness (See Below – Population Considerations).	preferences, lived experience, values and costs.
		Clinical Considerations (Page 83). Stigma	Addressing the stigma related to having a mental illness is a key goal of the RANZCP. We support a long-term vision for Australia where stigma and discrimination based on mental ill-health are no longer barriers to treatment access and quality of life. The RANZCP therefore recognises the guideline's consideration of stigma within the opioid deprescribing process. We welcome the promotion of language guides for clinicians, and the guidance for health professionals to avoid prejudicial language that perpetuates stigma (e.g., replacing the term addict with person centred language). This guidance will help reduce self-stigma amongst those who experience mental ill-health and, and structural stigma towards those affected by mental ill-health.	Noted.
		Psychosocial considerations	The RANZCP welcomes guidance to address the patient's psychosocial influences when developing a deprescribing plan. Transition of care plans offers tailored support across the lifecycle by considering the consumer's individual circumstances and needs (goals/support networks/stressors/care barriers). Care plans can be modified to ensure the maximum level of support during the prescribing process. Such pertinent contingencies are effectively articulated in the guideline. The guidance could be strengthened by the specific inclusion of any mental health condition that the patient may have within a care plan. Mental health comorbidities would greatly impact the success of the deprescribing process and should be specifically highlighted to reflect this importance. The draft guideline should also iterate that	Noted. This has been modified as suggested: "Planning for deprescribing will involve discussing the person's beliefs and goals, assessing the person's support network and inquiring about whether additional support will be required. This may involve liaising with other healthcare professionals who are involved in the care of the person (e.g. psychologist, psychiatrist, etc)."

		Engaging the person	any deprescribing plan should also be developed in partnership with the family/carer (see above - Recommendation 11), and any other healthcare professionals who are involved in the care of the person (such as psychiatrists). It is imperative that treatment to deprescribe opioids is done with the engagement of the patient, who is informed and understands the purpose, nature, benefits, side-effects, risks, and alternatives of a proposed procedure or treatment. Supported decision making in this manner can also improve outcomes for the patient and the experiences of care for consumers, carers and families, whilst strengthening consumer capacity, dignity and autonomy. This engagement is also critical to the right and capacity of the patient to make informed choices and autonomous decisions relating to their opioid usage and pain management. For further information on the RANZCP's position, see Position Statement: Enabling supported decision-making. The RANZCP is encouraged that these considerations are made when assessing opioid deprescription. The guideline stresses the importance of engaging the person taking opioids (and/or their family or carer) in the conversation about deprescribing suitability. This includes the potential benefits and harms of deprescribing for the individual person.	Noted.
		Population Considerations (Page 90)	The inclusion of population considerations within the guidance is an effective inclusion to the draft guideline. The RANZCP supports the guideline's contention that healthcare professionals should provide clinically and culturally appropriate care when deprescribing opioids. It is encouraging to see recommendations focus on tailored care for unique community needs, which takes into consideration the social determinants of health. The RANZCP strongly supports the specific inclusion of the unique experiences and needs of Aboriginal and Torres Strait Islander	Noted.

		Australian Aboriginal and Torres Strait Islander peoples Culturally and linguistically diverse (CALD) populations	People when providing guidance on deprescribing Opioid Analgesics, referencing their higher rates of mortality and morbidity and incidence of long-term opioid use and opioid related harm. Patient care is hampered by difficulties translating mainstream work practices to meet the specific needs of Aboriginal or Torres Strait Islander clients, with a lack of cultural understanding. There must be system-wide recognition of the role of culture and community in the healing process. This will support continuous quality improvement in the deprescribing process. The RANZCP therefore welcomes the guidance to respond to the unique needs of Aboriginal and Torres Strait Islander peoples through care that is culturally suitable. The provision of useful resources for clinicians on this matter is another positive inclusion to the guideline. The inclusion of people from CALD population and their unique healthcare barriers (language difficulties, health literacy, lack of cultural relevance and appropriateness of treatment programs, concerns about trustworthiness and inclusivity of mainstream services, fear of consequences of service involvement) is a similarly beneficial inclusion to the draft guideline. The RANZCP welcomes the consideration of the Australia's multi-cultural and multi-lingual society, and the disparities in opioid treatment across racial/ethnic minority residents. Considering such social determinants of health, the guideline's focus on ways to optimise the care of CALD populations in the context of opioid deprescribing is applauded. Such permutations within the guideline will support clinicians to offer person centred care, tailoring services to allow CALD communities to overcome barriers of equitable access to treatment.	

		Rurality	The RANZCP supports the guidelines consideration of the unique health outcomes and care needs of rural and remote communities, in this case an increased prevalence of pain condition and long-term opioid use. Clinical guidance that is aware of the social determinants of health within rural communities allows health practitioners to learn and tailor the model of care where applicable. Considerations of the relative scarcity of pain management health services within rural areas compared to metropolitan areas is another apt inclusion to the guideline. This inclusion will support health practitioners to provide patient centred care that is reflective of the healthcare barriers that rural patients and their care systems encounter (limited infrastructure and recreation opportunities, larger geographic distances, limited transportation and reduced access to health services).	
		Consumers with Mental Health Conditions	Considerations of people with mental health conditions across all recommendations would improve the efficacy of the draft guideline. Major depression is the most common mental illness associated with chronic pain, whilst high rates generalised anxiety disorder, post-traumatic stress disorder and substance misuse have also been described. In patients with chronic pain presenting for treatment, the prevalence of major depression is 30%–40%. Chronic pain has psychological component. It is therefore important when deprescribing opioids, especially those with high dose, guidance considers the high risk of opioid addiction from those with mental health conditions. The guideline could be improved with further consideration of how these multiple care needs interact. This includes concomitant medication for mental conditions, often prescribed by psychiatrists. The RANZCP suggests that the guideline recommend a multidisciplinary approach for health practitioners to achieve a better understanding of the patient, liaising with mental	Noted. A section on 'Individuals with Mental Health Conditions' has been included in the 'Population Considerations'.

			health professionals to deduce the reasoning behind his use of this medication, and any other concerns worth noting. Noting the scope of the evidence-based guidelines, the RANZCP suggests a more holistic and interdisciplinary approach that provides health practitioners with the guidance required to address these complex mental health comorbidities within patients deprescribing from opioid analgesics. This guidance should include both pharmacological and psychiatric/psychotherapeutic care models and other support services, which include but are not limited to cognitive behavioural therapy, psychotherapy, diet and exercise coaching, conflict counselling. Guidance should also note interactions between opioid abuse with trauma, with more attention to trauma informed care and trauma specific treatments. The expertise of addiction psychiatrists is of particular use when providing guidance on deprescribing opioids for people with mental health comorbidities, considering both the addictive nature of opioids and addiction psychiatrists' experience dealing with symptoms of withdrawal. The RANZCP offers its support to the Guideline Development Group in this regard. Members have drawn RANZCP's attention to the Agency for Clinical Innovation Network, which provides a range of resources for health practitioners to assess and manage the psychological dimension of chronic pain.	Noted. We acknowledge that these would be valuable additions, however inclusion of a detailed deprescription of psychiatric/psychotherapeutic care models and other support services is outside the scope of this current guideline. Noted. Thank you for providing these additional resources – they have been included under the practice points for Recommendation 1. Referral pathways to addiction psychiatrists have been flagged in Recommendation 6 and 9.
26	Organisation Australian Psychological Society (APS)	Overall	The Australian Psychological Society (APS) is pleased to provide a response to the consultation regarding the Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics (the guideline). Despite little evidence supporting extended use of opioid analgesics to treat non-cancer pain[1], many patients use such medication in spite of significant long-term risks[2]. This is particularly problematic given the availability of alternative evidence-based approaches such	Noted.

			as psychological treatment[2–4]. The APS supports the responsible, evidence-based deprescribing of opioids for appropriate patients in favour of alternative evidence-based pain management techniques. We also commend the development of the Guideline as an attempt to support general practitioners to deprescribe these analgesics in suitable patients safely. The APS embeds social impact and sustainability in our operations, advocacy, and initiatives guided by the United Nations global Sustainable Development Goals (SDG)[5]. We consider the responsible use and discontinuation of opioid analgesics is an important global healthcare challenge, as despite consumption decreasing between 2009-2019, there is still work to be done to reduce opioid misuse worldwide[6]. Given this, the development of the Guideline goes some way toward SDG 3: Ensure healthy lives and promote well- being for all at all ages[7]. In this submission, the APS has endeavoured to provide a response that highlights the most salient issues and recommendations from an evidence-based psychological perspective. In preparing our response, we consulted broadly across our national membership of psychologists, some with highly specialist knowledge relevant to the area. Although we appreciate the very bounded and focussed nature of the guideline, we suggest that there may be a missed opportunity to promote a biopsychosocial[8,9] model of pain to support patients on their deprescribing journey or, ideally prevent certain patients from taking opioid analgesics in the first place. Although evidence may still be emerging to support the best approaches to reducing opioid use, research suggests that "risk-targeted psychosocial interventions improve medication use outcomes[10](p. 385)". Psychologists are therefore well placed to assist General Practitioners (GPs) in supporting their patients to deprescribe opioid analgesics.	

			In consultation with our members and consideration of the development of the Guideline, the APS recommends:	
		Background	Greater focus on prevention and early intervention – first and foremost, given the risks and high rates of hospitalisations11 associated with opioid use, and the strength of evidence in favour of, for example, Cognitive Behavioural Therapy (CBT)[3] for pain management, it is essential that the guideline urges practitioners to consider alternative non-pharmacological pain treatment and management techniques as first line treatments. Although page 23 of the guideline clearly defines the decision to initiate opioid use as being outside the scope of the document, this represents a lost opportunity to: reduce unnecessary opioid prescription, and provide support to GPs by including the full context of the decision-making process. As suggested in the guideline, we agree with including an acknowledgement that opioid prescription may not be the best fit for every patient as the first recommendation, and referring GPs to the "relevant clinical practice guidelines" (see p. 23) to assist in determining the suitability of these analgesics. Furthermore, recent evidence indicates pain medication beliefs and pain catastrophising is linked with opioid use[10]. Importantly, this research suggests that early psychological co-intervention may help to improve opioid use outcomes[10].	Noted. Advice about the management of pain was outside the scope of this guideline. For any guideline, decisions need to be made about the scope/what clinical questions to include to ensure that the guideline can actually be completed. We are also cautious of providing incomplete information about pain prevention and early intervention and have recommend that end-users utilise existing pain management guidance for this purpose. The provided reference supporting early psychological co-intervention to improve opioid use outcomes[10] has been incorporated.
		Background	Greater emphasis on the psychological influences of opioid use and misuse – developed in the late 1990s[12], the term "yellow flags" was developed to describe psychosocial barriers or factors contributing to slower rates of recovery from musculoskeletal pain. Although conceptualisations have developed since this time[13], there is a need to consider the psychological factors that influence both pain and ultimately opioid use, high-dose use[10], and misuse[14].	Noted.

			There is currently no consensus as to the best way to measure psychological influences, however, the APS recommends the Committee consider the evidence[15,16] in support of, or against, available measures e.g. [17] as part of holistic patient-centred care. Further, we suggest screening for psychological risk factors and that they be factored into the deprescribing plan as psychological management may be indicated[9,12,13]. Psychosocial risk factors could be included in the guideline around page 24, when considering the patient's "benefit-harm profile".	Noted. We have modified the 'Deprescribing Plan' Section to included information about referrals to other healthcare professionals when developing and enacting a deprescribing plan. "A deprescribing plan should specify realistic and relevant goals of treatment, detail the intended process of dose reduction and identify potential supports that may be required throughout the deprescribing process. This may include involvement of other relevant healthcare professionals (e.g. psychiatrists, psychologists etc)."
		Guiding Principles and Executive Summary	Elevation of the role of psychologists – Given the psychosocial influences on chronic pain outcomes as described above, as well the psychological influences on opioid misuse14 and use10, psychological co- interventions may prove beneficial when deprescribing. In addition to considering pain beliefs and behaviours, over 44% of people with chronic pain also suffer from co-morbid depression or anxiety18. As regulated health professionals, psychologists use evidence-based approaches to help patients manage a number of psychological challenges2. Accustomed to working in an interdisciplinary fashion, psychologists are central to a shared, biopsychosocial treatment approach2.	Noted. Psychologists have been added to list of healthcare professionals for target audience and in practice points for referrals. The role of psychologists has also been highlighted in 'Population Considerations' under the section 'Individuals with Mental Health Conditions'.

			Patients who exhibit clear psychological risks should consult with a psychologist or other appropriate professional early to developed tailored approaches to reduce long-term disability or chronicity2,12,13. There are opportunities to elevate the importance and role of psychologists and the biopsychosocial model of pain in supporting patients during deprescribing opioid analgesics in the guideline such as in the "Guiding Principles" (p. 24- 25) and the Executive Summary.	
		Patient engagement	Role of patient education and empowerment - The APS emphasises the importance of patient education as a powerful tool for people to understand their experience and begin to feel empowered to improve their health2,19. Given this, we suggest that education be included as a co-intervention on Table 5 (p. 72), while acknowledging that evidence in this field may be still emerging e.g 20. We also note that the inclusion of the "proportion of population who ceased opioids" without further comment or context may result in treatment recommendations that are not tailored to the individual (e.g. from the table it appears as though the vast majority of patients would benefit from clonidine and benzodiazepines for opioid detoxification. Benzodiazepines, for example, have also been linked to serious outcomes e.g. 21).	Noted. We have not included 'education' as a co-intervention, as it was not identified within our evidence review as a studied co-intervention for opioid deprescribing. We do acknowledge that additional context is required for Table 5 and we have provided additional text to clarify this.
		Stigma	Importance of stigma reduction - The APS notes that the "contribution of psychological, social and psychiatric factors should not lead to the conclusion that a pain syndrome is primarily psychogenic22(p. 6)". It is important to emphasise both psychological and physical experiences of pain and that a holistic approach must address both. In addition to beliefs about the origins of pain, evidence suggests that over 72% of US respondents believed that people who are addicted to prescription opioids either lack self-discipline or are to blame for the problem (or both), despite the highly addictive nature of the drugs23. These stigmatising beliefs may create substantial barriers when accessing psychological and other treatments24.	Noted. The section on 'stigma' has been expanded to include additional information provided.

			We commend the inclusion of stigma as an important consideration in the guideline (e.g. p. 83) and suggest that psychologists may be able to assist in the reduction of perceived (or self) stigma for individuals and contribute to public health stigma-reducing initiatives.	
		Rurality	Greater consideration of support for Australians in regional and remote communities – The Australian Institute of Health and Welfare report that the highest (population-adjusted) rates of opioid dispensing is in inner- and outer- regional areas[11]. Given this, it is important that adequate support is given to Australians outside of metropolitan regions to deprescribe and seek alternative treatments. In recent times, this need has been exacerbated by the inaccessibility of pain management centres due to the COVID-19 pandemic[25]. Ideally, the guideline should consider telehealth or other treatment options while acknowledging more research in this area is needed[25].	Noted. This section has been extrapolated on, as suggested.
		Importance of interdisciplinary teams	The APS commends the inclusion of Recommendation 10 in its promotion of ”interdisciplinary or multidisciplinary care, or a multimodal approach which emphasises non-pharmacological and self-management strategies to deprescribe opioids” (p. 53). However, we suggest that it is elevated to be amongst one of the first recommendations, given the importance of involving other health professionals throughout the deprescribing process2,26,27.	Noted. We have selected the order of the recommendations to reflect the key clinical questions. We have first provided recommendations on ‘when’ to deprescribe, followed by ‘how’ to deprescribe.
		Expectations of the use of the document	It is important to acknowledge that GPs are time-poor and have to balance many competing demands and priorities see 28. Introduction of the guideline will not be the “magic bullet29(p. 530)” for every patient and practice and should not replace appropriate training and a strong interdisciplinary approach. Given the lengthy and detailed nature of the guideline, it is likely that some practitioners will only refer to the summary on an ongoing basis. It is essential, therefore, that some of the biopsychosocial and	Noted. We are developing additional guideline resources to ensure that the guideline in acceptable and useful for end-users. We are planning to publish a guideline summary in a peer

			interdisciplinary approach be integrated into the Executive Summary in an easy to digest, accessible format.	reviewed journal and develop an implementation toolkit with resources to aid in implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources. We are currently collaborating with end-users to develop these resources and test their usability in clinical practice.
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27	Individual responses compiled by Organisation The Royal Australasian College of Physicians (RACP) Australasian Faculty of Public Health (AFPHM): Respondent 1		Thanks for the opportunity to comment on this draft guideline on an important issue. While I agree strongly that this is a priority issue, my concern is the lack of system supports to actually put these guidelines into place. Recommendations and Guidelines that clinicians feel are impossible to implement are likely to undermine efforts in this area, which is especially concerning as this is primarily for a patient cohort who at baseline are likely to experience high levels of clinician counter transference and social and health inequities. The gap between work as imagined and work in practice worries me. The two recommendations where I am most concerned about this are 1 and 6 - the majority of opioid initiation is not done in the multidisciplinary pain or addiction specialist setting. Rather, as recognised elsewhere in the guideline this occurs primarily in primary and emergency care, and following hospital admission. I'd be very interested to learn about the engagement with prescribers in these settings in considering the feasibility of implementing recommendation 1 in practice. It appears the evidence for this is largely consensus driven. I would like this recommendation to either include or be accompanied by evidence-based advice on how best practice implementation should occur, with appropriate training and supports. As ever, I am concerned about any additional workload for GPs amidst the current rebate setting where this kind of complex interaction and care is disincentivised. Similarly, the lack of availability of specialist addiction and pain services is likely to hamper recommendation 6 in practice. There is a substantive wait list for these patients in metropolitan areas and very limited service availability in rural and regional areas, where GPs are often leading and managing opioid replacement care. This is also a conditional recommendation with the possibility of commencing deprescribing by GPs, which is a little confusing. I think that exploring in greater	Noted. We plan to work with relevant organisations in implementing this guideline and will endeavour to evaluate the impact of the guidelines once released. Difficulties in accessing care and treatments have been considered in the evidence-to-decision framework when developing the guideline recommendations and have been highlighted throughout the guideline document. Consensus recommendation were provided when there was insufficient evidence to make an evidence-based recommendation.

			detail the types of clinical contexts where this might be considered is an important factor given the service inadequacies and inequities outlined above. There is an unfortunate cycle around the evolution of chronic pain and addiction affecting people who experience socioeconomic inequities and I think that inaccessible non-opioid treatments including physiotherapy, specialist pain management and addiction services are likely to hamper voluntary engagement with de-prescribing and continue to drive initiation of opioids, and none of this falls within the scope of this document. Perhaps these drivers should be considered given their interplay in providing holistic patient-centred care.	
	Individual responses compiled by Organisation The Royal Australasian College of Physicians (RACP) Australasian Faculty of Public Health (AFPHM): Respondent 2		I agree with the comments from Respondent 1. In addition, it would be useful to see economic analysis of benefits of implementing these challenging recommendations. They likely are cost negative and if this realisation led to funding streams then disadvantaged communities may reap the benefit. Working at the remote Aboriginal /hospital interface too often I see patients discharged from emergency departments with Endone but no clear diagnosis. If opioids had stewardship like antibiotics, and specialists (telehealth) consultation was required then funding may flow and outcomes improve. Other recommendations hinge critically on recommendation 1, and avoiding inappropriate opioid prescribing at the outset.	Noted. An economic analysis was outside the scope of this guideline. The purpose of this guideline is for use in primary care specifically, and relates to opioid deprescribing, rather than prevention of opioid initiation. We have provided reference to the recently released Australian Commission on Safety and Quality in Health Care - Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard, which may be directly relevant to this feedback.
	Individual responses compiled by Organisation		This is a very important issue for the Chapter of Addiction Medicine and for medical practice in general. One of the AChAM's Evolve recommendations is “Do not deprescribe opioids in patients with chronic pain and opioid dependence”. This recommendation does	Noted. The AChAM’s recommendation to “Do not deprescribe opioids in patients with chronic pain and opioid

	The Royal Australasian College of Physicians (RACP) Australasian Chapter of Addiction Medicine (AChAM): Respondent 3		not of course cover patients who have no history of opioid dependence and don't develop it from taking prescribed opioids. My interpretation of the deprescribing literature (largely from the US) is less favourable than is indicated in the evidence review and recommendations, including the systematic review by Mathison et al. My view is that efforts to reduce inappropriate opioid prescribing and avoid consequent morbidity and mortality necessarily involve the regulatory authorities (in NSW the Pharmaceutical Regulatory Unit). With the current recommendations, there could be a lot of effort by general practitioners leading to minimal benefits and potentially compromised patient care, including perpetuation of opioids in patients with opioid dependence where this is missed. I would also have expected this to be a GP- or at least medically-led exercise.	dependence" mirrors the guideline content.
	Individual responses compiled by Organisation The Royal Australasian College of Physicians (RACP) Australasian Chapter of Addiction Medicine (AChAM): Respondent 4		I share Respondent 3's concerns about these guidelines. I have a background in guideline development both in Australia and for the World Health Organisation. There are no Australian NHMRC guidelines on this issue, so this is an area in which it would be useful to have such a document. Overall, the guidelines recommend that people who are not demonstrating clinical benefit from opioids (the assessment of which is somewhat unclear), or who have specific side effects (a small number are mentioned - some like overdosing on opioids are not covered), should gradually reduce their opioids in a consensual manner. While this sounds eminently reasonable and patient friendly, we know this gradual reduction is a challenging process and often results in never-ending plans for reduction. The draft Guideline's own evidence summary shows that it rarely produces the desired outcomes. I have a number of concerns about the process of their formation, the questions it addressed, and the interventions that have been considered and those that haven't. Regarding the process, the most important omission is the conflict of interest declarations within the Draft Guideline. The draft includes a	Noted. Guideline Development Group members COI's have all been

			statement saying that everyone made declarations, however it is not stated which conflicts were considered acceptable and who made the decision. Given that the guidelines recommend a relatively weak intervention (gradual consensual dose reduction),it is important to show there is no industry influence in this process. The methodology of the guideline development is not specified in sufficient detail in the draft. While it describes itself as an evidence-based guideline, the process of health technology assessment was not described. Normally an evidence-based guideline would list a number of key clinical questions and then there would be an attempt to systematically review the evidence for each question. If a recent systematic review had been conducted, this systematic review would be assessed according to GRADE methodology. While the guideline says it uses GRADE, in my experience GRADE is only applied to systematically reviewed evidence. Whilst the draft states that a "systematic review of international guidelines" has been submitted for publication, a review of guidelines is not a systematic review of the evidence. A review of systematic reviews can be considered a systematic review of the evidence however, it does not appear to have been done. Some of the key clinical questions (and practical administrative questions) appear not to have been addressed in these guidelines: • In what situations are the benefits of continuing opioids greater than risks (this will define the population for deprescribing)? • In which situations is urgent deprescribing required (i.e. high risk overdosing situations, i.e. person has presented to hospital following an opioid related adverse event)? • How should rapid opioid cessation be managed (i.e. comparing opioid detoxification, transfer to buprenorphine, inpatient vs outpatient)? • What is the role of transferring to high dose buprenorphine as opposed to deprescribing opioids? • How to transfer to high dose	transparently reported in the Administrative report which was available during public consultation. This is in accordance with the requirements of the NHMRC. We note that the 'relatively weak intervention (gradual consensual dose reduction) reflects the available evidence. Full details of the systematic process for evidence synthesis and review has been documented in the Technical report. GRADE methodology has been utilised. The "systematic review of international guidelines" is an appendix and is not the evidence review conducted to develop the guideline recommendations. We note the suggested additional key clinical questions, however these are largely outside the scope of this opioid deprescribing guideline. For any guideline, decisions need to be made about the scope/what clinical questions to include to ensure

			buprenorphine from high doses of opioids? • How to deal with the mismatch between patient preferences (i.e. more opioids) vs clinician concerns (i.e. stop opioids due to safety concerns)? • How to handle the inherited patient? • Is it ok not to prescribe opioids for non-cancer pain? Some interventions were missing from consideration: • High dose buprenorphine as an alternative to gradual reduction • long-acting buprenorphine injections • Inpatient detoxification • Specific inpatient techniques such as accelerated detoxification with a degree of sedation (ranging from ketamine infusions to general anaesthesia) • How to initiate methadone and buprenorphine in people with opioid dependence Overall, I think the draft guideline is not "evidence based", it does not address many of the questions needed and could be substantially improved. I suggest adding a more transparent declaration on conflict of interest, removing "evidence based" from the title, and convening the panel of experts for consensus recommendations on some of the issues raised above.	that the guideline can actually be completed. We acknowledge that many of the suggested questions are valuable and could be considered in a future guideline. Specific suggested interventions were not identified in the evidence review. The term 'evidence-based' relates to the robust process of guideline development which was grounded in and driven by evidence, rather than the certainty of evidence for particular recommendations. The evidence-based development process included a systematic retrieval and analysis of evidence and use of GRADE methodology to determine the certainty of evidence. The certainty of the evidence informing each recommendation has been transparently reported. In the absence of RCTs, we used lower levels of evidence including expert opinions to

				form low or consensus-based recommendations.
	Individual responses compiled by Organisation The Royal Australasian College of Physicians (RACP) Australasian Chapter of Addiction Medicine (AChAM): Respondent 5		I find Respondent 4's arguments hard to fault. There is another bit that's missing from the draft Guideline. I attended a pain symposium two weekends ago and the anaesthetist made some interesting comments about high opioid dose patients and trying to manage their post-operative pain. The predictable linear dose response curve that occurs at lower opioid doses completely disappears. They gave the example in post knee-replacement surgery, where pain management is near impossible. The anaesthetists were advocating de-prescribing to a level preoperatively so as to create a more viable therapeutic window. In the end we need to be clear about the goal of the therapeutic intervention and make that clear to the patient. Without their buy-in, it's going to be a wicked problem.	Noted. The role of pre-operative opioid deprescribing has been flagged as an area for future research. This guideline has emphasised the need for shared-decision making for opioid deprescribing decisions.
	Individual responses compiled by Organisation The Royal Australasian College of Physicians (RACP) Australasian Chapter of Addiction Medicine		I note comments from Respondents 3, 4 and 5. I have the following concerns about the draft Guideline: • Group composition: The Guideline Development Group comprises self-appointed experts who no doubt have expertise but are self-appointed and do not represent stakeholder groups such as AChAM and there is only one consumer representative. That would not be a usual NHMRC Guideline development process. Also, from what I can see, these experts are largely drawn from one institution. • The recommendations: Most of these are not evidence-based recommendations, they are mostly consensus statements: Recommendation 1: Since there is no evidence that deprescribing plans actually work. and almost no experience of them being used in Australia, it is not clear why this recommendation is included. Recommendations 2 and 3: Most patients are long term patients. How does one assess whether there has been "clinically meaningful	Noted. The guideline development group represented a broad range of clinicians, researchers, methodologists and a consumer, in accordance with NHMRC guidance. Our guideline group members represent a range of institutions both in Australia and Internationally. We intentionally sought additional input from Organisations such as RACP (AChAM) through the public consultation process.

	(AChAM): Respondent 6		improvement" with opioids compared to pre-opioids if, for example, a patient commenced taking opioids prescribed by another doctor 8 years ago? It is also important to address the issue of whose therapeutic goal needs to be met (i.e. the doctor's or the patient's). This is easy when the therapeutic goals of the patient and doctor align but difficult when they don't. Recommendation 4 – I have some significant concerns about this recommendation. I appreciate that there can be risks of adverse events with opioids but they are only risks and they can be modified by dose reduction or opioid rotation without needing cessation (e.g. sleep apnoea). As for other sedative use, the POINT study tells us that over 50% of patients are on long term opioids and co-morbidities are common amongst these patients who tend to be the biggest 'chemical copers' and most resistant to dose reduction. In addition, it is not clear why this recommendation focuses on prescribed doses greater than 60-100mg oral morphine equivalent daily dose. I understand the epidemiology, but patients are not statistics, having an increased odds ratio of harm from 'big data' that 100mg has worse population outcomes than 50mg does not mean that everyone on 100mg is 'bad', but OK if on '50mg'. That is a disconnect in understanding epidemiological risk and patient care. Recommendation 6 - For those with OUD the Draft Guideline recommends transfer to methadone / BPN. However, given there is no evidence for this as there are no trials suggesting methadone or BPN OAT programs are safer or as effective as morphine or oxycodone for chronic pain management, it is not clear why this recommendation is included. There is little or no high-level evidence that a patient treated with 100mg morphine has worse outcomes than a patient treated with 24mg Suboxone. And the implications for the patient need to be taken into account – daily attendance at a pharmacy paying $40 a week and associated stigma which the Draft Guideline makes no mention of at all. Transfer to OAT is fine if your goal is to treat opioid dependence. but what about treating the	We acknowledge that our guideline development group has limitations and for future updates of the guideline, we will endeavour to broaden involvement. The term 'evidence-based' relates to the robust process of guideline development which was grounded in and driven by evidence, rather than the certainty of evidence for particular recommendations. The evidence-based development process included a systematic retrieval and analysis of evidence and use of GRADE methodology to determine the certainty of evidence. The certainty of the evidence informing each recommendation has been transparently reported. In the absence of RCTs, we used lower levels of evidence including expert opinions to form low or consensus-based recommendations. We have emphasised the importance of shared decision making when developing a

			patient's pain and opioid dependence? In addition, Australian research (POINT study) tells us 15-20% of patients meet moderate-severe OUD criteria (these tend to be the high dose high problem patients who we most need to address their opioid use). So the impact of this recommendation would that 15-20% of long term opioid patients for pain be treated with OAT which would more than double the number of patients in OAT in Australia in a context where there are shortages of OAT prescribers. This raises genuine concerns about the feasibility of such a recommendation. Furthermore, recommending transfer to OAT can become a "dump and run exercise" (i.e. "you are addicted so go to an addiction doctor to treat you") – and compounded by the stigmatising effects of such a recommendation, because when the patient looks up what Suboxone is indicated for – they do not see pain management – they only see addiction on the label. Recommendation 7: Reducing doses by 10-25% every 4 weeks is not consistent with my experience of treating high dose long term opioid patients. My experience of high dose deprescribing efforts is that it takes many patients >12 months to come off (some do quicker – but by no means most). I can never recall bringing a long-term high dose patient off all opioids in 4 months. The Draft Guideline also does not cover withdrawal management for patients coming off opioids, or the common rebound in pain severity upon discontinuation of opioids. General points: I have no problem with voluntary deprescribing for patients. As long as it is voluntary. But in that regard, I question the need for a guideline that is essentially consensus-based as there is so little evidence supporting most of these recommendations that tell us to voluntarily deprescribe. The Draft Guideline makes no mention of approaches to reduce opiate risks that are not just about deprescribing and does not cover treatment agreements, staged supply, regular monitoring for aberrant behaviours such as UDS,	deprescribing plan and have provided links to validated tools for monitoring clinical outcomes. In response to concerns about translating 'big data' to patient care, we acknowledge that clinical judgement is required when applying recommendations. We have included the following statement to highlight this concept: "We present recommendations for clinicians to consider within the context of each person." Further, our wording of this recommendation is "we suggest considering". Recommendation 4 has been reviewed and updated. Recommendation 6 is consistent with the evidence-base for individuals with opioid use disorders. There is a specific guideline section on 'Stigma'. We acknowledge concerns related to the implementation of guideline recommendations.

			RTPM of medications from other doctors. Deprescribing is not the only solution – yet the only one offered here. I also concur with Respondent 3's assessment that the risks and harms of deprescribing are not put forward in a balanced manner. The risks are well documented in the US literature, where deprescribing started 5-10 years before us. The harms are stigmatisation and distress for patients, distress for doctors, diversion to illicit markets (e.g. fentanyl),for increased suicide and death and not necessarily better pain outcomes (some patients DO get better pain outcomes, but not universal – estimated at <50% of patients benefit in some studies I have seen).	We plan to conduct ongoing monitoring of the relevance, acceptability and impact of guideline recommendations in clinical practice. We agree that opioid deprescribing is not the only solution, however it is the focus of this guideline and hence, recommendations contained within this guideline relate specifically to opioid deprescribing. We note there is a guideline section on 'Opioid Withdrawal'. We have provided references to relevant studies examining the harms of opioid deprescribing. The guideline group will review any additional references provided during public consultation and consider their eligibility for inclusion in the guideline.
28	Organisation Painaustralia	Overall	Painaustralia welcomes the opportunity to provide input into the Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics Draft Guideline. Painaustralia is the national peak body in Australia working to improve the quality of life of people living with pain, their families, and carers, and to minimise the social and economic burden of pain. Our members include pain and other	Noted.

			specialists, health practitioners, health groups, consumers, and researchers. We appreciate the opportunity to contribute input into this draft guideline. We have consulted with our consumers and received feedback which has guided our submission.	
		Page 20 – Background	Painaustralia recommends including the terms 'accessible' and 'affordable' in the final sentence of the first paragraph with regards to pain management services , as accessibility and prohibitive costs are two major barriers which prevent consumers with chronic pain from utilising pain management services.	Noted. This has been modified as suggested.
		Page 29 - Guideline Development Group members.	The lack of consumer representation within the group is concerning as there is only one. While there are 17 members of the Guideline Development Group, there is only one consumer representative. As the elected consumer has a medical background, their perspective may be different from diverse consumer representatives with lived experience. Painaustralia encourages the inclusion of specific consumer cohorts - such as those living in rural and remote communities, to demonstrate understanding of consumer concerns and issues spanning across a wide selection of demographics.	We note the concern. We attempted to have consumer input throughout guideline development, having conducted a comprehensive qualitative study to inform the guideline content and scope (including consumers across a range of demographics). Additionally, we had an active consumer representative with lived experience as a member of our guideline development group. We appreciate that the consumer representative on the guideline development group is not representative of the lived experience of all consumers. Finally, we consulted with a range of consumer organisations and

				individuals throughout public consultation. We would value the opportunity to work with consumer organisations such as Painaustralia further through the development of guideline resources for consumers.
		Page 37- Recommendation 1	It is important to include the specific mention of the importance of allied health professionals for evidence-based non-opioid treatment modalities. It is imperative that there is explicit information for health professionals to be able to support consumers who need to taper off opioids safely, such as education and access to pain management specialists. The Guideline should make it a priority to ensure that the deprescribing process is a decision taken in full consultation with the consumer, with the clinician taking adequate time to discuss the individual personal circumstances.	Noted. This has been included in a Practice Point for Recommendation 1. Noted. Noted.
		Page 39- Recommendation 2	Information regarding referral to allied health professionals, and discussion of alternative pain management options are important to include within this recommendation.	Noted. This recommendation does not relate to 'how' to deprescribe opioids. As such, this information has not been included in this section.
		Recommendation 8	It is necessary to include the tailoring of deprescribing plan based on the person's clinical characteristics, goals, and preferences within this recommendation.	Noted.

		Page 51- Recommendation 9	It is important for this recommendation to include that deprescribing should be carried out with the understanding of the cost of alternative treatments for the consumer.	Noted. We have encouraged consideration of the cost of alternate treatments in Recommendations 10 and 11.
		Other consumer input	Recommendation about the use of avoiding stigmatising language. Consumer feedback that involuntary opioid deprescribing should not be undertaken except in extraordinary circumstances where the patient is in danger of imminent serious harm e.g., recent overdose.	Noted. We have not developed a recommendation pertaining to avoiding the use of stigmatising language, however there is a guideline section on 'Stigma' and practice points contain information about using non-stigmatising language. A Practice Point for Recommendation 8 states: "Opioid deprescribing should, where possible, be voluntary in nature with the deprescribing plan mutually agreed upon by the person taking the medication and the healthcare professional to facilitate person-centred deprescribing. This may involve discussions around which medications will be decreased first or the rate of taper. The plan may be adjusted over time to meet the person's ongoing needs." Our guideline development group feels it is important to

				encourage voluntary opioid deprescribing. The evidence informing the benefits and harms of opioid deprescribing which demonstrated improvements in pain, function and quality of life were largely derived from studies involving voluntary opioid deprescribing. Evidence of increased harms (suicide, overdose, illicit opioid use) in the context of involuntary opioid deprescribing informed the need for voluntary opioid deprescribing where possible.
29	Government Department Victorian Department of Health	Overall	Page 5: Glossary. Suggest include description of 'co-intervention', to clarify its meaning when first encountered in the text. Page 23, describing the target population. The draft includes a target problem that includes "cancer-related" but suggest you include "cancer survivors", as this is a distinct group within the "cancer-related" group that might be more suited for consideration of opioid deprescribing, given that there may be psychological considerations sustaining and confounding the understanding of opioid use in the treatment of pain, resulting in clinically inappropriate continued opioid analgesic use. Prior experience of pain due to cancer or its treatment may also influence the cancer survivor's perception of pain. Pain is common problem in cancer survivors either due to the cancer itself or to its treatment, but because many cancer survivors now live longer than 10 years there is concern about the long-term	Noted. Modified as suggested. Noted.

			adverse effects of opioids and the risks of misuse, abuse, and overdose in the nonpatient population[1]. Substance use or misuse such as that involving tobacco, alcohol or injecting drug use are risk factors for several cancers, so there may be a high prevalence of cancer survivors with a history of substance misuse who would be vulnerable to inappropriate use, or misuse of opioid analgesics. There is also concern about the potential adverse effects in cancer survivors of prolonged use of opioids that may complicate recovery, such as sedation, cognitive impairment, tolerance, potential immunomodulation and endocrine dysfunction[2]. Peripheral neuropathies are a major cause of pain in cancer survivors, and pain following chemotherapy or surgery often has neuropathic features[3]. Treatment with agents specific for neuropathic pain may either be more useful or have an opioid sparing effect. Nociceptive pain tends to be more responsive to opioids, even though opioids may reduce neuropathic pain. Opioids seem to be more effective in intermediate term studies of up to 12 weeks, being mostly effective in peripheral neuropathic pain compared to supraspinal neuropathic pain and being least effective in central neuropathic pain[4]. Note: These comments relate to Recommendation 3 about cancer survivors.	Noted. Modified as suggested.

[1] Glare PA et al. Pain in cancer survivors. J Clin Oncol 2014;32(16): 1739–1747.

[2] Brown M. Farquhar-Smith P. Pain in cancer survivors; filling in the gaps. Brit J Anaesthesia, 2017;119: 723–36.

[3] Brown MRD et al. Pain in cancer survivors. Brit J Pain 2014;8:139-153

[4] Schembri, E. Are Opioids Effective in Relieving Neuropathic Pain?. *SN Compr. Clin. Med.* **1,** 30–46 (2019). https://doi.org/10.1007/s42399-018-0009-4.

			Suggested text: The target population of this guideline is adults (aged ≥ 18 years old) prescribed one or more opioids for any type of pain (e.g. acute, chronic, cancer-related (including cancer survivors), in end-of-life care). Page 37: Recommendation 1. The third practice point includes the text: "Optimisation of appropriate non-opioid pharmacotherapy may improve pain management and may have an opioid-sparing effect. Consider the use of evidence-based non-opioid pharmacotherapy where appropriate". Consider including the sentence: "Avoid sole reliance on opioids", as this recommends against what may be common practice, and reinforces the recommendation to use non-opioid pharmacotherapy. Use of the word 'avoid' also implies that there is prescriber discretion about whether to follow this recommendation. Page 39: Recommendation 2. The practice points for this suggestion to initiate deprescribing of opioids could mention the need to ask the patient or seek information about the person's experience of opioid overdose. At present it is common for opioid prescribing to continue following a non-fatal opioid overdose[5]. Experience of a non-fatal opioid overdose should rank highly as the single most important reason to consider deprescribing: overdose survivors have an increased risk of further non-fatal and fatal opioid overdose[6].	Noted. Modified as suggested. Noted. Modified as suggested. Noted. Modified as suggested. Noted.

[5] Larochelle MR et al. Opioid Prescribing After Nonfatal Overdose and Association With Repeated Overdose: A Cohort Study. Ann Intern Med 2016;164:1-9. doi:10.7326/M15-0038

[6] Larochelle MR et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. Ann Intern Med 2018; 169:137-145. doi:10.7326/M17-3107

			Page 41. Recommendation 3. See the previous comments about including cancer -survivors in groups targeted for consideration of opioid deprescribing. Note that pain following surgery or cancer chemotherapy often has features of neuropathic pain and may be more responsive to anti-neuropathic agents. Cancer survivors have an increased risk of suicide[7], and limiting access to lethal means of suicide is one of the few suicide countermeasures supported by evidence[8 9]. Page 46. Recommendation 6. This recommendation suggests the use of medication assisted treatment of opioid use disorder when appropriate, and refers to the national guidelines as a resource. Some jurisdictions provide for easier access for treatment of opioid use disorder by medical practitioners, by providing brief online advice about treatment of a limited number of patients without the need to attend educational sessions. In Victoria, medical practitioners can provide treatment with buprenorphine/naloxone for up to 10 patients without the need to undergo in-person training, by preparing themselves by reading a brief guide that can be accessed at: https://www.health.vic.gov.au/publications/brief-guide-to-prescribing-buprenorphine The recommendation also describes the potential to refer the patient for appropriate treatment. The notion of a 'warm' referral is	Noted. Information about 'warm referrals' has been included in the guideline.

[7] Osazuwa-Peters N et al. Suicide Risk Among Cancer Survivors: Head and Neck Versus Other Cancers. Cancer 2018;124:4072-4079.
[8] Barber CW et al. Reducing a Suicidal Person's Access to Lethal Means of Suicide: a research agenda. Am J Prev Med 2014;47(3S2):S264–S272.
[9] Krysinska K et al. Best strategies for reducing the suicide rate in Australia. Aust NZ J Psychiatr 2016;50(2):115–118. DOI: 10.1177/0004867415620024

			emerging in the literature and describes a process of the health provider arranging an appointment and taking care to ensure that the potential fellow practitioner or specialist is contacted, and the person is provided with correspondence explaining the person's medical history and the reason for referral[10]. A warm referral may be more likely to ensure that transition of care for a patient with opioid use disorder for appropriate treatment than if the patient themselves have to make arrangements without assistance. Page 51. Recommendation 9. Is it worth discussing the findings and description in the article by James et al.2019[11] that in their discussion of the deaths associated with deprescribing, speculated that "This study's finding that overdose death was increased in patients discontinued from COT could relate to interruption of other medical care, loss of tolerance, and/or destabilization of an underlying opioid use disorder". Monitoring the patient or assessing these factors that could contribute to the risk might be worthwhile. Page 62. Number of surgical discharges in Australia. You describe: "In the Australian context, studies have shown that a small percentage of the population who initiate opioids post-surgically transition to chronic use (1.3-10.5%).164-167 However, given the frequency at which surgical procedures occur, a large number of people may be affected".	Noted. We have referenced specific relevant monitoring practice points in Recommendation 9. Noted. Additional information on post-surgical opioid prescribing and use has been included in the Summary of Evidence which informs Recommendation 1.

[10] Ahmed OM et al. A scalable, automated warm handoff from the emergency department to community sites offering continued medication for opioid use disorder: Lessons learned from the EMBED trial stakeholders. J Substance Abuse Treat 2019;102:47–52.
[11] James JR et al. Mortality After Discontinuation of Primary Care–Based Chronic Opioid Therapy for Pain: a Retrospective Cohort Study. J Gen Intern Med 2019 DOI: 10.1007/s11606-019-05301-2

Urgency	Public hospitals	Private hospitals	Total
Emergency	316,292	49,057	365,349
Elective	778,080	1,522,548	2,300,628
Not assigned or reported	87,878	30,468	118,346
Total	1,182,250	1,602,073	2,784,323

You could provide a number to reinforce the importance of post-surgical opioid prescribing in contributing to the number of patients receiving chronic opioid treatment for non-cancer pain.

Lalic et al described the prevalence and initiation of use of opioid analgesics prescribed through the Australian Pharmaceutical Benefits Scheme (PBS)[12]. They found that about 3 million adults used opioids and more than 1.9 million adults initiated PBS opioids use each year. About half were initiated by general practitioners, but 25% were initiated by surgeons (6.6%), interns (8.3%) or anaesthetists (10.1%), suggesting that a substantial proportion of opioids were initiated in hospital, and a large proportion following postoperative discharge.

The New Zealand Health Quality and Safety Commission reports that almost half of those people dispensed a strong opioid had a possible 'trigger event', attending a public hospital as an inpatient or outpatient in the week prior, suggesting these prescriptions are generated in hospital[13].

[12] Lalic S Ilomaki J, Bell JS, et al. Prevalence and incidence of prescription opioid analgesic use in Australia. Br J Clin Pharmacol (2019) 85 202–215.

[13] Health Quality & Safety Commission. Atlas of healthcare variation. Opioids. Updated October 2019. http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcarevariation/

			There were 2.8 million hospital separations with a surgical AR-DRG in Australia in 2018-19, the last financial year prior to the current pandemic, most of which (1.6 million, 58%) occurred in private hospitals (see table). If the proportion of these separations were like that described by Allen et al, 2020 (59%), this would account for a substantial proportion of opioid initiation in Australia[14], keeping in mind that many of these patients may have already been prescribed opioids prior to surgery. Table: Separations with a surgical AR-DRG: Australia, 2018-1915 It might be useful to refer to a recent article describing opioid treatment of post-operative pain, including the possible mechanism of persistent post-surgical pain[16]. It refers to a study of subjects in Tromso, Norway that revealed that chronic post-surgical pain accounted for approximately a third of chronic pain cases in the community[17]. Given that this section suggests developing and implementing a deprescribing plan for persons being prescribed opioids at the point of opioid initiation, then the moment of discharge from hospital after surgery, with opioids for post-surgical pain, would seem to be an important moment in the patient's clinical journey to implement this plan, or at least communicate this to the patient and managing the transition of care to the patient's general practitioner.	Noted. Reference to the new Standard has been included in the guideline.

Opioids. (accessed 10/3/2021).

[14] Allen ML et al. Post-discharge opioid use and handling in surgical patients: A multicentre prospective cohort study. Anaesthesia Intensive Care 2020;48:36–42.

[15] Source: Australian Institute of Health and Welfare. Admitted patient care 2018–19: Australian hospital statistics. https://www.aihw.gov.au/reports-data/myhospitals

[16] Glare P, Aubrey KR, Myles PS. Postoperative pain management and opioids 1: Transition from acute to chronic pain after surgery. Lancet 2019; 393: 1537–46

[17] Johansen A, Romundstad L, Nielsen CS, Schirmer H, Stubhaug A. Persistent postsurgical pain in a general population: prevalence and predictors in the Tromso study. Pain 2012; 153: 1390–96.

			This might be something to communicate to the Australian Commission on Safety and Quality in Health Care which is in the process of developing a National Opioid Stewardship Program largely centred on hospital practice[18]. Page 64: discussion of Recommendation 4 (Consensus) which suggests considering deprescribing for individuals taking opioids for chronic pain with one or more of the following clinical characteristics: a) Sleep-disordered breathing or sleep apnoea b) Chronic obstructive pulmonary disease (COPD) When discussing the mechanism of opioid overdose death you have concentrated on the role of respiratory depression in patients with these disorders, it would be good to refer to opioid-induced ventilatory impairment (OIVI), which recognises that opioid overdose deaths often involve collapse of the upper airway and obstruction of ventilation19, whereas formerly the traditional view has been that the main mechanism of overdose is respiratory depression. Page 65 where the depressant effects of combinations of depressant medications on risk of overdose, you describe: "Medications with sedative properties can potentiate opioid-induced respiratory and sedative effects, thereby elevating the risk for adverse events among those receiving long-term opioid therapy, such as falls, fractures, respiratory depression and fatal overdose". There is now clear evidence that respiratory depression is not the sole effect of combinations of depressant medications on	Noted. Recommendation 4 has been updated, however this information is still useful and has been incorporated into the summary of evidence. Noted. This has been updated to include mention of and reference to OIVI.

[18] https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-opioid-analgesic-stewardship-program-discussion-paper

[19] Macintyre PE et al. Opioids, ventilation and acute pain management. Anaesth Intensive Care 2011; **39:** 545-558.

			ventilation. There is also a high prevalence of airway collapse and obstruction of the upper airway in opioid overdose, whether due to opioids or to opioids in combination , and the term opioid-induced ventilatory impairment (OIVI)20 is more appropriate and inclusive of these different effects. Page 87: Prescription Drug Monitoring Programs (PDMP). You describe that "PDMPs may also encourage the continued prescription of opioids who are not identified as being at risk by the PDMP". You are correct in describing that PDMPs are a public health initiative designed to reduce harms associated with increased opioid prescribing by providing healthcare professionals with additional information about the supply of opioids at the time of prescribing. The last sentence in the paragraph describes that: "PDMPs may also encourage the continued prescription of opioids who are not identified as being at risk by the PDMP". PDMPs provide information about eh supply of monitored medicines to enable a more informed decision about further prescribing of opioids and other monitored medicines and may provide alerts about patient circumstances that may constitute a risk, but do not identify patients at risk or advise about whether or not to continue further prescribing. To clarify, instead of "PDMPs may also encourage the continued prescription of opioids who are not identified as being at risk by the PDMP", we suggest: "Information provided by PDMPs to prescribers and pharmacists about the supply of opioids and other monitored medicines to a	Noted. Modified as suggested, using the term 'individual' in preference to 'patient'.

[20] Macintyre PE et al. Opioids, ventilation and acute pain management. Anaesth Intensive Care 2011; **39:** 545-558.

			patient may fail to identify patients who may be at risk, allowing continued prescribing".	
30	Government Department Western Australian Department of Health		Thank-you for the opportunity for WA Health to provide stakeholder feedback on the consultation on Evidence-Based Clinical Practice Guidelines for Deprescribing Opioid Analgesics. WA Health provide in principle support for the broad objectives articulated in this document and have provided feedback for your consideration in Attachment 1. WA Health aligns with the principles outlined in the document for minimising harms of prolonged opioid use which is evident through our current review of opioid stewardship practices building on the work of the Sustainable Health Review 2019 and widespread engagement with the Choosing Wisely and National Prescribing Services MedicineWise resources. The Medicines and Technology Unit on behalf of WA Health have provided collated feedback after consulting with the Medicines and Poisons Branch, the Officer of the Chief Medical Officer, Office of the Chief Nurse and Midwifery Office, and Office of the Chief Allied Health Officer, as well as the WA Therapeutic Advisory Group, the WA Medication Safety Collaborative, and the WA High Value Health Care Working Group.	Noted.
		General Feedback Purpose	The purpose of this guideline developed by the National Medical Health and Research Council (NMHRC) is 'To assist healthcare professionals to determine WHO should be considered for deprescribing, WHEN to deprescribe and HOW to deprescribe'. The target audience is stated to be General Practitioners. WA Health recommend that the document is reviewed as to its length as this would be prohibitive to is uptake by the intended audience and some of the content is repetitive.	Noted. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid implementation. This will include both an algorithm for use by healthcare professionals, as well as

			To align with future workforce plans, more inclusive language should be used. For example, nurse practitioners are a growing workforce, and other specialties in primary health care, aged care mental health community palliative care and in rural/remote locations may be better suited to implementing and coordinating the deprescribing program. This guideline is intended only for the management of chronic opioid users in primary care and does not adequately emphasise the importance of clear management plans at the time of initial opioid prescription, which is the strongest predictor of chronic opioid use. The purpose of deprescribing (i.e. gradual reduction of dose in the context of chronic use) is inadequately distinguished from the deliberate use of only short/well defined courses of opioids for acute pain. A statement on page 17 'this is the first evidence-base guideline produced anywhere in the world' conflicts with Page 21: 'Existing clinical guidance from RACGP, TGA, Faculty of Pain Medicine (ANZCA)'. There are also seven deprescribing guidelines listed in Appendix 1 of the Guidelines.	consumer resources. We are currently collaborating with end-users to develop these resources and will test their usability in clinical practice. Noted. We have attempted to use more inclusive terminology (i.e. prescriber, healthcare professional) as suggested. However, we note the primary target audience of this guideline is General Practitioners and where appropriate, we have used this term. Noted. The term 'Deprescribing' has been defined and justified in the glossary and main text. Noted. This is the first 'evidence-based' opioid deprescribing guideline as this term relates to the robust process of guideline development which was grounded in and driven by evidence. The evidence-based development process included a systematic retrieval and analysis of evidence and use of

				GRADE methodology to determine the certainty of evidence.
		Audience	Although there is value in deprescribing guidelines, the opportunity for this document to influence initial prescribing behaviour has not been adequately addressed. There should be links between opioid initiation and deprescribing guidelines with alignment of content and style. A well-developed pain management plan created with the patient at the outset of treatment should clearly identify who is responsible for amending it, and under what conditions amendment might be appropriate. There is an expectation that general practitioners will be equipped and resourced to take initiative and responsibility, without being explicit about how the primary care multidisciplinary team might be engaged, nor the resources which might be available (or need to be developed to account for the deficit in resources in chronic pain and addiction medicine). Communication between prescriber, pharmacist, other members of the team and the patient/carer is fundamental to success but is not addressed in this document. Digital health and digital pathways have not been explored to address many of the barriers, but especially communication. Effective drug-monitoring programs are dependent on nationwide ePrescribing (for example through real time prescription monitoring) and support the clinician-patient accountability requirements in a deprescribing contract.The target patient population is insufficiently defined, and it is unclear when acute, short-term use becomes long term chronic use. lmbedded in text on page 47, it states that opioid use for less than a week can be ceased without tapering. Page 47 has the highest	Noted. We acknowledge the benefit of this, however recommendations and resources related to pain management more broadly were outside the scope of this guideline. Noted. We acknowledge the benefit of inclusion of this information, however articulating referral pathways for multidisciplinary care approaches is outside the scope of this guideline and is likely very context specific. Noted. We have discussed the role of prescription drug monitoring programs in the context of opioid deprescribing. We acknowledge that this guideline has not explored digital health pathways in depth. The Recommendation on page 47 states: “We recommend

			density of actual information of the entire document, but this is neither indexed nor emphasised.	gradual tapering of opioids. Abrupt cessation of opioids without prior dose reduction may increase risk of harm." The additional text (practice points) is intended to support the implementation of Recommendation 7.
		Structure	The section 'Guiding Principles' interferes with the flow - it should be incorporated into the more practical 'Clinical Considerations' section. WA Health recommends that the 'Methods' would be more appropriate as an Appendix. The summary of guidelines is too brief to be useful and contains many repeated concepts. The use of level of evidence as headings for the recommendations makes them more difficult to read. It would be more helpful to the reader to pull the theme of the recommendation into the heading - i.e. Recommendation 1- Deprescribing plan (consensus recommendation).	Noted. An overview of methods is required to inform the guideline and recommendation development process. Noted. We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources. We are currently collaborating with end-users to develop these resources and will test their usability in clinical practice. We hope that these strategies will address the structural concerns and facilitate improved implementation of the guideline into practice.

		Guiding principles	The list of opioids available in Australia should aim to be comprehensive and include generic and brand names to be a helpful addition to the document. If there is evidence for differing risk of dependency, value in acute pain vs chronic pain, for each opioid, this information should be presented. The option to develop a deprescribing plan verbally only (page 25) is not appropriate . A deprescribing plan which is not recorded in writing/medical notes is a conversation and not a plan. Mutually agreed targets cannot be referred to if the plan is verbal only.	Noted. We have chosen to use generic (active ingredient) terminology throughout this guideline as it is reported to increase consumer health literacy around their medicines and make communication clearer and unambiguous and improve safe and quality use of medicines with consistent and standardised descriptions of medicines. We did not find evidence for differing risk profiles for outcomes based on the type of opioid. Noted. We agree that a written plan is ideal. The decision to include reference to a verbal agreement came from concerns that it is not feasible for prescribers to document a deprescribing plan in every occasion due to time constraints and workload pressures. Hence we have stated: ““A deprescribing plan is ideally a written document,2 but may be a verbal agreement between the person and the healthcare professional.” Verbal agreements may also be

				more appropriate depending on an individual's literacy.
		Methods	All the GPs on the committee were content experts, not necessarily representative of the target audience. The only 'end-user' was the 'independent consumer representative', who is only identified as 'Dr Janney Wale' who was not otherwise identified and declared no conflicts of interest. We are not informed of her credentials as a consumer representative. The selection process and participation for the participants of the Healthcare Professionals focus groups and subsequent individual interviews was inadequately described. 20 persons with acute and chronic pain were interviewed, but no information on selection criteria were defined.	Noted. The GPs on the committee are practicing physicians. The consumer representative has lived experience of chronic pain and opioid use. This has been clarified in the guideline document. Noted. The full methods for the qualitative interviews can be found in the Technical Report or full publications of the studies.
		Findings	The most powerful evidence for deprescribing is not mentioned until page 55: there is no evidence for a long-term benefit of opioids in chronic pain. This should be emphasised in the executive summary.	Noted. This has been included in the executive summary.
		Areas of debate	Differentiation between maintenance and chronic pain use is an important issue for open and frank discussion with the person using opioids: these are two aspects which need to be addressed simultaneously. The question is not how to classify people, but how best to support their emotional/social/psychological needs. This can be made clear, as well as the fact that these issues are beyond the scope of this document.	Noted.
		Stakeholders	WA Health agrees that opioid deprescribing guidelines are required but this document offers policy rather than guidance. The importance of addressing psychosocial factors was under-emphasised in the recommendations. A reference has been made to Hamilton M, Mathieson S, Gnjidic D, et al. Barriers, facilitators , and resources to opioid deprescribing in	Noted. Noted. This paper is now published and referenced.

			primary care: experiences of general practitioners in Australia. Pain. 2021; Online ahead of print on Page 79. If this reference is relevant, a summary of its content should be included.	
		Clinical considerations	This section includes highly relevant and useful information which should be included in the main part of the Recommendations, rather than imbedded in text on page 83.	Noted. This section largely contains information that was outside the scope of the key clinical questions and therefore was not included in the evidence review. As such, this information cannot easily be integrated into evidence-based recommendations
		Legal and Ethical	This section would make sense as a sub-section of Opioid-related risk minimisation. If a person is not willing to agree to voluntary deprescribing against medical advice , they are then by definition 'drug dependant' and therefore Schedule 8 medication s cannot be legally prescribed without a permit. Page 90: remove the incorrect sentence 'No other evidence-based guidelines were identified that focussed on the deprescribing of opioids.' This section would be more useful in the Clinical Considerations section.	Noted. We have opted to keep this section distinct from 'opioid-related risk minimisation strategies'. Noted. This information is captured. Noted. This is the first 'evidence-based' opioid deprescribing guideline as this term relates to the robust process of guideline development which was grounded in and driven by evidence. The evidence-based development process included a systematic retrieval and analysis of evidence and use of GRADE methodology to

				determine the certainty of evidence.
		Gaps in knowledge and future research	WA Health would also suggest development of resources for junior medical staff, discharge nurses and hospital pharmacists to improve prescribing habits and communication with the patient and the GP. Resources for junior medical staff to inform patients about alternate pain management strategies, and multimedia information for people who use opioids regularly should be developed. Packet sizes and PBS limitations should be considered. Although more relevant to initiation, these initiatives could support eventual de-prescribing.	Noted. We are planning to develop an implementation toolkit with resources to aid implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources. We are currently collaborating with end-users to develop these resources and will test their usability in clinical practice. This has been detailed in the 'Dissemination and Implementation Plan'.
		Recommendations Recommendation 1	Recommendation 1 is the crux of the document, but rather than providing an overview of how this might be achieved merely lists nine other resources which are already available. There appears to be no attempt to distil all this information into useful guidelines. It is questionable as to what this document adds to the two-page National Prescribing Service NPS MedicineWise resources currently in development to support the Australian Commission for Safety and Quality in Health Care's Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard. The following questions were posed by the WA Health reviewers - Is the deprescribing plan developed between the patient and the prescribing doctor? How is it communicated with any other 'deprescribing practitioner?'	Noted. The NPS MedicineWise resource (https://www.nps.org.au/safe-use-of-opioids-in-acute-pain) focuses on safe use of opioids in acute pain. The scope and content of this guideline is broader. Noted. The questions posed relate to how to implement the recommendation, rather than the than the recommendation itself. A deprescribing plan has been defined as "a plan agreed

			The original prescription is often provided by a hospital doctor with verbal instructions to the patients at a time when they are confused, distressed, experiencing side effects with little regard for the level of health literacy of the patient or their carers. Rather than separating the process of prescribing and deprescribing, the deprescribing plan should be included at the time of planning treatment (such as before surgery), with adequate records which are shared with the patient and their primary care professionals. An electronic record which can be a living document would be most useful.	upon by the person taking the medication and their health care professional to facilitate person-centred medication dose reduction or cessation." Noted.
		Recommendation 2, 3 and 4	For Recommendation 2, 3 and 4 WA Health recommend a change in emphasis for ease of reading. For example, '2. For chronic, non-cancer pain, we suggest initiating deprescribing if.. .' It was unclear as to the distinction between 'agreed therapeutic goals' and 'meaningful improvement from baseline in function, quality of life or pain'. WA Health suggest that these two concepts should be merged and further elaborated upon. Chronic cancer-survivor pain is often combined with physical, emotional and psychosocial aspects including loss, grief and fear of relapse, which are often strongly linked to pain. A pain management plan is also required for non-opioid pain management. The distinction between 'suggestions' (nine) and 'recommendations' (only two) weakens the value of this document.	Noted. We plan to refine the guideline language further when we conduct usability testing with end-users. Noted. We have further explained the meaning of 'improvement from baseline function' and how this can be informed. Noted. This terminology has been used in accordance with the methodology for developing evidence-based recommendations and guidelines.
		Recommendation 5 and 6	Recommendation 5 and 6 should be combined to emphasise the importance of not deprescribing in circumstances where expert teams (palliative or addiction medicine) should be harnessed. The	Noted. We have opted to keep two distinct recommendations for consistency and clarity in

			distinction between the 'low-evidence' and the 'consensus' could be referenced within the text.	the guideline document. This is particularly important due to the varying classifications of the Recommendations (I.e. One is evidence-based and one is consensus-based). Further, the recommendations are targeted at different population groups.
			Recommendation 6: The focus on pharmacological-only approach is too narrow. Having recommended against GP-management of opioid use disorders, resources to do so are limited. The role of deprescribing guidelines is to provide resources for primary care practitioners to manage patients in the community while waiting for access to addiction medicine specialist care. Consideration of provision of adequate medicolegal support for them to do so should be considered.	Noted. We have not recommended against GP-management of opioid use disorders. Rather, we have stated “GPs can offer, or arrange, evidence-based treatments for people with an opioid use disorder. This may include medication-assisted treatment with buprenorphine or methadone and associated strategies, in combination with behavioural therapies. Depending on the skills and experience of the healthcare professional, this may occur in the general practice setting in collaboration with a pharmacist, through an addiction medicine specialist, or a combination of both.” This may depend on the experience/skill/confidence of

				the prescriber and the complexity of the patient. We acknowledge that GPs may require additional advice whilst awaiting access to specialist care/services and there may be a need to put measures into place in the interim to increase patient safety. As such, we have provided a direct reference to the National guidelines for medication-assisted treatment of opioid dependence which includes information on 'Recommended regimens for patients transferring from prescribed pharmaceutical opioid preparations'.
		Recommendations 7-11	WA Health recommend that these recommendations be combined into one comprehensive and more detailed summary.	We have opted to keep distinct recommendations for consistency and clarity in the guideline document. This is particularly important due to the varying classifications of the Recommendations (I.e. evidence-based vs consensus-based).
			Recommendation 8 should recognise the risks that the deprescribing practitioner may not always be informed of 'the bigger picture' or long-term pain management plan by other specialists in a timely	Noted. We have included population specific considerations within the

			fashion. Awareness of vulnerable populations such as young people, those with mental illness or those with low health literacy who may be limited in their ability to engage in an authentic tailored deprescribing relationship due to power imbalances.	guideline, however realise that these considerations are not comprehensive of all clinical situations which may be encountered in practice.
			Recommendation 9: 'Assessing response overtime may be useful' (p51) undermines the emphasis given in recommendation 7 and 9 and in the section 'Findings' to plan regular reviews based on time opioids have been used and dose levels.	Noted. This has been reworded as suggested.
			'Monitor and document cognitive and functional status... ' (p51) should be supported with commentary on which of the nine tools listed are helpful for specific concerns. The information is provided in the ensuing dot points, but it is not easy to find or read.	Noted. The order of the Tools has been modified to reflect the parameters listed in the text.
			Real time prescription monitoring programs are available in many states and could be an important tool nationally that are mandatory for opioid prescription and dispensing.	Noted.
			This is very difficult fora GP-led model to achieve. Communication between team members (including the patient/carer) remains fundamental, and digital health could be explored to achieve this recommendation.	Noted.
			There is inconsistency between the use of general practitioner responsibility and "healthcare professional". Need to define one term and use it consistently.	Noted. We have attempted to use inclusive terminology throughout to reflect the range of healthcare professionals who may be involved in the care of the person. GPs are the target audience and have

				sometimes been referred to specifically.
			Recommendation 10: The difficulty of implementation ought not limit the strength of the recommendation. If it is a valuable recommendation then make it strong, so that health services can use it to leverage better resourcing.	Noted. In accordance with the EtD framework used, contextual and implementation information influences the strength of recommendations.
			A section which deals with suggested tapering protocols would also be helpful here. The recommendation for at least monthly reviews is included in 'Findings' but not in 'Recommendations'. Acknowledgement at pain must still be managed, even with opioid deprescription is an important component of recommendation 10 and 11. The digital health initiatives make many non-pharmacological treatments accessible, including isolation reduction strategies.	Noted. Tapering protocols have been referenced in the guideline. The monthly review is contained in the practice point: “Practically, one-monthly review may be appropriate, but more frequent monitoring may be required at the beginning and end of the deprescribing process, or if there is concern about managing a person’s health condition.
			Recommendation 10 suggests referral of ALL patients to a specialist multidisciplinary clinic whenever it is available. WA Health would advocate the development of primary care multidisciplinary networks, but the role of the guidelines should be to help identify which patients would most benefit from such a service. Federal funding and support would be required.	Noted.
		Other comments	The recommendations remain non-specific, leaving all the details to the referenced resources. There is a profound overlap between deprescribing and the safe, effective management of chronic pain. Practice points are not expressed in an easily accessible/digestible manner. The dot points do not represent separate ideas but depend on each other. In-text visual aids and examples need to be presented in a standard format to enable easy recognition.	Noted. We plan to refine the layout and of the document after the recommendations and content are finalised.
			Page 48 has a typo: (MED rather than OMEDD)	Noted. This has been modified.

			Page 49 does not adequately emphasise the value of non-pharmacological supports.	Noted. This Recommendation relates to the individualisation of the deprescribing plan, rather than deprescribing interventions / supports.
			The online opioid equivalent dose calculator would be more beneficial if it also included pros and cons of different preparations; for example, why prescribe fentanyl rather than codeine? When might Tapentadol be considered? To reference the resource without an indication on how it should be used is neither a guideline nor educational.	Noted. Additional information regarding the use of the calculator has been included and links to 'Clinical Considerations' provided. Recommendations about prescribing opioids is outside the scope of this guideline.
			The rationale and research evidence summary in this section were both fully explored in the Findings section and add little to strengthen the guidelines.	Noted. Other feedback has suggested the rationale and research evidence summary is useful. We have opted to keep this information to support the recommendations.
		Conclusion	This publication does fill a real gap in knowledge in the scientific levels of evidence for deprescribing, but it is not a suitable document to be used as guidelines. Major restructuring would be required to suit the purpose as stated in the document.	Noted.
31	Individual	Overall	Thanks for the opportunity to comment on this draft I was surprised to see as your target population you included patients taking opioids for cancer-related or end of life pain. Opioids have been recognised as entirely justifiable in this patient group for ongoing opioid therapy.	Noted. We agree that the identified populations are distinct from those with acute and chronic non-cancer pain. As such we thought it was necessary to include these

				populations within the guideline. We note that the guideline distinguishes between cancer survivor and cancer-related pain. Further, we have a specific recommendation against deprescribing in persons nearing end-of life.
		Key Clinical Questions	In the Key Clinical Questions i) I would argue that the evidence says yes it can be harmful! (Covington, E. C., Argoff, C. E., Ballantyne, J. C., Cowan, P., Gazelka, H. M., Hooten, M., Kertesz, S. G., Manhapra, A., Murphy, J. L., Stanos, S. P. J., & Sullivan, M. D. (2020). 'Ensuring Patient Protections When Tapering Opioids: Consensus Panel Recommendations [Consensus Panel Recommendations].' Mayo Clinic Proceedings, 95(10), 2155-2171. https://doi.org/10.1016/j.mayocp.2020.04.025 Mackey, K., Anderson, J., Bourne, D., Chen, E., & Peterson, K. (2020). 'Benefits and Harms of Long-term Opioid Dose Reduction or Discontinuation in Patients with Chronic Pain: a Rapid Review.' Journal of General Internal Medicine, 35, 935-944. https://doi.org/10.1007/s11606-020-06253-8 Hallvik, S. E., Ibrahimi, S., Johnston, K., Geddes, J. R., Leichtling, G., Korthuis, P. T., & Hartung, D. M. (2022). 'Patient outcomes after opioid dose reduction among patients with chronic opioid therapy.' Pain, 163, 83-90. https://doi.org/ 10.1097/j.pain.0000000000002298 The principles of patient-centred care and opioid reduction are stated but not emphasised If there is no indication that the patient wishes to stop their opioid analgesics. Without that informed consent I would argue that deprescribing is unethical (Rieder, T. N.	Noted. These references have been included in the evidence summary to demonstrate the potential harms of opioid deprescribing / in the surrounding guideline text (where the study design precluded inclusion in the evidence synthesis). Noted. This sentiment is expressed in 'Legal and Ethical considerations' and this reference has been used.

			(2020). 'Is Non-consensual Tapering of High-Dose Opioid Therapy Justifiable?' AMA Journal of Ethics, 22(8), E651-E657.) Patient engagement has been shown very important to the success of deprescribing. (Darnall, B. D., & Fields, H. L. (2021). Clinical and neuroscience evidence supports the critical importance of patient expectations and agency in opioid tapering. Pain, published online ahead of printing. https://doi.org/doi: 10.1097/j.pain.0000000000002443)	Noted. This reference has been incorporated.
		CDG membership	I felt it interesting that in the GDG that, although there are some well-respected academic physicians and pharmacists, there was no recognised Pain Specialist Clinicians (Member/Fellow of Faculty of Pain Management, ANZCA). They also had no-one representing Palliative Care clinicians. There were lots of addiction specialists who might take a different view to those who are treating patients with CNCP and certainly some have already expressed their bias against the use of opioid analgesics in CNCP. They had a consumer representative but not one from a group supporting Persistent Pain patients such as Chronic Pain Australia .	The guideline development group represented a broad range of clinicians, researchers and methodologists and consumer, in accordance with NHMRC guidance. We had representation from general practitioners and pain physicians. We intentionally sought additional input from relevant individuals and organisations with expertise in pain management and palliative care. We acknowledge that there are limitations in the representativeness of our guideline development group, and future updates of the guideline, we will endeavour to broaden stakeholder involvement.

				We attempted to have consumer input throughout guideline development, having conducted a comprehensive qualitative study to inform the guideline content and scope (including consumers across a range of demographics). Additionally, we had an active consumer representative with lived experience as a member of our guideline development group. We appreciate that the consumer representative on the guideline development group is not representative of the lived experience of all consumers. Finally, we consulted with a range of consumer organisations (including Chronic Pain Australia) and individuals throughout public consultation.
		Recommendation 1	Agree. It's always important that prescribers have an 'escape' route prepared whenever a medication is prescribed.	Noted.
		Recommendation 2	Agree. This has been present in Opioid patient contracts for some time but very rarely taken up and used by GPs. Will these guidelines improve this ??	Noted. We plan to undertake monitoring process for dissemination and use.
		Recommendation 3	Agree, but only If the patient is willing to have their opioid analgesics deprescribed.	Noted.

		Recommendation 4	Disagree. I think this should be rewritten! What evidence are you using to justify deprescribing opioids to patients with sleep apnoea and COPD? I don't think the evidence outside of an anaesthetic setting is strong enough. What evidence are you using to justify deprescribing opioids to patients with prescribed doses of OMEDD =60 -100mg? I would agree with the 100mg but the 60mg? Does that mean that by opioid deprescribing you actually mean maintaining opioid doses on chronic use to <100mg/day? Without that clarity there is the potential for significant harm occurring in this vulnerable group of patients. Another social experiment like the BERT letters to GPs?	Noted. Recommendation 4 has been modified and the dose threshold has been removed. Additional justification for identifying sleep apnoea and COPD as co-morbidities of particular concern has been incorporated.
		Recommendation 5	Question Why is this being limited to end of life and how is this described? You are excluding some of the target population identified in the beginning of your document! I would agree with removing it but then adjust your target population up front.	Noted. We have elected to keep this recommendation as is as it reflects the broad target population of the guideline.
		Recommendation 6	Agree. But this then discriminates against pain sufferers who don't have an opioid use disorder!	Noted.
		Recommendation 7	Agree absolutely. This is where most of the deprescribing risks arise from. However most GPs don't have the capacity or the patience to do this safely. It doesn't seem to be compatible with the care paradigm exhibited by many GPs (6minute medicine!) Does a deprescribing plan require the patient to reduce and cease their opioids are you recommending deprescribing to an OMEDD dose of <100mg? The evidence provided by Fishbain (2019) and Mackey (2020) demonstrate the gains made by patients taking OMEDD >100mg but the gains for OMEDD >60mg were more modest. Would agree that if patient has been on short-term opioids then the plan should always be to discontinue the opioid if possible.	Noted. Stipulations about doses are not provided in the definition of a deprescribing plan.

			Most of the acute withdrawal symptoms, especially the sympathomimetic symptoms, can be adequately managed if considered up front an prophylaxis provided.	
		Recommendation 8	Agree Opioid deprescribing should involve consideration of a person's starting dose and the available opioid dosage forms - Is there any role for the use of IR release formulations in the management of CNCP? If patients can manage their pain on these only then I think they should be ceased if at all possible (there are few painful flare conditions that can only be managed with an opioid!) Opioid equianalgesic calculators may not be helpful in deprescribing because they don't take into account the lack of cross-tolerance between opioid analgesics and the quoted opioid equivalence of tapentadol, for example, does not seem to work well.	Noted. Additional information on the potency of opioids and conventional vs atypical opioids has been included under 'Clinical Considerations'. Considerations when using equianagesic calculators has now been referenced as suggested.
		Recommendation 9	Agree Monitoring should always assess pain and function. There was no physical or psychological functional tools listed. I would suggest a Pain Self Efficacy Questionnaire (PSEQ) (Nicholas, M. K. (2007) The pain self-efficacy questionnaire: Taking pain into account. European Journal of Pain (London, England), 11(2), 153-163. https://doi.org/10.1016/j.ejpain.2005.12.008 and a DASS psychological assessment tool (Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. British Journal of Clinical Psychology, 44, 227-239.)	Noted. Modified as suggested.
		Recommendation 10	Agree I do not think that a GP should contemplate deprescribing opioids without the support of other members of the healthcare team. The patient must feel that they can access a member of this team very easily and this is just not something most GPs can undertake. A	Noted. We have placed further emphasis on the importance of multidisciplinary teams throughout the guideline

			group of individuals is therefore required and could consist of a clinic or practice nurse, a pharmacist, a psychologist, a psychiatrist and the prescriber.	document and in the context of Recommendation 10.
		Recommendation 11	Agree I think this is essential and was surprised to see that only very low level of evidence. In our pain clinic we offer MBSR and physical activity (walking and aquatic physiotherapy) as adjuncts to opioid deprescribing. We are considering group based opioid deprescribing to offer individuals peer support.	Noted.
		References	Of note was the date was missing from the Mathieson (reference 84) - it was 2020	Noted and updated.
		Conclusion	I am concerned that the working group seems to have decided de facto that opioids are ineffective and inherently bad and may have lost a sense of open-mindedness in the process. It's interesting that in the Pain Management programs offered by some centres like RNSH, which require patients to be deprescribed from their opioids before participation, ~50% restart their opioid therapy afterwards! Despite the evidence that is often presented there are many patients who are able to utilise long term opioids without developing opioid use disorders or developing the long term harms. Some other, mainly legacy, patients have no other treatments and acquire some QoL from their opioid analgesia.	Noted.
32	Individual	Overall	These documents are thorough and highlight the lack of evidence. Recommendations are balanced position statements. The panel is either pharmacists or addiction clinicians, and a consumer, it lacks broader expression of interest and requests broader engagement from those working in pain medicine.	Noted. The guideline development group represented a broad range of clinicians, researchers, methodologists and a consumer, in accordance with NHMRC guidance. We had representation from general practitioners and pain physicians. We intentionally

				sought additional input from relevant individuals and organisations with expertise in pain management. We acknowledge that there are limitations in the representativeness of our guideline development group, and future updates of the guideline, we will endeavour to broaden stakeholder involvement.
			I have one concern. Definition of opioid dependence is the same as opioid use disorder. This causes confusion and the consequence of this is doctors treating patients prescribed opioids – 1/ at a loss what to do when a patient does well with a safe monitored dose of opioid therapy, 2/ confusion cancer / cancer survivor patients and 3/ many just treated as opioid use disorder and de-prescribed. Physical dependence is in one of the tables but not care not defined These are those patients with no features of misuse, impaired ability to control use, craving, priority of opioids over other activities and do well on a safe, monitored dose of opioid.	Noted. We have included both the ICD-11 definition of 'Opioid dependence' and the DSM-5 definition of 'Opioid Use Disorder' in this guideline. Noted. Physical dependence has been defined in the glossary as "A state of adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, reducing blood level of the drug or administration of an antagonist".
		Page 45	Page 45 advised to contact drug and alcohol specialist advisory service. In Qld this is checked on Q-Script. However Q-script is not	Noted. We provided additional state/territory specific links

			up to date and registered OTP clients authority is not necessarily listed. Queensland, GC particularly, have interstate prescribed OTP patients that QHH would not be aware of and not easy to check if information is not provided by patient. We do not know if Qld doctors can register to access Interstate real time monitoring programs. NSW is lagging behind other states, slow to roll out RTM.	regarding prescription drug monitoring programs.
			There are OTP patients with cancer and those that required acute pain management and some that require acute on chronic pain management. This is not covered by document. The document does acknowledge that this group of patients exist. There are some recommendations for this situation in the ANZCA acute pain scientific evidence guidelines. This care is best managed with the support of a pain specialist with some expertise in addiction medicine. It is important chronic pain management is not by addiction specialist, it is out of scope of practice. For example I have just seen a young lady on OTP Methadone and pregnant prescribed 290mg methadone daily in last trimester of pregnancy under care of AODS service. Mum and baby are OK, mum is back down to 85mg with plan to wean to abstinence. The evidence is poor, quoting from the evidence between 1 and 81% of opioid prescribed clients have a opioid use disorder. The authors consistently state opioids are weaned to minimise harm.	Noted. Acute on chronic pain management recommendations are outside the scope of this guideline. As noted, there is existing guidance in this space.
		Research Evidence Summary	Adverse effects when deprescribing opioids have the potential to cause significant harm, and have been identified as a key reason for disengagement with deprescribing.59 There is emerging evidence of	Noted.

			an association between opioid deprescribing and overdose, suicide and mental health crises due to cognitive and psychological withdrawal effects.55, 56, 131, 147 Frequent and close monitoring throughout the opioid deprescribing process is warranted to prevent or minimise potential harms. This is contrary to what some AODS specialists have said to me in the past. There is no risk stopping opioids suddenly. These same clinicians considered themselves senior to me and would not listen to my experiences (attempted suicide) when another doctor reverse opioid therapy suddenly with naloxone. (the doctor who nearly killed the patient was reprimanded and not allowed to work in ED nor work in addiction). I am pleased common sense has prevailed.	
			All opioid tapering (and opioid rotation) guidelines are based on oral morphine equianalgesia. This is not the same as opioid potency and potency is important when considering rotation. It is less important with a safe weaning regime.	Noted. We have updated the section 'Clinical considerations' to include additional information about the potency of opioids and the difference between conventional and atypical opioids.
			Caution is required when mentioning multidisciplinary persistent pain services. These are only available in a limited number of tertiary facility and our care of rural patients is lacking. It will be continue to be difficult to support rural patients without additional funding and resources. The virtual telehealth pain pilot program funding ended. It left about 50 patients 'hanging' and we are still trying to work out how to finish care.	Noted. We have commented on issues related to accessibility of such services.
		Recommendation 11.	We recommend the consideration of evidence-based co-interventions to support opioid deprescribing. Consistent low certainty evidence suggests that regardless of intervention, mean pain scores and functional measures improved or did not significantly change for most persons who reduced or	Noted.

			discontinued opioids.78-84, 149-151. Quality of life improved may accompany deprescribing opioid (is seen in practice). This is the opioid deprescribing program we have prepared but waiting for enough staffing to start. With the possibility of another pharmacist joining the team, we might be able to start.	
		Page 55 – summary	There is possible harm from long term prescribed opioids, however no evidence supporting the benefit. This evidence will never be collected, it is considered unethical prescribing long term opioids with possibility of harm. There will be some who need long term opioids (no different to those patients who need long term HRT, antipsychotics, antiepileptics, antidepressants) and this is a clinical decision harm versus benefit. The main measure is functional improvement along as regular screening for physiological harm. Visual or numeric Pain scores is not adequate. There is a subpopulation of opioid misuse, estimated to be about 7%. These must be identified early before harm occurs. GPs in general are not trained to manage pain nor trained in addiction medicine.	Noted.
			Opioids have a limited role in chronic pain management and not recommended for the most common conditions eg OA. Opioids should be lowest effective dose, in many cases the patient doesn't need them. But this is where the persistent pain service is useful because the patients are looking for alternatives to manage their pain, this is the purpose of the pain programs. GP education is crucial. Addiction nor pain management are not prioritised and it would seem no on the radar in GP training programs RACGP and ACRRM. This was the value of the GPWSI program but it seems very few GPs were interested, even if just for the education and knowledge. In the current climate and risks, GPs are steering away from managing patients with chronic pain. This will increase the demand	Noted.

			on the persistent pain service. AODS are referred a lot of chronic pain patients, this is inappropriate and stressing AODS system. If we could provide local GP education, this would change the situation. The evidence is poor and the recommendations in this document reflect common sense medical practice. I hope this influences and brings on change to the current draconian legislation.	
33	Organisation The Society of Hospital Pharmacists of Australia (SHPA) Collated from SHPA's Pain Management Specialty Practice Group and Surgery and Perioperative Medicine Specialty Practice Group	Glossary	Deprescribing: Members report that although the reference for this definition is given, it does not truly reflect that reference and the agreed definition for deprescribing, which is 'Deprescribing is the process of withdrawal of an inappropriate medication, supervised by a health care professional with the goal of managing polypharmacy and improving outcomes'. 1 When discussing tapering, weaning, withdrawing of opioids, the aim by necessity differs with the individual circumstances. This definition (i.e., aim to cease) is used throughout but it is felt that it is not reflected in the information and recommendations it contains. Deprescribing Plan: As above, members recommend that it should be mentioned in the definition that the plan is to facilitate dose reduction OR cessation Opioid Use Disorder (OUD): Two criteria are 'tolerance' and 'experiencing withdrawal'. Members ask if these are two aspects of same state, i.e. adaption? Members report that if these two are present, then is OUD suggested? They question if these are more so physical signs, compared with the OUD definition and recommend at least one further criterion required before OUD can be implied. Taper: 'The gradual dose reduction of a medication for the purpose of discontinuation'. Members question whether tapering implies discontinuation is the overall aim or purpose.	Noted. We have included a definition of deprescribing which is appropriate for the context of deprescribing opioids (noting this may be slightly different to other deprescribing recommendations). This feedback mirrors feedback received by other individuals and organisations during public consultation. We agree that cessation is not always possible or the ideal outcome from opioid deprescribing. In acknowledging the reviewers comment that there is clear individual variability in analgesic needs and opioid response, we have modified the definition slightly to provide clarification. The definition now reads: "Deprescribing is the process for withdrawal of a medication (dose reduction or cessation),

				supervised by a healthcare professional, with the goal of improving outcomes and where relevant, managing polypharmacy" Noted. The definitions for 'Opioid Use Disorder' is in accordance with DSM-5 criteria. An Asterix has been added to state "*Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision." – relevant to the two criteria of 'tolerance' and 'experiencing withdrawal'. The definition for the term 'Taper' has been modified.
		Acronyms	oMEDD: Although oMEDD is written in full here, it is not defined, which would be useful as some GPs may not be aware of what it means without explanation. 'MME' is then used throughout the recommendations, which implies there is a different meaning to those who are unsure. Would be useful to include both of these in the 'Acronym' list and possibly, both in the definitions. 'MED' is also used in table, so it might be useful to add that as well, just to quickly provide some definition so that GPs are reassured they are not missing something.	Noted. OMEDD has been defined in the glossary and used throughout the document.

		Executive Summary: How to use this guideline	Reference 24 is meta-analysis by Busse et al. 2 Please check this is the correct reference as only vomiting is mentioned as an adverse effect in that reference. Members report that perhaps the CDC guidelines are meant to be referred to here for reference 23. 3	Noted. CDC guideline (ref 23) has been referenced in the place of ref 24. An additional reference (Australian data) has been included also.
		Summary of Recommendations	Consensus Recommendation 1: Add 'or when first reviewed by the GP' (e.g., following transitions of care). Suggest to add this as a qualifier, as GPs are the target audience for these guidelines. Consensus Recommendation 4 d: Should this be qualified with 'or proportionately lower, if at risk of harm due to age, frailty, CKD etc.' See earlier point re: oMEDD. Supporting information refers to 'MME'. Conditional Recommendation 10: Add after non-pharmacological 'and non-opioid'	Noted. We have opted to keep this recommendation as is to ensure applicability of the recommendation across different healthcare professionals (including specialists, dentists and nurse practitioners who may prescribe opioids) and to encourage prescribers in any setting to develop a plan for opioid reduction or cessation at the point of initiation. This recommendation is supported by the content of the recently released Australian Commission on Safety and Quality in Health Care - Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard. Noted. Recommendation 4 has been modified. OMEDD has been defined in the glossary and used throughout the document.

				Noted. We have not modified this recommended as suggested due to a lack of evidence from our evidence review on the effectiveness of non-opioid medicines in opioid deprescribing. Information about non-opioid prescribing is included as a practice point.
		Background	Page 21, last paragraph: Remove ‘with aim to cease’	Noted. This now reads “Deprescribing is the process for withdrawal of a medication (dose reduction or cessation)”.
		Guiding Principles	Page 24, first paragraph: Remove ‘with aim to cease’ Page 25, first paragraph: To support member feedback above, re: removing ‘aim to cease’, after advising to restart ‘at the previous minimum effective dose.’ This point reinforces that reduction in dose also constitutes ‘deprescribing’, as the dose has been reduced to a more suitable one when considering benefit and harm.	Noted. This now reads “Deprescribing is the process for withdrawal of a medication (dose reduction or cessation)”.
		Recommendation 1	Members agree with this recommendation and add that it is always important that prescribers have an ‘escape’ route prepared whenever a medication is prescribed. Additional points to consider: After ‘Avoid repeat prescribing for acute conditions’, add: Prescribe small pack sizes. Provide specific patient opioid information (e.g., the PSA handout - suggest that a copy is included in these guidelines or a similar patient resource)4 Consider commencing an ‘Opioid agreement’ if the patient requests a repeat after an acute episode	Noted. We have refrained from including information about the prescribing of opioids as it was outside the scope of this guideline and is available in relevant references (provided in the practice points of Recommendation 1). Noted. We have expanded the practice points in Recommendation 1 to include the provision of information to

				persons being prescribed opioids.
			There are three plans/patient documents mentioned in this recommendation: Agreed pain management plan (i.e., includes other modalities, strategies and aims of treatment) An opioid deprescribing plan (may not be required if the first – the pain management plan- does not rely on opioids) An opioid 'agreement' (also known as a 'treatment agreement' or 'prescriber agreement') which can support both of the above but is neither a 'deprescribing', or a 'pain management' plan. It is introduced as a concept in the 'Research Evidence Summary' but not discussed prior to that point.Research Evidence Summary, page 38: As above, the research evidence summary appears to mix these three plans up a bit. Perhaps speak to each plan/document independently and be clear where the recommendation fits in. "The recommendation to initiate a deprescribing plan at this stage (initiation) is based on.." Last sentence: 'This highlights the importance of discussions surrounding the intended duration of use and deprescribing early in the opioid prescribing process.' In practice, the time for this to occur would be when the GP is called upon to prescribe opioids after a transition from acute care for treatment to acute pain from surgery or trauma. At the point of transfer of prescribing to the GP, the issue of dose reduction should be discussed, and a plan agreed to. This could be more specific: Assess (and discuss) the expected time of pain requiring opioid analgesia. Prescribe small quantities of opioid. Provide specific opioid information for the patient. If this is a repeat prescription, consider an agreement with caveats around future	Noted. The Pain Management plan and deprescribing plan have been defined in the glossary and guiding principles. In the absence of direct evidence of the benefit of pain management and deprescribing plans, the guideline development group has provided a consensus recommendation informed by evidence on the effect of 'treatment agreements'. Noted. Some of these concepts have been incorporated as suggested (provided in the practice points of Recommendation 1). Prescription of other medicines (laxatives) has not been included.

			prescribing. Co-prescribe non-opioid and non-pharmacological option, and laxatives.	
		Recommendation 2 Page 40 – _Research Evidence Summary	Members agree with this recommendation. This has been present in opioid patient contracts for some time but very rarely taken up and used by GPs Includes the point that there is low certainty (consistent) evidence that mean pain scores and functional measures improve or do not change in people with CNCP who have REDUCED or discontinued opioids. It must be acknowledged that the aim of deprescribing is to reduce and perhaps cease the opioid. Second-last sentence of paragraph will need clarification. Should there be 'compared to' in the sentence or a 'smallER' proportion?	Noted. Noted. Modified as suggested. Noted. This has been clarified.
		Recommendation 4	Members believe this should be rewritten to reflect current evidence. Members report that there is a lack of evidence to support deprescribing opioids to patients with sleep apnoea and COPD with limited evidence outside of an anaesthetic setting. Members question deprescribing opioids to patients with prescribed doses of OMEDD of 60mg. Would that in turn mean that for it to qualify as opioid deprescribing, you must maintain opioid doses on chronic use to <100mg/day?	Noted. We have modified Recommendation 4, and removed reference to dose thresholds. Additional justification for the inclusion of certain co-morbidities in the context of increased risk of opioid related harms has been included.
		Recommendation 5	Members feel that this is excluding some of the target population (those in end-of-life care) identified in the beginning of the document.	Noted. This recommendation intends to be inclusive of all populations identified in the target population.
		Recommendation 6	Members agree, however this could discriminate against pain sufferers who don't have an opioid use disorder. Page 45: Perhaps introduce the definition here of OUD that has been used earlier (in glossary) so that 'severe' is distinct from having just two features. (See earlier point re: OUD glossary)	Noted. We have hyperlinked the term 'opioid use disorder' to the Guideline Glossary.

		Recommendation 7	Members agree and suggest that this is where most of the deprescribing risks appear from. However it was added that some GPs may not have the resources (time, correct skill set) to do this safely. Members require clarification if a deprescribing plan requires the patient to reduce and cease their opioids or recommending deprescribing to an OMEDD dose of <100mg? The evidence provided by Fishbain (2019) and Mackey (2020) demonstrate the gains made by patients taking OMEDD >100mg but the gains for OMEDD >60mg were more modest. Members agreed that if patient has been on short-term opioids then the plan should be to discontinue the opioid if possible, and added that most of the acute withdrawal symptoms, especially the sympathomimetic symptoms can be adequately managed. Page 47: "If a person has been using opioids short term (e.g. <1 week) or has been using opioids infrequently, opioids may be discontinued without gradual tapering." The caveat here should discuss the daily dose used. Whilst the sector is moving away from SR opioids, if a patient was on for example, oxycodone/naloxone 20/10mg twice daily for 3 days or less than 7 days, they should still be tapered rather than ceased, as per rapid taper practices in hospitals5.	Noted. Stipulations about doses are not provided in the definition of a deprescribing plan. Noted. Noted.
		Recommendation 8	Opioid deprescribing should involve consideration of a person's starting dose and the available opioid dosage forms - is there any role for the use of IR release formulations in the management of CNCP. If patients can manage their pain on these only then I think they should generally be ceased. Opioid equianalgesic calculators may not be helpful in deprescribing because they don't take into account the lack of cross tolerance between opioid analgesics and the opioid equivalence of tapentadol, for example, does not seem to work well.	Noted. Noted. This has been clarified in the section: 'Clinical Considerations'.

			Page 49: Members suggest input, if possible, from a pharmacist. This can be a general practice pharmacist but also through a HMR as an initial consultation can be provided, then two follow-up HMRs if highlighted in the first report. Especially good timing if the opioid is commenced during a hospital stay and the person is discharged to the GP with opioids and an expectation to manage. It would be good to have this promoted as many GPs are not familiar with this HMR allowance and it provides the ideal opportunity for involving a pharmacist in these processes. It may be of interest to a local pharmacist to get involved.	Noted. Reference to the potential role of Home Medicines Reviews (HMRs) has been included in the guideline document.
			Practice points, fourth major dot point: Additional factor to consider is tapering process of uneven doses when doses are taken more than once dose daily. Discussion with patient about the best timing to have the lower dose, means that they have contributed to the decision and therefore is a more patient-centred approach.	Noted. 'Timing of doses' has been added to this practice point as suggested.
			Practice Points, sixth major dot point: Considering concomitant medications. It may be appropriate to commence withdrawal of another medicine before withdrawing the opioid (especially if they have been taken concurrently for some time). Examples of these are gabapentinoids (common concomitant medication needing tapering) or a benzodiazepine.	Noted. This has been reflected in Recommendation 4 which speaks to concomitant medications.
			Practice points, last dot point: When referring to oral morphine equivalents, might be a good time to bring in the initials previously used (oMEDD, MME, MED) and an explanation as to what it is. For example 'for comparison, an opioid dose is often estimated by converting it to the oral morphine equivalent daily dose, a method to standardise the dose based on the knowledge that different opioids with varying potency may produce a similar analgesic effect.'.6	Noted. OMEDD has now been defined in the glossary and used throughout the document. This information has been incorporated into the practice point as suggested. Noted. Modified as suggested.

			Page 50, first line: Typo ‘of the Australian AND New Zealand College…’	
		Recommendation 9	Monitoring should assess pain and function, however there are no physical or psychological functional tools listed. Members suggest the Pain Self Efficacy Questionnaire (PSEQ)7 and a DASS psychological assessment tool (DASS-21).8	Noted. Modified as suggested.
		Recommendation 10	Members feel that the GP would benefit from the support of other members of the healthcare team before deprescribing opioids. The patient must feel that they can access a member of this team very easily and it is felt that it may not be something most GPs can undertake. A group of individuals is therefore required and could consist of a clinic or practice nurse, a pharmacist, a psychologist, a psychiatrist and the prescriber. Close communication within the team is essential to maintain treatment integrity and a common message.	Noted. An emphasis on the importance of multidisciplinary teams has been incorporated in this section with the suggested healthcare professionals listed. We note that this recommendation relates to opioid deprescribing, rather than pain management more generally.
		Recommendation 11	Members feel that co-interventions are essential and were surprised to see very low level of evidence for this. It was noted in that in some member pain clinics, MBSR and physical activity such as walking and aquatic physiotherapy were offered as adjuncts to opioid deprescribing.	Noted.
		Clinical Considerations	Page 85, table 7: History of gastritis: perhaps advise to consider current precautions, e.g., GI problems when there was a history of positive helicobacter is not a reason to avoid NSAID now. The use of “simple” when describing analgesics may be problematic. Members would prefer to avoid terminology such as 'simple' as this gives the wrong message to patients as it is an adjunct analgesic, which has a role. It was added that it may be best to avoid use of this in a document describing a context in which language is so important and might be repeated by GPs or pharmacists when talking to patients.	Noted. Modified as suggested. Noted. Modified as suggested.

		Other comments	Some members were surprised to see the target population including patients taking opioids for cancer-related or end of life pain as opioids have been recognised as justifiable in this patient group for ongoing opioid therapy.	Noted. Guideline Scope and Target population have been defined and justified.
		Key Clinical Question 1	Some members argue that the evidence suggests that deprescribing can be harmful in some situations.9 10 11 While the principles of patient centred care and opioid reduction are stated, if there is no indication that the patient wishes to stop their opioid analgesics and without informed consent, some may argue that deprescribing opioids is unethical. 12 Members believe that patient engagement is really important to the success of deprescribing.13	Noted. These references have been included in the evidence summary to demonstrate the potential harms of opioid deprescribing / in the surrounding guideline text (where the study design precluded inclusion in the evidence synthesis).
		Guideline Development Group Composition	Guideline Development Group (GDG): GDG membership lacks a Pain Specialist Clinician (Member/Fellow of Faculty of Pain Management, ANZCA) and someone representing Palliative Care clinicians. There was representation from addiction specialists who might take a different view to those who are treating patients with Chronic Non-Cancer Pain (CNCP).It was noted that there was a consumer representative but not one from a group supporting Persistent Pain patients such as Chronic Pain Australia.	The guideline development group represented a broad range of clinicians, researchers, methodologists and a consumer, in accordance with NHMRC guidance. We had representation from general practitioners and pain physicians. We intentionally sought additional input from relevant individuals and organisations with expertise in pain management. We acknowledge that there are limitations in the representativeness of our guideline development group, and for future updates of the guideline, we will endeavour to

				broaden stakeholder involvement. We attempted to have consumer input throughout guideline development, having conducted a comprehensive qualitative study to inform the guideline content and scope (including consumers across a range of demographics). Additionally, we had an active consumer representative with lived experience as a member of our guideline development group. We appreciate that the consumer representative on the guideline development group is not representative of the lived experience of all consumers. Finally, we consulted with a range of consumer organisations and individuals throughout public consultation (including Chronic Pain Australia).
		Hyperlinks	Hyperlinks change with time. Perhaps include some firm advice or summarise the key concepts, so that some of target audience (GPs) do not have to negotiate hyperlinks continually. (This point refers to the whole of the guideline document.)	Noted. It is difficult to balance including relevant information and linking to existing relevant resources. We plan to monitor the hyperlinks and update if needed during guideline updates.

				We are planning to publish a guideline summary in a peer reviewed journal and develop an implementation toolkit with resources to aid implementation. This will include both an algorithm for use by healthcare professionals, as well as consumer resources.
		References	Note that a date was missing from the Mathieson reference (reference 84), it was 2020.	Noted. This has been modified.
		Other	Despite the evidence that is often presented there are some patients who are able to utilise long term opioids without developing opioid use disorders or developing the long term harms. Some other, mainly legacy, patients have no other treatments and acquire some QoL from their opioid analgesia.	Noted.
		Population Considerations	Paediatrics: One deficiency is that there is not much reference to opioid reduction in paediatric and adolescent patients. While literature concerning deprescribing in the paediatric and adolescents may be lacking, there are times when members may we have to address the issue, particularly if GPs have initiated opioids for acute or chronic pain management. They feel that this group should be acknowledged/recognised and referred to specialist services.	We note that the guideline scope focussed on adults (aged 18 and over). However, we agree with the comment provided and have suggested this as an area for future research.
		References	1Reeve E., Gnjidic D., Long J., et al. (2015). A systematic review of the emerging definition of 'deprescribing' with network analysis: implications for future research and clinical practice. British Journal of Clinical Pharmacology. 80(6):1254-68. https://doi.org/10.1111/bcp.12732 2 Busse J.W., Wang L., Kamaleldin M., et al.(2018) Opioids for Chronic Noncancer Pain: A Systematic Review and Meta-analysis. JAMA. 320(23):2448-60. https://doi.org/10.1001/jama.2018.18472	Noted.

			3 Dowell D., Haegerich T.M., Chou R. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA. 315(15):1624-45. https://doi.org/10.1001/jama.2016.1464 4 Pharmaceutical Society of Australia. Opioid Medicine Factsheet. https://static1.squarespace.com/static/5e740bedf405dd1739e884c3/t/5f20bd59cb89373480ee69f0/1595981146679/PSA+Opioid+Medicine+Fact+Sheet+_FINAL.pdf 5 Bui, T., Grygiel, R., Konstantatos, A., Christelis, N., Liew, S., Hopkins, R., & Dooley, M. (2020). The impact of an innovative pharmacist-led inpatient opioid de-escalation intervention in post-operative orthopedic patients. Journal of opioid management, 16(3), 167–176. https://doi.org/10.5055/jom.2020.0565 6 Nielsen S., Degenhardt L., Hoban B., et al.(2016). A synthesis of oral morphine equivalents (OME) for opioid utilisation studies. Pharmacoepidemiology Drug Safety. 25(6):733-7. https://doi.org/10.1002/pds.3945 7 Nicholas, M. K. (2007) The pain self-efficacy questionnaire: Taking pain into account. European Journal of Pain (London, England), 11(2), 153-163. https://doi.org/10.1016/j.ejpain.2005.12.008 8 Henry, J. D., Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. British Journal of Clinical Psychology, 44, 227-239. 9 Covington, E. C., Argoff, C. E., Ballantyne, J. C., Cowan, P., Gazelka, H. M., Hooten, M., Kertesz, S. G., Manhapra, A., Murphy, J. L., Stanos, S. P. J., Sullivan, M. D. (2020). 'Ensuring Patient Protections When Tapering Opioids: Consensus Panel Recommendations [Consensus Panel Recommendations].' Mayo Clinic Proceedings, 95(10), 2155- 2171. https://doi.org/10.1016/j.mayocp.2020.04.025 10 Mackey, K., Anderson, J., Bourne, D., Chen, E., & Peterson, K. (2020). 'Benefits and Harms of Long-term Opioid Dose Reduction or Discontinuation in Patients with Chronic	

			Pain: a Rapid Review.' Journal of General Internal Medicine, 35, 935-944. https://doi.org/10.1007/s11606-020-06253-8 11 Hallvik, S. E., Ibrahimi, S., Johnston, K., Geddes, J. R., Leichtling, G., Korthuis, P. T., Hartung, D. M. (2022). 'Patient outcomes after opioid dose reduction among patients with chronic opioid therapy.' Pain, 163, 83-90. https://doi.org/ 10.1097/j.pain.0000000000002298 12 Rieder, T. N. (2020). 'Is Non-consensual Tapering of High-Dose Opioid Therapy Justifiable?' AMA Journal of Ethics, 22(8), E651-E657. 13 Darnall, B. D., Fields, H. L. (2021). Clinical and neuroscience evidence supports the critical importance of patient expectations and agency in opioid tapering. Pain. https://doi.org/doi: 10.1097/j.pain.0000000000002443	
34	Individual	Overall	As a chronic pain patient & advocate, based in Brisbane, & a member of the Australian Pain Management Assoc. [APMA], I thank you for the opportunity to present my concerns & feedback with regard to the Univ. of Sydney's Draft Guideline for de-prescribing opioid analgesics, as follows: The Australian Government Therapeutic Goods Administration Opioid Prescription Guidelines, updated 1-6-20, state as follows: "Opioids CAN be used as part of the management of chronic non-cancer pain in circumstances where other pharmacological and non-pharmacological treatment strategies have not been effective, and the impact of poorly controlled pain has been considered." [REF Below] https://www.tga.gov.au/prescription-opioids-information-health-professionals?fbclid=IwAR0O6jL1HhpYl_HayeIUSPfudaabZKwTOZOXoh9VmcN2h8V2gW0PvgRFEc Yet, due to negative influences from the failed "War Against Drugs" in America, our Australian Authorities have become unreasonably anti-opioid & fearful of addiction. Chronic pain patients in Australia are being tapered or "involuntarily de-prescribed" off their life-	Noted. We have promoted voluntary opioid deprescribing in the guideline and acknowledged the value of shared decision making between people taking opioids and their healthcare professionals in decisions about opioid deprescribing. E.g. Practice Point for Recommendation 8 states: "Opioid deprescribing should, where possible, be voluntary in nature with the deprescribing plan mutually agreed upon by the person taking the medication and the healthcare professional to facilitate person-centred deprescribing. This may involve discussions around which medications will

			saving & mobility-restoring pain killers, by Doctors who have misapplied the 2020 TGA Opioid Prescribing Guidelines, despite this practice not being officially supported. Forceful tapering or involuntary de-prescribing is NOT acceptable, & has not worked in America, where hundreds of thousands of pain patients [if not more] have been abandoned & harmed. The premise that "patients do not experience increased pain or decreased function" when de-prescribed opioids is absolutely NOT true for the vast majority of people. One of the Studies you are promoting to validate this observation, ONLY has a very small sample size of 290 people, AND relies solely on people self-reporting & remembering their exact doses & dates of opioid reductions, without any reference to accurate dosing regimens. Hardly a high quality "evidence-based" Study?	be decreased first or the rate of taper. The plan may be adjusted over time to meet the person's ongoing needs."
		Evidence	For example, the following American Jama Study [2021], carried out data analysis from 2008 to 2019, & "compared more than 113,000 patients who had been on long-term high-dose opioid therapy and had their dose tapered, with patients before or without tapering. The results are both logical and obvious – death and despair." Perhaps a far more realistic sample group size? https://pubmed.ncbi.nlm.nih.gov/34342618/ MORE EXAMPLES: "Discontinuation of COT [Chronic Opioid Therapy] did not reduce risk of death and was associated with INCREASED risk of overdose death." https://pubmed.ncbi.nlm.nih.gov/31468341/ "If a patient is functioning with adequate pain relief on his/her current dose of opioid, decreasing the dose...is not in the patient's best interest. The outcome of such a decision is likely to be INCREASED pain and decreased function."	Noted. We have reviewed the provided references and have incorporated many of the relevant articles in the guideline. Some of the provided articles did not meet the eligibility criteria for inclusion in our evidence review (e.g. commentaries / editorials).

			https://www.practicalpainmanagement.com/treatments/pharmacological/demystifying-opioid-induced-hyperalgesia?fbclid=IwAR2azOok_gau7M7hdmaruc8pQCMJTTpGPVzc88RgZcfaJCCm2FUOsZwJ0CM "Among patients prescribed stable, long-term, higher-dose opioid therapy, tapering events were significantly associated with INCREASED risk of overdose and mental health crisis." https://pubmed.ncbi.nlm.nih.gov/34342618/ "Rapid forced tapering can destabilize these patients, precipitating severe opioid withdrawal accompanied by worsening pain and PROFOUND loss of function." https://academic.oup.com/painmedicine/article/20/3/429/5218985?login=false&fbclid=IwAR15uhaTHLa9bqvrjgBhlxgGCgVg9deiNIwrD52bntjkef_-MMua5_V4_tY FURTHERMORE, we need to address the 'flawed research' which suggests there is NO evidence, or limited evidence, that opioids work successfully for chronic non-cancer pain. The problem is most Studies on this issue are never carried out for longer than 3months, due to lack of funding etc. Here is a 2018 Meta-analysis of 15 American Studies, which concluded: "This meta-analysis of FDA-required double-blind, randomized, placebo-controlled clinical trials of opioid analgesics for the treatment of chronic pain has shown that there is an ample evidence base supporting the efficacy of opioid analgesics for at least 3 months' duration, a standard period for the evaluation of treatments for chronic pain and other chronic disorders." https://pubmed.ncbi.nlm.nih.gov/29765246/ ANOTHER "structured evidence-based review of all available studies on the development of abuse/addiction and aberrant drug-related behaviors (ADRBs) in chronic pain patients (CPPs) with nonmalignant pain on exposure to chronic opioid analgesic therapy (COAT)" &	

			concluded: "Within this grouping for those studies that had preselected CPPs for COAT exposure for no previous or current history of abuse/addiction, the percentage of abuse/addiction was calculated at 0.19%." https://pubmed.ncbi.nlm.nih.gov/18489635/ ANOTHER comprehensive American Article, which states in part: "Opioid analgesic prescribing and related overdoses are in decline, at great cost to patients with pain who have benefited or may benefit from, but cannot access, opioid analgesic therapy." https://academic.oup.com/painmedicine/article/19/4/793/3583229?fbclid=IwAR0mXFGo4R8mtaT1J5N-bHxmacLwp7ZGb5TirxNLzM3rX0Amw0vU61q7baY&login=false ANOTHER Large Study from 2017 [which has 28 References] states as follows: "In conclusion, long-term opioids are safe and effective in the management of chronic pain when used appropriately in a significant subgroup of people. Medical use of opioids is not what causes addiction. Curbing appropriate medical use will not solve the problem of illicit opioid use or opioid related harms. In fact, the evidence supports that the current harsh regulatory climate on prescribers is doing HARM to people with chronic pain. The solution is to provide enhanced timely care to those struggling with addiction and substance use disorders and better access to interdisciplinary care for people with chronic pain conditions." https://www.tandfonline.com/doi/full/10.1080/24740527.2017.1319733?fbclid=IwAR0LJtE820CPDvrBFQPHFnkjfeHHwgZfJhQYSNMgpZcJZjOGad-U-0S0jkM	
		Guideline Development Group Composition	AND FINALLY: I note the "multidisciplinary" guideline development group for the Draft Opioid De-prescribing Guidelines are largely addiction specialists, physiotherapists, RNs, pharmacists, de-	The guideline development group represented a broad range of clinicians, researchers,

			prescribing experts, pain epidemiologists, systematic review experts, methodologists, GP's & just one consumer representative. WHY are there NO Pain Management Specialists, who practice pain medicine & deal with this cohort of patients daily? HOW can such a Group write guidelines on de-prescribing opioids for chronic pain patients without input from even ONE Pain Management Professional? Yet we have three addiction medicine specialists having a disproportionate representation into the fate of opioid prescribing in Australia? In my opinion, gained from 13 years as a patient with Lived Experience, the vast majority of Addiction Specialists know very little about chronic pain, or pain in general, as it is not part of their training or day-to-day clinical practice. Surely, they are busy dealing with those unfortunate people who suffer from psychological addiction issues, trauma and/or substance abuse disorder...NOT those chronic pain patients who have been using their opioids as prescribed for many years?	methodologists and a consumer, in accordance with NHMRC guidance. We had representation from general practitioners and pain physicians. We intentionally sought additional input from relevant individuals and organisations with expertise in pain management. We acknowledge that there are limitations in the representativeness of our guideline development group, and for future updates of the guideline, we will endeavour to broaden stakeholder involvement. We attempted to have consumer input throughout guideline development, having conducted a comprehensive qualitative study to inform the guideline content and scope (including consumers across a range of demographics). Additionally, we had an active consumer representative with lived experience as a member of our guideline development group. We appreciate that the consumer representative on

				the guideline development group is not representative of the lived experience of all consumers. Finally, we consulted with a range of consumer organisations and individuals throughout public consultation.
35	Individual	Overall	I have many painful conditions including endometriosis and EDS. I get seizures from my pain thanks to my neurological disorder that was triggered because my pain was not correctly managed. Doctors are already terrified of prescribing medication to manage chronic pain. We do not need more unnecessary fear mongering hurting pain patients. I was born like this. I did nothing to deserve being in this position. Yet I have been treated worse than any animal ever could be. It is illegal to let an animal suffer yet doctors are encouraged to leave people to suffer. I cannot engage in physical therapy or psychological support without pain medications. I get convulsions, I don't think clearly and I overheat from the tremors from my pain flares. I stop going to the toilet. I lay in foetal position and scream until my throat is raw because my pain is already ignored and unmanaged. This change will only make it worse for people like me! It's disgusting you are encouraging this policy!	Noted. Some of the presented concerns are reflected in the guideline section entitled "Stakeholder values and preferences".
36	Individual	Overall	Deprescription of opioid medication will end my life. I am 37 years old. I have had more than a dozen orthopaedic surgeries as a result of my work. I can no longer work due to my injuries. I take oxynorm every day. Before I had tried everything available. I am also currently on medical marijuana that helps with my sleep and mood but not with my pain. I have a pain specialist and have had for 8 years or so. They tried me on many different medications. Some worked for short times but not well enough, but most either made me sick or closed my throat, so much to the point where I needed a full UPPP as my uvula had become completely swollen all the time. I had sleep	Noted. We have attempted to highlight throughout the guideline document that voluntary opioid deprescribing is encouraged, and the value of shared-decision making between people taking opioids and their healthcare

			apnea and was not breathing. Some drs tried to blame my pain medication, after I had the UPPP I have not have a problem since. Before I was on opioids I could hardly do anything. I was stuck inside for years. I will continue to need surgery over the course of my life and still live with pain, but it is tolerable enough that I can live a semi normal life. Before that my pain caused a deep depression and anger the causes the break up of my marriage and a strain on many relationships. I may take more than what a man in a suit tells me, my body works differently to 99.9% of people. I have had a DNA TEST DONE by my medical professionals to see why I couldn't take certain medications, what works best and why my body processes medication quickly. The answer, I am an individual. Oxynorm works best for me, gives me the best pain relief while keeping my head clear unlike other medications. Blanket bans are the dumbest idea I have ever heard. I now have a loving girlfriend, I have a house, I taught myself to study the sharemarket and have now set up myself and generations to come, all while taking opioids. I can have a full day, week, month out with friends and family that I couldn't before, I no longer need anti depression medication.But, if I don't have it I'm in bed. For days. I do ketamine infusions every year or so to give me a break from the medication and keep my tolerance down. I still wake up around 7am in 7-8 out of 10 pain, but once I had my medication that is down to a 4-5 and I can function. I recently took it upon myself to go cold turkey for 3 weeks to see what difference it would make as I keep hearing they are the devil. Sure I went through withdraws after 8 years, they were done in 5 days. But after 3 weeks in bed from pain, no life and relationship starting to deteriorate again I started back on and my life is as good as it could be. A individual, an adult should be able to determine there own course of treatment. We know what works best for us. We shouldn't be dictated to by someone who has never walked a mile in our shoes. We as adults and as humans have to right to choose our own path in life. There is already enough bs regulations, drs are already scared to	professionals in any decision about opioid deprescribing. Some of the presented concerns are reflected in the guideline section entitled "Stakeholder values and preferences".

			prescribe, they are already breaking their oath leaving patients in pain because they don't want the government on their back. If I could get by on Panadol and this was proposed I would be writing the same letter.The opioid "crisis" in Australia is not the same as America. The stats include illegal drugs and suicide. We could be headed for a real one if parents were forced off of medication that helps them live normal lives. We all know fentanyl is cheap and cartels are always eager to make a profit. They know Australians pay more for drugs than anywhere else in the world. This will cause a massive influx like it has in the USA. Poverty, family breakdown and overdose WILL THEN be a crisis. The number of accidental overdosed on my medication would be as many as people who have been bitten from shark last summer. Even if they said it was an accident, anyone who had taken opioids knows that taking more than prescribed is not an accident! Punishing the many for the actions of a few or the ideologies of a few who do not experience what many people do every single day is a disgrace, and disgusting to even be thought about. How about you let us decide what is best for us. We shouldn't even need permission. Those are my thought on this subject, you will find that most people are in the same boat and don't have a voice as they are suffering already under the current system.	
37	Individual	Overall	I'm going to keep this short due to the submission date The main points I would like to see considered, are: * that the implementation of real time monitoring of prescriptions actually work to prevent abuse by overprescribing, * chronic pain sufferers with diagnoses of conditions that are known to be painful are reliant upon the option of opiods to function and maintain quality of life, * statistics do not show the chronic pain sufferers are abusing opiods,	Noted.

			* deprescribing opiods does certainly remove the ability to function adequately. Please consider these points when discussing the terrible concept of making deprescribing an across the board recommendation. I cannot oppose this strongly enough.	
38	Individual	Overall	Thank you for the opportunity review the draft guidelines. I have a few concerns. Firstly, I have concerns about the lack of patient representation. There is only one patient/consumer representative and it's not clear if she has lived experience of either chronic pain or long-term opioid therapy. If she does not have lived experience with chronic pain and long-term opioid therapy, she is not an appropriate patient representative. Additionally, I note that she is a PhD in Pharmacology, I think it unlikely that she is contributing as a lay consumer representative, but as another pharmacist, of which there are already seven, plus two pharmacologists. There is a strong risk for bias, and I believe, for the reasons above, that no true patient consultation has been undertaken. **No opioid deprescribing guidelines should be produced without consulting people living with chronic pain who rely on opioid therapy.** Second, there is not a single pain management doctor on the committee, yet there are three Addiction Medicine specialists, seven pharmacists and two pharmacologists. Associate Professor Bridin Murnion lists themselves as an expert in Pain Medicine, yet a look at their LinkedIn reveals no qualifications or clinical experience in pain management, only addiction medicine.	Noted. We attempted to have consumer input throughout guideline development, having conducted a comprehensive qualitative study to inform the guideline content and scope (including consumers across a range of demographics). Additionally, we had an active consumer representative with lived experience as a member of our guideline development group. We appreciate that the consumer representative on the guideline development group is not representative of the lived experience of all consumers. Finally, we consulted with a range of consumer organisations and individuals throughout public consultation. The guideline development group represented a broad range of clinicians, researchers, methodologists and a

			Hence, despite their claims, there are **no** pain management physicians included in this group. Addiction medicine is a vastly different speciality than pain medicine, and while this document claims significant crossover of these patient cohorts, this is not supported by the evidence. Development of Opioid Use Disorder, and other serious adverse events, in chronic pain patients on long term opioid therapy is **very rare, less than 1%.** Addiction medicine specialists ONLY see the patients who develop Opioid Use Disorder (the 1%) and not the vast majority (99%) who take opioids successfully and enjoy reduced pain, increased function, and reduced disability. Clearly, Addiction medicine specialists' perspectives on opioid therapy will be biased towards harms as they do not have experience or understanding of the true clinical picture of chronic pain patients. Source: Cochrane review. Cochrane reviews are the gold standard in evidence. **Cochrane review – Long-term opioid management for chronic noncancer pain** **2010** https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006605.pub2/full?highlightAbstract=pain%7Cchronic%7Copioid **No opioid deprescribing guidelines should be produced without consulting pain medicine doctors who manage people living with chronic pain every day. Pain management doctors not only have the education and training, but they have real world experience with real patients. Pain management doctors are the experts in opioid prescribing, NOT addiction medicine doctors.** Another very serious omission in these guidelines is what action to take in the event that the chronic pain patient deconditions, i.e.	consumer, in accordance with NHMRC guidance. We had representation from general practitioners and pain physicians. We intentionally sought additional input from relevant individuals and organisations with expertise in pain management. We acknowledge that there are limitations in the representativeness of our guideline development group, and for future updates of the guideline, we will endeavour to broaden stakeholder involvement. Thank you for providing the suggested reference. We have included information in the guideline regarding the prevalence of opioid use disorders in persons taking opioids for chronic pain.

			experiences increased pain, increased disability, reduced function and reduced quality of life as the opioid dose is reduced.	
		Recommendations	**No set of recommendations is complete without covering all likely outcomes, and increased pain is a very common outcome when tapering opioid pain medication**. In the full document it is clearly stated that if the patient deconditions, i.e. experiences increased pain and loss of function, after reduction or cessation of opioid dose that the medication should be reinstated at the previous lowest effective dose: *"If a person has noticeable decline in condition after dose reduction/cessation (after exclusion of other causes) then the medication should be restarted at the previous minimum effective dose."* (page 25) However, this directive has been completely removed from the summary document. The closest paragraph in the summary document reads: *"Where opioid deprescribing results in significant withdrawal symptoms or a noticeable decline in function, quality of life or pain control, consider pausing the taper to stabilise and re-evaluate the person's pain status, diagnosis, overall clinical status, coping mechanisms and psychosocial factors before resuming deprescribing. When resuming deprescribing, consider slowing down both the amount and frequency of the opioid reduction. Opioid deprescribing may not always be unidirectional and opioid dose increases may be necessary."* Which has an entirely different tone and emphasis i.e. that deprescribing must continue regardless of loss in function and increased pain. The long form document recognises that deprescribing should only occur when the harms outweigh the benefits and the goal of deprescribing is to **find the lowest dose that manages the person's pain**. The summary paragraph has lost this	Noted. The statement: "If a person has noticeable decline in condition after dose reduction/cessation (after exclusion of other causes) then the medication should be restarted at the previous minimum effective dose." Has been included as a practice point in Recommendation 8 (with the main guideline document) as suggested.

			meaning and focuses on deprescribing to zero regardless of patient harm. When deprescribing results in significant decline in function, the patient has surpassed their lowest effective dose, and that lowest effective dose should be reinstated, as stated in the long form document. There needs to be a recommendation explicitly stating this, in the recommendations section, because most practitioners will only read the recommendations, not the full documents. Perhaps recommendation 8 could be expanded to include this. Eg. "We recommend tailoring the deprescribing plan based on the person's clinical characteristics, goals and preferences. *If a person has noticeable decline in condition after dose reduction/cessation (after exclusion of other causes) then the medication should be restarted at the previous minimum effective dose."*	
		Evidence	**No guidelines are complete if they do not address all likely outcomes and increased pain and loss of function is a likely outcome of deprescribing.** The evidence referenced that states that patients do not experience increased pain or increased pain interference is of low to very low quality. It is a very small study (290 participants), relies on patient's recollection of up to 18 months ago, and itself references other studies that are of low and very low quality. The study did not confirm the patient's tapering doses via their medical records, which could easily have been done, and 4 patients died. The study authors made no attempt to discover if these deaths were related to deprescribing, despite the other referenced studies finding that involuntary deprescribing is associated with a **very high risk of overdose and suicide when patients are involuntarily tapered**. If these deaths were related to opioid deprescribing, this represents a 1% death rate on opioid deprescribing, which seems far too high to be acceptable.	Noted. We have transparently reported the certainty of evidence and have rated the certainty of evidence across a range of outcomes, including pain and function. We acknowledge that there is potential harms associated with opioid deprescribing and have detailed this is the guideline.

			Faced with a dearth of high-quality evidence, it's even more important that chronic pain patients on long term opioid therapy be consulted, but this did not occur	
		Summary of Findings	**No guidelines should be based on low to very low-quality evidence, but particulary when the serious adverse events are a high risk of suicide and overdose.** The studies refenced in the summary document found a high risk of very serious harms, on involuntary opioid prescribing. These harms included overdose and suicide. This is not addressed in any of the recommendations. Given the severity of these harms – death! – a new recommendation should be added that **involuntary opioid deprescribing should NOT be undertaken except in extraordinary circumstances where the patient is in danger of imminent serious harm, e.g. recent overdose.** Perhaps this too could be added to recommendation 8.	Noted. The term 'evidence-based' relates to the robust process of guideline development which was grounded in and driven by evidence, rather than the certainty of evidence for particular recommendations. The evidence-based development process included a systematic retrieval and analysis of evidence and use of GRADE methodology to determine the certainty of evidence. The certainty of the evidence informing each recommendation has been transparently reported. In the absence of RCTs, we used lower levels of evidence including expert opinions to form low or consensus-based recommendations. We agree that when guidelines have recommendations with a low certainty of evidence they may be more difficult to implement in practice. This is the case with many areas of

				research. We have identified priorities for implementation in the 'Dissemination and Implementation' plan and have identified areas for future research which are urgently required to guide practice. A Practice Point for Recommendation 8 states: "Opioid deprescribing should, where possible, be voluntary in nature with the deprescribing plan mutually agreed upon by the person taking the medication and the healthcare professional to facilitate person-centred deprescribing. This may involve discussions around which medications will be decreased first or the rate of taper. The plan may be adjusted over time to meet the person's ongoing needs."
		Recommendation 1	As for the recommendations themselves, Consensus **recommendation 1** states "Developing and implementing a deprescribing plan for persons being prescribed opioids at the point of opioid initiation. " This is not appropriate. As stated in the document chronic pain patients only need to be deprescribed if the harms outweigh the benefits, therefore this recommendation should read "**Developing and implementing a deprescribing plan for persons being**	Noted. This Recommendation was informed by evidence of persistent opioid use following initial opioid prescription. As stated in the recommendation, it should be implemented at the point of opioid initiation. This recommendation is supported by existing clinical

			prescribed opioids at the point of opioid initiation. The deprescribing plan will come into effect in the event of adverse events, or if the treatment is ineffective". Many patients benefit from long term opioid therapy and the wording of this recommendation implies that all patients on long term opioid therapy need to be deprescribed in the future. This is not supported by the evidence. This opens the door for doctors to deprescribe patients who are doing well, on stable doses and experiencing good pain relief and improved quality of life. We know this is already happening, but currently doctors who undertake involuntary deprescribing are in breach of the current prescribing guidelines.	guidance and ensures there is a plan for reviewing pharmacotherapy and trialling reduction or cessation if appropriate. The guideline emphasises the importance of shared-decision making, stating that "A deprescribing plan is a plan agreed upon by the person taking the medication and their health care professional to facilitate person-centred medication dose reduction or cessation. This plan is ideally developed when medicines are initiated but can be instituted at any time point. A deprescribing plan should specify realistic and relevant goals of treatment, detail the intended process of dose reduction and identify potential supports that may be required during deprescribing. Progress should be evaluated at regular intervals against mutually agreed upon outcomes and goals. The plan may be adjusted to meet the ongoing needs of the person."

		Recommendation 4	**Recommendation 4,** part c states that opioids should be deprescribed if "Concomitant use of medicines or substances with sedating effects e.g. benzodiazepines, alcohol, gabapentinoids, antipsychotics and sedating antidepressants". These medications are often co-prescribed by experienced pain management physicians. This should be a caution against co-prescribing, NOT a reason to deprescribe opioids. And if a patient can only be on one of these medications, the patient should be allowed to choose which medication is most effective for them, not automatically deprescribe the opioid. Part d states that patients should be deprescribed if "Prescribed doses greater than 60-100mg oral morphine equivalent daily dose (OMEDD)." This is not an evidenced based recommendation. Patients metabolise opioids differently due to their individual genetics and biology therefore different people, get different pain relief from the same dose of opioid. That is, one person on 50mg daily of morphine equivalent may get good pain relief, while another would need a higher dose for equivalent pain. This is evidence-based fact. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704133/ Therefore, if all patients above 100MME are force-tapered, the patient who requires the higher dose due to their genetics will never get adequate pain relief for no other reason than their biological makeup and an arbitrary dose limit. **There is no place for daily dose ceilings and each patient must be treated individually and their dose titrated according to the severity of their pain, their genetics, biology and individual response to the opioid pain medication**.	Noted. We have reflected this sentiment in the following Recommendation Practice Point: "Healthcare professionals need to consider clinical outcomes when making decisions about the appropriateness of opioid deprescribing in populations at increased risk of opioid-related harms. This includes considering the person's response to opioids in terms of their function, quality of life, pain and adverse effects (see Recommendation 2 for further information). Optimisation of medical management of comorbidities and the overall medication regimen is required. This may involve reducing or stopping other substances such as benzodiazepines or alcohol in addition to, or instead of, opioid deprescribing." Recommendation 4 has been modified to remove the dose threshold.

			While its oft said that higher doses are higher risk, the evidence does not bear that out. This study shows that 86% of opioid overdoses in chronic pain patients occurred at a dose LOWER than 90MME https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626611/ And this recent study from the University of Sydney says that *"Opioid dependence – and other problematic opioid behaviours in people with chronic pain – is associated with patient risk factors, rather than simply higher opioid doses".* *Lead author Dr Gabrielle Campbell, said "The most important and consistent patient risk factors associated with problematic opioid use in our study were younger age and histories of substance use and/or mental health problems – that's consistent with previous research,"* *She further stated "It is possible that this emphasis on dose comes from the ability to easily measure and respond to dose thresholds, compared with the relative complexity and time considerations of assessing other clinical factors that substantially contribute to opioid-related risk,"* *So basically, doctors are targeting higher doses, because its easy.* https://newsroom.unsw.edu.au/news/health/problem-opioid-behaviours-associated-pre-existing-risks-not-just-dosage?fbclid=IwAR128jpvyzZ7b2UG3HbWUEJs37py442gcwuX74MZklXKYooxSUjmoCQuLio The US CDC guidelines in 2016 caused great harm to chronic pain patients due to the suggestion of a 90MME limit and the force tapering /involuntary deprescribing that subsequently occurred.	

			The CDC has since recanted all daily dose limits, acknowledged that this was a huge mistake that caused great harm to chronic pain patients, and has removed all daily dose limits from its new guidelines which are currently at draft stage and open for comment. We, in Australia, should not keep making the mistakes that the US made, even while the US has realised that mistake and is reversing those recommendations. Sources: https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html https://www.cdc.gov/media/releases/2022/s0210-prescribing-opioids.html#:~:text=As%20of%20today%2C%20the%20draft,%2C%20through%20April%2011%2C%202022. https://painpatientadvocacy.org/the-science-behind-90mme-as-the-upper-limit-for-opioids-prescribed-for-chronic-pain/ **Part D of recommendation 4 should be removed. There is no placed for MME limits on opioid prescribing. Its not supported by the science and the pharmacologists would know this.**	
		Other problems	In the Glossary: **Aberrant Prescription Behaviour** includes a definition of "Any behaviours on the part of the person taking opioids that suggest the presence of a substance use disorder…". Part of that definition is "unsanctioned dose escalation" and "emergency department visits for chronic pain management" and even obtaining opioids from "multiple pharmacies" Dose escalation and emergency room presentation is far more likely a sign of a pain flare, or under treated pain. These should NOT be considered signs of "aberrant prescription behaviour" or opioid use disorder or substance use disorder, particularly if these are isolated occurrences.	Noted. The term has been used in the context of diagnostic criteria, other definitions and guidelines, and studies included in the evidence synthesis, and has therefore been defined in the glossary. We have modified the definition to reflect the concerns expressed and minimise misinterpretation.

			There are times when a patient will need to visit a different pharmacy than their usual pharmacy, this too is not necessarily a sign of opioid use disorder. By the same token, it is sometimes necessary to see a different GP for opioid scripts, e.g. when current GP is on holiday. Also, getting a second opinion, would be grounds for the first GP to involuntarily deprescribe. I realise this is not the intention of the draft guidelines, but the June 2020 guidelines explicitly stated that patients should not be involuntarily deprescribed, yet many patients were. Many doctors misinterpreted and misapplied those guidelines, so future guidelines need to be specific and thorough to prevent further misapplication and misinterpretation. These guidelines make it all too easy for a GP to abandon a pain patient for normal behaviours that are not aberrant or signs of doctor shopping. These references should be removed from the definition of Aberrant Prescription Behaviour.	
		Overall	In summary, these guidelines have been created by professionals who are not involved in the actual care of chronic pain patients, and who have no experience long term opioid therapy. Therefore, they have a bias against opioids, and do not see the benefits. All the evidence quoted is low to very low quality, and no guidelines should be based on very low-quality evidence. Given the lack of high-quality evidence, patient consultation is even more vital, but this opportunity has been missed. The consumer representative consulted is a pharmacist, and its very unclear if they even have lived experience of either chronic pain or long-term opioid therapy. Therefore, it's fair to say there has been no patient consultation in this process. There has also been no consultation with practicing pain management doctors, which is unconscionable to my mind. The US experience has shown that when guidelines for prescribing or deprescribing are not well thought out and are made with no patient or expert consultation, and no clinical experts in pain	Noted.

			medicine, then patients suffer serious harms. In the US this has included overdose and suicide deaths when patients were involuntarily deprescribed. The US CDC has realised the error in its 2016 policy and is currently reversing those flawed guidelines. Australia must not make the same mistakes the US made. Instead, we have an opportunity to learn from them and avoid the same serious harms to the chronic pain population who use opioids long term safely and effectively to improve their function and quality of life.	
39	Individual	Overall	Panadol is not a suitable pain relief substitute for Opioid pain relief. Having a spinal disc completely crushed and deteriorated is not "imagined pain" or a psychological condition" or "an addiction". De prescribing is not benefiting actual pain sufferers. Lowering or "tapering dosage" lowers the quality of life of a person suffering pain, they end up doing less (with no break through pain relief). EG: Cannot stand at a kitchen bench to prepare meals. EG: Shopping and carrying groceries, becomes more painful EG: Cleaning and vacuuming becomes excruciating, surrounds in home become dirty and cause depression. Forcing patients to do daily/twice weekly pain relief pick-ups (with no records of medication abuse) restricts persons quality of life to travel/holiday visit friends and family, they cannot go far as they have to pick up medication. Small pleasures such as fishing, enjoying playing games with younger relatives becomes impossible with not suitable pain relief medication levels. Methadone is a man made Opioid/chemical, forcing patients to substitute and attend clinics/chemists- travelling during lockdown- pandemic is not duty of care. Patients with Chronic pain cannot work =relying on Welfare. Methadone (chemist/government fee) and travel costs can be up to	Noted. We have reflected some of the presented concerns in the guideline section entitled "Stakeholder values and preferences" which has directly informed the evidence-to-decision framework and strength of recommendations.

			$70.00 per week (they go without food or resort to theft.) Fixed income= $140 less per F/N fortnight. Ask have you yourself suffered chronic Pain?	
40	Individual	Summary of Recommendations	I am writing to you as a chronic pain patient that has had chronic pain for the past 43 years. Thank you for the opportunity to express my views on the University of Sydney's Draft Guidelines of De-prescribing of Opioid Analgesics. From reading the summary of recommendations, there seems to be a big push to get chronic pain patients off opioids. If the lowest effective dose of opioids manages the person's pain, making them more mobile, and have a quality of life with some involvement in activities, why would you want to de-prescribe them even if they have been on them long term? There are studies to show that if doctors reduce the effective dose of opioids, it is likely to cause more pain. "If a patient is functioning with adequate pain relief on his/her current dose of opioid, decreasing the dose...is not in the patient's best interest. The outcome of such a decision is likely to be INCREASED pain and decreased function." https://www.practicalpainmanagement.com/treatments/pharmacological/demystifying-opioid-induced-hyperalgesia?fbclid=IwAR2azOok_gau7M7hdmaruc8pQCMJTTpGPVzc88RgZcfaJCCm2FUOsZwJ0CM	Noted. We have attempted to present the evidence relating to benefits and harms of opioid deprescribing in a balanced manner. We agree that opioid deprescribing is not always appropriate and have recommended that opioids only be deprescribed if the harms of continuation outweigh the benefits. This sentiment has been emphasised in the guideline following public consultation feedback.
		Recommendation 2	Recommendation 2 in the draft is as follows, We suggest initiating deprescribing for persons taking opioids for chronic non-cancer pain, if (any of the following): a) there is a lack of overall and clinically meaningful improvement from baseline in function, quality of life or pain,	Noted. We have clarified that baseline function (and improvements / declines) may be determined by both the person taking opioids and their healthcare professional(s). This may be aided by the use of

			b) there is a lack of progress towards meeting agreed therapeutic goals, OR c) the person is experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains. The concerns I have for this recommendation are immense. How is a meaningful improvement going to be defined and measured? Who is going to determine what is meaningful and improved? Meaningful can mean one thing to one person and something else to someone else. What if there is disagreement over how much improvement has been made? Does the doctor have the POWER just to deprescribe if there's a difference of opinion? This is ridiculous. Chronic pain patients have a right to be prescribed their medication without judgement. It is NOT them that has caused the opioid crisis, it's people taking heroin and illegal Fentanyl that's the problem!! Second lot of concerns are to do with serious or intolerable adverse effects. All medication has the potential to have adverse side effects. If that happens do we just automatically de-prescribe? No. This happened in my case. I was having some emotional side effects from an opioid I was taking so under doctors supervision, I stopped the medication that was causing the issues, I started a different one and went back to the old one I was on. I was NOT de-prescribed. Under this recommendation, Chronic pain patients might be afraid to tell their doctors that they are having an adverse reaction to a particular opioid if they are worried that they might be de-prescribed, therefore suffering in silence. In fact, they might not even be aware or realise the side effect they have reported is "adverse", yet could lead to deprescribing IF in the Dr's opinion he believes it DOES warrant deprescribing This is morally not right. How is having a side effect to an opioid any different to having	validated tools (as presented in Recommendation 9) We agree that opioid deprescribing is not always appropriate and have recommended that opioids only be deprescribed if the harms of continuation outweigh the benefits. This sentiment has been emphasised following public consultation feedback.

			a side effect to another medication? You look for another medication that is right for you and that might be another opioid!!	
		Recommendation 4	Recommendation 4, in the draft is as follows, We suggest considering deprescribing for individuals taking opioids for chronic pain with one or more of the following clinical characteristics: a) Sleep-disordered breathing or sleep apnoea b) Chronic obstructive pulmonary disease (COPD) c) Concomitant use of medicines or substances with sedating effects e.g. benzodiazepines, alcohol, gabapentinoids, antipsychotics and sedating antidepressants d) Prescribed doses greater than 60-100mg oral morphine equivalent daily dose I believe that this recommendation has the potential to be interpreted the wrong way by some GP's. Some GP's might think if you are on 70mg oral morphine equivalent daily dose that you automatically need to be tapered or stopped. This is NOT the case studies show that higher doses of opioids are safe for long term use. Many patients can live a life where they are engaged in society, whether that be working, home duties, socialising, being patient advocates, exercising, all because they are on a stable dose of opioids that they use responsibly. What would be the point of changing this because a piece of paper says so. As the below study shows, tapering stable, long term higher dose opioid therapy patients INCREASES the risk of overdose or mental health.	Noted. We agree with your concern and have removed a dose threshold from the guideline recommendation. The suggested reference is incorporated in the guideline.

			"Among patients prescribed stable, long-term, higher-dose opioid therapy, tapering events were significantly associated with INCREASED risk of overdose and mental health crisis." https://pubmed.ncbi.nlm.nih.gov/34342618/	
		Overall	Overall, the guidelines in this draft seem to look for excuses in my opinion, these are not valid reasons to de-prescribe opioid patients who are doing well and living meaningful lives. There seems to be loopholes, where doctors could use reasons to get patients off their meds without them wanting to. This is morally and ethically wrong. The majority of Chronic Pain non cancer patients use their opioid medication as directed and are on the same dose for a number of years. Talking as someone with lived pain, I feel we deserve to get medication without judgement and stigmatisation.	Noted. We have attempted to provide clear, evidence-based recommendations. We have also highlighted that each recommendation is to be "to considered within the context of each person."