Multimedia Appendix D - ANZCTR updates and reasons.

**Intervention/exposure**

**Study type**
Interventional

**Description of intervention(s) / exposure**
Patients with chronic non-cancer pain on long term opioid therapy who are starting opioid tapering will be randomised to receive either a text message and video intervention in addition to usual care or usual care alone, for 4 weeks.

Before the intervention commences, participants in the intervention group will receive written information about what kind of messages they will receive, what messages they can send and what information will be provided in response to those messages.

Participants randomised to the intervention group will initially receive an educational video (about chronic pain and opioid tapering) of approximately 10 minutes to watch on their phone or computer that contextualizes the text messages they will be receiving. The video will be followed by text messages sent to their mobile phone for four weeks, one or more times per day (one text minimum; participants can choose to receive more as needed), including weekends. Messages will be sent at random times between 9 AM and 5 PM.

The library of text messages are intended to increase the recipient’s self-efficacy to taper opioids. The domains covered by the texts include validation, motivation, education and some therapeutic advice and support on the key domains of pain, withdrawal symptoms, function/quality of life, mood and tapering. There will be some messages that all participants will receive. Other messages will be randomly selected from blocks in the message library so that participants receive messages from each domain. Some of the messages that participants receive will be phrased as questions in order to tailor the amount of messages that are sent. These messages will be infrequently sent. Such as a weekly reminder the person can reply “MORE” to receive a greater number of messages over the subsequent week. These responses will alter the content of the SMS intervention to be personalised or more in line with the users preferences. There is no limit to the number of times that messages can be sent by the participant to the SMS system. The researcher who uses the SMS system as part of the study will monitor the incoming messages. However, participants will be instructed that unless replying to a query question their responses will not be replied to. Participants will not be expected or required to respond to the SMS system.

Participants in the intervention group will receive all scheduled messages, unless they choose to withdraw from the study. Delivery of and responses to the messages will be recorded automatically on the text messaging system. If a message was not delivered or not responded to when needed, a second message will be sent. Participants can also withdraw from receiving the intervention by replying “STOP” to the text messages at any time. The trial coordinator will then contact the participant to ascertain if the participant is fully withdrawing from the study or just from receiving text messages but will continue to complete the follow-up data collections.

**Update**
Patients with chronic non-cancer pain on long term opioid therapy who are tapering opioids will be randomised to receive either a text message and video intervention in addition to usual care or usual care alone, for 4 weeks.

Participants randomised to the intervention group will initially receive an educational video (about chronic pain and opioid tapering) of approximately 10 minutes to watch that contextualizes the text messages they will be receiving. The video will be followed by text messages sent to their mobile phone for four weeks, twice per day including weekends. Messages will be sent at random times between 9 AM and 5 PM.

The library of text messages are intended to increase the recipient’s self-efficacy to taper opioids. The domains covered by the texts include validation, motivation, education and some advice and support on the key domains of pain, withdrawal symptoms, function/quality of life, mood and tapering. All participants in the intervention group will receive the same messages in the same order. Participants will not be expected or required to respond to the SMS system. Participants will be instructed that their responses will not be replied to.

Participants in the intervention group will receive all scheduled messages, unless they choose to withdraw from the study. Delivery of the messages (and responses, if any) will be recorded automatically on the text messaging system. If a message was not delivered, a second message will be sent. Participants can also withdraw from receiving the intervention by replying “STOP” to the text messages at any time. The trial coordinator will then contact the participant to ascertain if the participant is fully withdrawing from the study or just from receiving text messages but will continue to complete the follow-up data collections.

Reason

Intervention was reviewed by a group of clinicians, patients, a consumer representative and, based on their feedback, further development of the intervention was done by the research team. Change in frequency of messages sent (now always 2x per day) and all participants will receive the same messages in order to increase consistency of intervention between participants. Some decisions are based on the available functionality of the messaging system (e.g. not 2-way messaging function).
Outcomes

**Primary outcome [1]**
The primary outcome is self-efficacy (confidence) to taper opioids (SETO) in the presence of chronic pain. SETO will be measured using a scale developed specifically for the purpose of this pilot study, which we have called OTSEQ. It is based on Bandura’s self-efficacy theory and guides for constructing self-efficacy scales. The scale consists of the following 3 items:

I can manage my pain with a lower dose of opioids.
I can use alternative methods other than opioids to manage my pain.
I can get on with my life while reducing the dose of opioids.

Responses are confidence levels ranging in 10-percentile intervals from 0% (anchored as ‘not at all confident’) to 100% (anchored as ‘completely confident’).

**Update**
The primary feasibility outcome is patient acceptability. The primary objectives of this pilot RCT are to a) evaluate the feasibility of an mHealth intervention designed to improve opioid tapering self-efficacy in patients with chronic noncancer pain and b) evaluate the feasibility of a future trial methodology. Several feasibility measures will be evaluated in this study with the acceptability being the main feasibility measure in this pilot trial. The main question in this survey reflecting acceptability is whether participants would recommend the intervention to be used for supporting patients with chronic noncancer pain during opioid tapering.

**Reason**
Since this is a pilot RCT, the primary objective is to evaluate feasibility not efficacy, and therefore the primary feasibility outcome is considered as patient acceptability.

**Timepoint [1]**
The primary outcome (SETO) at baseline prior to randomization and at the end of each week of the trial (end of Week 1, 2, 3, and 4).

**Update**
To assess acceptability of the intervention, participants in the intervention group will be surveyed at the end of week 4.

**Reason**
Change in outcome measure.

**Primary outcome [2]**

**Update**
The primary measure for evaluating potential effectiveness is change in opioid tapering self-efficacy. This will be measured using a single-item questionnaire developed for this study (OTSEQ, Opioid Tapering Self-Efficacy Questionnaire). It is based on Bandura’s self-efficacy theory and guides for constructing self-efficacy scales. The scale consists of one item: "How confident are you at the present time that you can reduce your dose of opioid medication?" Response is confidence level ranging in 10-percentile intervals from 0% (anchored as ‘not at all confident’) to 100% (anchored as ‘completely confident’). The face validity of the scale was evaluated by a panel of clinicians with experience in pain management and/or opioid tapering. Cognitive debriefing and further edition were done after interviewing with 6 patients.

**Reason**
As a secondary objective, this trial will evaluate potential effectiveness. Prescription Opioids Tapering Self-Efficiency changed from 3- to single-item measure based on feedback from a group of consumers and clinicians (face validity). Aim to decrease burden on participants and in line with co-design approach. Primary timepoint updated as missed in error.

**Timepoint [2]**

[New primary outcome]

**Update**

Opioid tapering self-efficacy will be measured at baseline prior to randomization and then at the end of each week of the trial (end of Week 1, 2, 3, and 4). Note: Only the intervention group will repeat answer to the OTSEQ after viewing the education video.

**Reason**

As a secondary objective, this trial will evaluate potential effectiveness. Prescription Opioids Tapering Self-Efficiency changed from 3- to single-item measure based on feedback from a group of consumers and clinicians (face validity). Aim to decrease burden on participants and in line with co-design approach. Primary timepoint updated as missed in error.

**Secondary outcome [1]**

Opioid dose in past 24 hours

Participants will self-report their total opioid usage during the previous 24 hours (drug names, doses, regimen). The total daily opioid use will be expressed in mg of oral morphine equivalents (OME) using the University of Sydney Faculty of Pain Medicine’s opioid calculator (http://www.opioidcalculator.com.au/).

**Update**

Change in opioid dose: At baseline participants will self-report their medication (drug names, doses, regimen). During the trial, participants will be asked whether they had any change in their opioid dose in the past week using an open-ended question, and if yes, to name the medications and specify the dose changes: The total daily opioid use will be expressed in mg of oral morphine equivalents (OME) using the Faculty of Pain Medicine’s opioid calculator (www.opioidcalculator.com.au).

**Reason**

To record opioid dose (and its change) over the week. To reduce burden of assessments since this may not change each week. And, based on consumer and clinician feedback.

**Timepoint [1]**

Completed at baseline prior to randomisation and then at the end of each week of the intervention period (weeks 1-4).

**Secondary outcome [2]**

Pain intensity

Participants will complete the pain intensity subscale of Brief Pain Inventory - Short Form (BPI-SF) (Cleeland and Ryan, 1994). The 4-item BPI-SF pain intensity subscale measures worst, least and average pain in past 24 hours as well as current pain, using 11-point (0-10) numerical rating scales (NRS), 0 being ‘no pain’ and 10 being ‘pain as bad as you can imagine’.

**Update**

Change in pain intensity: Participants will complete the Pain, Enjoyment of Life and General Activity scale (PEG) (Krebs et al, 2009). The 3-item PEG scale measures intensity of pain (on average) and interference of pain with enjoyment of life and general activity in the past week, using 11-point (0-10) numerical rating scales (NRS), 0 being ‘no pain’ / ‘does not interfere’ and 10 being ‘pain as bad as you can imagine’ / ‘completely interferes’.

**Reason**

Based on feedback from a group of consumers and clinicians and research team reviewing current literature to decrease assessments burden on participants with a valid but short scale.
**Timepoint [2]**
The BPI-SF will be administered at baseline prior to randomisation and then at the end of week 4 of the intervention period

**Update**
Pain intensity will be measured at baseline prior to randomisation and then at the end of each week of the trial (end of Week 1, 2, 3, and 4).

**Reason**
Use of a shorter scale enables weekly assessments.

**Secondary outcome [3]**
Pain interference

Participants will also complete the pain interference subscale of the BPI-SF. This subscale assesses how much pain interferes with 7 life domains (general activity, mood, walking ability, work, social activity, sleep, and life enjoyment). All seven items are rated on a 0–10 NRS where 0 = ‘does not interfere’ and 10 = ‘completely interferes’.

**Update**
Change in pain interference: Participants will complete the Pain, Enjoyment of Life and General Activity scale (PEG) (Krebs et al, 2009). The 3-item PEG scale measures intensity of pain (on average) and interference of pain with enjoyment of life and general activity in the past week, using 11-point (0-10) numerical rating scales (NRS), 0 being ‘no pain’ / ‘does not interfere’ and 10 being ‘pain as bad as you can imagine’ / ‘completely interferes’.

**Reason**
Based on feedback from a group of consumers and clinicians and research team reviewing current literature to decrease assessments burden on participants with a valid but short scale.

**Timepoint [3]**
The BPI-SF will be administered at baseline prior to randomisation and then at the end of week 4 of the intervention period

**Update**
Pain interference will be measured at baseline prior to randomisation and then at the end of each week of the trial (end of Week 1, 2, 3, and 4).

**Reason**
Use of a shorter scale enables weekly assessments.

**Secondary outcome [4]**
Mood/distress

Participants will complete the Depression Anxiety Stress Scales (DASS-21) (Lovibond and Lovibond, 1995). It is a 21-item measure that assesses distress along the 3 axes of depression, anxiety, and stress. Items are rated from ‘never’ = 0 to ‘always’ = 3. Total score for each dimension of depression, anxiety and stress ranges from 0 to 21.

**Update**
Mood/Distress: Participants will complete the Generalised Anxiety Disorder 2-item (GAD-2) (Korenke, Spitzer, Williams, & Monahan, 2007) and Patient Health Questionnaire-2 (PHQ-2) (Kroenke, Spitzter & Williams, 2003) for weekly assessments. Each questionnaire contains 2 items screening anxiety and depression symptoms respectively and responses range from ‘Not at all’ = 0 to ‘Nearly every day’ = 3

**Reason**
Based on feedback from a group of consumers and clinicians and research team reviewing current literature to decrease assessments burden on participants with a valid but short scale.

**Timepoint [4]**
The DASS-21 will be administered at baseline prior to randomisation and then at the end of week 4 of the intervention period.
Update
The GAD-2 and PHQ-2 will be administered at baseline prior to randomisation and then end of each week of the trial (end of Week 1, 2, 3, and 4).

Reason
Use of a shorter scale enables weekly assessments.

**Secondary outcome [5]**
Severity of withdrawal symptoms
Participants will complete a modified version of the Subjective Opioid Withdrawal Scale (SOWS) (Handelsman et al., 1987). The scale has 16 items measuring opioid withdrawal symptoms rated from 0 = ‘not at all’ to 4 = ‘extremely’. For the purposes of this study, we have modified the final item (“I feel like using now”) so that it is applicable to a person taking prescribed opioids for pain (“I feel like taking a dose of pain medication”).

Update
Withdrawal Symptoms: Using an open-ended question, participants will be asked if they had experienced any withdrawal symptom in the past week, and if yes, to explain. They also will be asked if they felt unwell in any other way in the past week and, if yes, to explain.

Reason
To reduce burden of completing a long questionnaire every week.

**Timepoint [5]**
The SOWS will be completed at baseline prior to randomization and then at the end of each week of the intervention period (weeks 1-4)

Update
Withdrawal symptoms questions will be completed at baseline prior to randomization and then at the end of each week of the trial (end of Week 1, 2, 3, and 4)

Reason
Change name of measure.

**Secondary outcome [6]**
Satisfaction with care
Participants will rate their current level of satisfaction with care with a 7-point Likert scale ranging from very dissatisfied to very satisfied (Darnall et al., 2020). They may also input free text responses

**Timepoint [6]**
The Satisfaction With Care scale will be administered at baseline prior to randomisation and then at the end of week 4 of the intervention period

Update
The Satisfaction with Care scale will be administered at the end of week 4 of the trial.

Reason
Error

**Secondary outcome [7]**
Readiness to Taper
Participants will rate their current level of readiness to taper using a single item 6-point Likert scale with responses ranging from 1 = ‘not ready’ to 5 = ‘very ready’, adapted from the EMPOWER study (Darnall et al., 2020)

Update
[Marked for deletion]

Reason
Readiness to taper scale no longer completed after the intervention group has watched the education video. This was an error. Readiness to taper is not an outcome and will be measured only at baseline as a potential predictor.

**Timepoint [7]**
The readiness to taper will be measured at baseline, and again after the intervention group has watched the educational video.

**Update**
[Marked for deletion]

**Reason**
Readiness to taper scale no longer completed after the intervention group has watched the education video. This was an error.

**Secondary outcome [8]**
Pain catastrophising
Participants will self-report their current thoughts and feelings about managing their pain using the Pain Catastrophizing Scale (PCS) (Sullivan et al., 1995). PCS is a validated self-report measure of the frequency of alarmist thinking about one’s pain. PCS consists of 13 items scored from 0 = ‘not at all’ to 4 = ‘all the time’, resulting in a total possible score of 52. The higher the score, the more alarmist the thinking.

**Update**
Pain Catastrophizing: Participants will self-report their current thoughts and feelings about managing their pain using the 6-item Concerns about Pain Scale (CAP-6, Amtmann et al., 2020) which is a new measure of pain catastrophizing developed using modern psychometric methodology.

**Reason**
Use of a shorter scale to decrease burden on participants.

**Timepoint [8]**
The PCS will be administered at baseline prior to randomisation and then at the end of week 4 of the intervention period.

**Update**
The CAP-6 will be administered at baseline prior to randomisation and then at the end of week 4 of the trial.

**Reason**
Outcome measure name change.

**Secondary outcome [9]**
Pain self-efficacy
Participants will self-report their current confidence to do things despite their pain with the Pain Self-Efficacy Questionnaire (PSEQ) (Nicholas, 2007). This 10-item measure assesses confidence in ability to do tasks and activities despite pain. Scores can range from 0 to 60, with lower scores indicating low levels of confidence for functioning despite pain.

**Timepoint [9]**
The PSEQ will be administered at baseline prior to randomisation and then at the end of week 4 of the intervention period.

**Secondary outcome [10]**
Acceptability of the intervention:
At the end of study (week 4), participants in the intervention group will provide in-depth feedback on their experience of receiving text message-based support (perceived usefulness, engagement, perceived barriers and facilitators, messages read, feasibility of frequency and timing). This will provide essential insight into acceptability and feasibility considerations for a larger trial. We will use a feedback survey containing 22 items, including Likert scales, descriptive and open responses, adapted from TEXT4MYBACK.
(ACTRN12618001263280) pilot study (“Trial registered on ANZCTR,” 2018)

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<td>Acceptability is now considered as the study primary feasibility outcome.</td>
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**Timepoint [10]**

*At the end of the 4-week intervention period, participants in the intervention group will complete measures of acceptability using the feedback survey.*

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**Secondary outcome [11]**

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<td>Dropouts, message delivery, missing data as other feasibility measures in addition to acceptability will be assessed by objective measures.</td>
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<td>Other feasibility measures are added as secondary outcomes.</td>
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**Timepoint [11]**

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Eligibility

Key inclusion criteria

Inclusion criteria:
- Age 18 years or older
- Diagnosed with a chronic (greater than or equal to 3 months) pain condition
- Using strong opioid analgesics equal to 60 mg per day Oral Morphine Equivalent for at least four weeks
- Being advised to taper opioids and agree to taper
- Able to understand written and spoken English
- Owns a mobile phone that can receive text messages
- Able to give written informed consent and comply with study procedures

Update
- Age 18 years or older.
- Diagnosed with a chronic (> 3 months) pain condition according to the International Classification of Diseases - 11th Revision.
- Have been using opioid analgesics at a dose of at least 40 mg/day Oral Morphine Equivalent for at least four weeks (i.e. participants are likely to have developed a certain level of physical tolerance).
- Have been advised by a clinician to taper opioids.
- Are voluntarily tapering opioid medications, as indicated by verbalised willingness and consent.
- Be currently tapering or will be tapering their opioid medications at the time of enrolment. There is no restriction on how many times patients may have attempted opioid tapering, nor is there any restriction of the period of time participants may have been tapering before entering the study.
- Able to understand written and spoken English.
- Own a mobile phone that receives SMS.
- Able to give written informed consent and comply with study procedures.

Reason
- Clarification of the study criteria and to increase recruitment.

Minimum age
- 18 Years

Maximum age
- No limit

Gender
- Both males and females

Can healthy volunteers participate?
- No

Key exclusion criteria

Exclusion criteria:
- History of being diagnosed with opioid use disorder
- Major, poorly controlled medical or mental health comorbidity
- Participation in another clinical trial concurrently

Update
- Cognitive impairment or intellectual disability preventing adherence to the study procedure.
- Evidence of severe opioid use disorder, based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Illicit substance use, including illicit opioid use, is not an exclusion criterion, however if it fits a wider pattern of symptoms indicating a severe opioid use disorder it may inform a decision that the participant is ineligible for the study.
- History of primary psychotic disorder, bipolar affective disorder, bipolar disorder with psychotic
features, depressive disorder with psychotic features, borderline personality disorder, antisocial personality disorder, or a positive family history (first degree relative) of psychotic disorder or bipolar affective disorder such that participants might be at more than low/negligible risk by participating in the study.

- Any other major, poorly controlled medical or mental health comorbidity.
- Participation in another clinical trial concurrently, since this will not constitute ‘usual care’ and can interfere with the study primary and secondary objectives by increasing the burden to patients and influencing estimates.

**Reason**

Clarification of the study criteria
### Study design

#### Purpose of the study

#### Treatment

#### Allocation to intervention

Randomised controlled trial

#### Procedure for enrolling a subject and allocating the treatment (allocation concealment procedures)

Allocation will involve contacting the holder of the allocation schedule who will be "off-site" and conduct randomisation based on the computer/software generated allocation schedule.

**Update**

RA1 will randomly allocate the participant to the study groups based on the randomization table in the REDCap. The randomization table (using block randomization based on the study site) will be generated at the beginning of the study by an independent member of the Clinical Trial Unit. Only the independent member of the PMRC Clinical Trial Unit will hold a copy of and have access to the randomization table (access to this table in REDCap will be limited for the research team members). RA1 has no access to the randomization table and only can see the assigned group after allocation by REDCap.

**Reason**

Clarification of the allocation process.

**Methods used to generate the sequence in which subjects will be randomised (sequence generation)**

Simple randomisation using a randomisation table created by computer software (i.e. computerised sequence generation).

**Update**

The randomization table (using block randomization based on the study site) will be generated at the beginning of the study by an independent member of the Clinical Trial Unit using the Research Randomizer software and then will be uploaded to the REDCap.

**Reason**

Adding a site and using block randomization based on the study site.

**Masking / blinding**

Blinded (masking used)

**Who is / are masked / blinded?**

The people assessing the outcomes
The people analysing the results/data

#### Intervention assignment

Parallel

**Other design features**

**Phase**

Not Applicable

**Type of endpoint(s)**

Efficacy

**Update**

Efficacy

**Reason**
The primary end-point of the pilot trial is feasibility. Evaluating the potential effectiveness is the secondary objective.

**Statistical methods / analysis**

For the pilot RCT we expect a difference between the two groups after the intervention of at least 2 points on each item of the self-efficacy scale (OTSEQ) giving an effect size $d = 1$. A sample of 20 in each group will provide 80% power to detect a significant difference between the two groups (at $p$ of < .05), allowing for a loss to follow-up rate of 10% during the study period.

All analyses will be blinded to the group status. Descriptive statistics of demographics and other baseline variables will be examined. The primary outcome will be compared between the two groups using independent sample t-test. We will calculate categorical frequencies and/or mean questionnaire scores for the secondary outcomes and compare the two arms using independent sample t-tests for continuous data or Fisher's exact test for categorical data. Normal distribution of the continuous data will be tested using the Kolmogorov-Smirnov test and non-parametric tests will be used if applicable. Linear mixed-model analysis will be used for comparison of the weekly (repeated) measures between the two groups. Explorative analyses will be done to find potential moderating and mediating factors. For all tests, statistical significance will be defined as $p <0.05$ (two-sided).

**Update**

Sample size was considered 20 in each study arm. This sample size is appropriate for the study primary and secondary objectives. Aiming for the intervention to be acceptable by 70% of the participants with 20% precision (i.e. at least 50% would recommend the intervention), 18 participants are required in the intervention arm. To evaluate the potential effectiveness of the intervention as compared with the control and assuming a medium standardised effect size (0.5), 12 participants are required in each group with 80% one-sided confidence interval approach which is suggested for pilot trials. To gather data to obtain estimates and calculate sample size for the future definitive trial, the recommended sample size for each study arm is 15 for a medium (0.5) standardised effect size. We also expect a loss to follow-up rate of 10% during the study period. Accordingly, the total sample size was calculated as 40. For feasibility and acceptability measures, descriptive statistics will be used. To maintain blindness, a separate database of these measures will be generated without record ID, demographic data, or group ID.

For the comparison of the potential effectiveness measures between the study groups, all analyses will be blinded to the group status. In this pilot trial the focus is on descriptive statistics and estimation, using confidence intervals, rather than formal hypothesis testing. Therefore, the confidence interval will be adjusted to 80% and one-sided. Descriptive statistics of demographics and all study variables over the 4 weeks will be reported. Mixed-model analysis will be used to test for the effect of Group x Time interaction for dependent variables of opioid tapering self-efficacy, pain intensity and interference, and mood. In all mixed model analyses, normal distribution of the residuals will be tested, and data will be transformed if needed to approximate residuals to normality. Mann-Whitney U test will be used for comparing the cumulative incidence of withdrawal symptoms and satisfaction. Correlation analysis (Pearson or Spearman correlation coefficients) will be done to find factors associated with opioid tapering self-efficacy. Analysis will be done using SAS software (v 9.4).

**Reason**

This pilot trial aims to evaluate feasibility not efficacy. The potential effectiveness is the secondary objective. Sample size calculation and statistical analysis are edited accordingly.
### Recruitment

#### Recruitment status
Not yet recruiting
Update Recruiting
Reason Status Changed

#### Date of first participant enrolment
**Anticipated**
- 1/07/2021
**Actual**
- Update 25/08/2021
Reason Updated

#### Date of last participant enrolment
**Anticipated**
- 1/03/2022
**Actual**
- Update 1/05/2022
Reason Updated

#### Date of last data collection
**Anticipated**
- 1/04/2022
**Actual**
- Update 1/06/2022
Reason Estimate extended

#### Sample size
**Target**
- 40

#### Accrual to date
**Final**
- Update 9
Reason
Update

#### Recruitment in Australia
**Recruitment state(s)**
- NSW
**Recruitment hospital [1]**
- Royal North Shore Hospital - St Leonards
**Recruitment hospital [2]**
- [New hospital]
<table>
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<tr>
<th>Update</th>
<th>Royal Prince Alfred Hospital - Camperdown</th>
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<td>Reason</td>
<td>New site, increase recruitment</td>
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**Recruitment postcode(s) [1]**

2065 - St Leonards

**Recruitment postcode(s) [2]**

[New postcode]

**Update**

2050 - Camperdown

**Reason**

New site, increase recruitment
Summary

**Brief summary**
This study will investigate the effect of a text message intervention compared to usual care, on prescription opioid tapering self-efficacy. Participants will be patients with chronic non-cancer pain conditions who are commencing prescription opioid medication tapering. 40 participants who meet the selection criteria will be randomized to receive either an educational video contextualising the intervention, followed by text messages for four weeks in addition to their usual care, or usual care alone. The message library consists of text messages that are intended to increase the recipient's self-efficacy to taper prescription opioids. This includes pain management and opioid tapering information, as well as supportive content. The study will compare the changes in opioid medication tapering self-efficacy, and a range of secondary outcomes (e.g. pain intensity and psychological distress) between groups across a 4-week intervention period.

**Update**
This study will investigate the feasibility and potential effectiveness of a text message intervention in addition to usual care, to improve prescription opioid tapering self-efficacy. Participants will be patients with chronic non-cancer pain who are commencing prescription opioid medication tapering. 40 participants who meet the selection criteria will be randomized to receive either an educational video contextualising the intervention, followed by text messages for four weeks in addition to their usual care, or usual care alone. The message library consists of text messages that are intended to increase the recipient's self-efficacy to taper prescription opioids. This includes pain management and opioid tapering information, as well as supportive content. The study will evaluate the feasibility of the intervention and a future trial methodology as the primary objective and compare the changes in opioid medication tapering self-efficacy between groups across a 4-week intervention period as the secondary objective to evaluate potential effectiveness.

**Reason**
Clarifying the primary objective (feasibility) and secondary objective (potential effectiveness) of this pilot trial.