East London NHS Foundation Trust

Guidelines for the Inpatient Treatment of Opiate Addiction

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Consultation Groups	Service managers and consultants of ELFT Specialist Addictions Services Medicines Committee
Approved by (Sponsor Group)	Substance misuse clinical governance group,Medicines Committee, Healthcare Assurance Committee
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Services	Applicable
Trustwide	x
Mental Health and LD	
Community Health Services	

Version Control Summary		
Version	**Date**	**Comments / changes**
1.0	April 2008	
2.0	November 2011	Max daily dose of methadone during induction reduced to 50mg (flow chart & page 14), example titration table added (page 14), clarification on how to titrate methadone (page 14)
3.0	April 2015	Updated guidance, added OOWS, removed reference to services that are no longer in existence.
4.0	January 2018	Updated and summarised into a flowchart for ease of use / access
5.0	November 2020	Reviewed and updated
6.0	21st June 2021	Chairs actions: Update of Drug and Alcohol Service contact details • Re-formatting of flow chart

Guidelines for treating opiate dependence on the ward

Patient admitted to the ward and is stating that they are dependent on opiates. They will either be using illicit drugs or be in treatment with the local drug service or their GP.

Has the patient been on a regular methadone or buprenorphine prescription administered within 3 days' pre-admission and has this been confirmed? (confirm by contacting the community prescriber or the dispensing pharmacy. The patient should know the name of either the prescriber or the pharmacy they attend.

No (or cannot confirm)

Yes (confirmed)

Treat as a new patient.

- Take a comprehensive history including:
- Type of drug used, list all drugs used plus alcohol use.
- Daily drug intake and time of last use
- Length of time of use at this level
- Any periods of abstinence, history of withdrawal symptoms
- Route of administration (IV, smoked, orally, nasally) if injecting, where. Examine sites of injection – assess condition, are they fresh or old, any signs of infection
- Daily cost of drug use, how use is funded
- Medical/social/forensic/psychiatric history
- Do a urine drug screen with either a dipstick test or lab test.

Continue with previously prescribed dose if confirmed and clinically safe

- Confirm when patient last had a dose of methadone/ buprenorphine (Subutex®)/illicit opiates.
- If it has been over 3 days since last prescribed dose of methadone/ buprenorphine (Subutex® clinical review is needed & treat them as a new patient.
- If on methadone, prescribe total daily dose in 2 divided doses & only administer evening dose if no signs of opiate intoxication
- If on sublingual buprenorphine (Subutex®), prescribe once daily
- Write "omit if sedated or intoxicated" on drug chart. If concerns about opiate toxicity, put patients on neuro observations
- Inform the community prescriber and the community pharmacy to cancel community prescription with Community Pharmacy to avoid multiple prescriptions in circulation

Is the patient dependent on opiates?

No

Yes

- Consider prescribing adjuvant medications to treat mild withdrawal symptoms (non-opiate pain relief, antidiarrheal medications etc)
- Motivational interviewing
- Continue to review the situation
- Refer to drug services post discharge

Prescribe Methadone in the first instance – Buprenorphine initiation can be complicated by precipitated withdrawal so consult addiction services.

- Commence methadone mixture 1mg / 1ml at a dose of 10 -15mg every 12 hours up to a maximum of 30 mg in the first 24 hours.
- If first dose of 10-15mg causes drowsiness, reduce or withhold the second dose. If the initial total daily dose (20-30mgs) holds the patient maintain at this dose till discharge.
- If dose is not keeping withdrawals at bay increase by 10mg each day up to a maximum dose of 50mg daily.
- Hold dose for 2-3 days before any further increases. Consult a specialist for dosage increases over 50mg. Split all daily doses into twice daily regime.
- Ward nurses should continually assess for signs of withdrawal or intoxication. Use short opiate withdrawal scale or the objective opiate withdrawal scale to rate degree of withdrawal.

On Discharge

- Do not prescribe any TTA's for opiate substitution medication; the pharmacy will not supply them if you do.
- Ensure the community prescriber is informed of the patient's discharge and is able to restart prescribing before discharging the patient. Fax or send details of opiate substitution therapy doses at discharge. Make sure the GP and community prescriber receive the discharge information before the patient gets there.
- Ensure the community prescriber is aware of any changes made or other medications the patient has been discharged on.
- If the community prescriber is unable to organise follow up immediately (for example at the weekend or after hours - most services will close after 17:00), patients may have to return to the ward for doses until the community prescriber can resume prescribing
- Try to avoid discharging at the weekend or in the evenings – patients should come to the ward for doses if the community prescriber cannot take over in time.
- If patients are on leave from the ward the administration of their opiate substitution remains the responsibility of the ward. The patient may have to come back to the ward for doss as they are still the wards responsibility.

Warnings and Points to Note

- Sources from which you can confirm a prescription are the community prescriber (GP or drug clinic) or the community pharmacy. The patient should be able to tell you the name and at least the street where they go to collect their medication.
- Patients will collect their medication from the pharmacy everyday under the supervision of the pharmacy team or less frequently. It is vital to ensure that the patient has collected their prescribed medication from the pharmacy regularly and not missed more than three consecutive days in the run up to admission. If they have then treat them as a new patient and do not administer the dose they were prescribed.
- Opiate dependent patients may leave the ward to use drugs and then return under the influence. To help avoid overdose split doses whilst they are in hospital
- If a patient has symptoms of overdose administer naloxone IM. It is an emergency drug. Follow the Trust policy on dealing with intoxication on in-patient wards.
- Methadone and buprenorphine should only be prescribed in patients who are dependent on opiates. Dependent patients will have withdrawal symptoms when they do not have opiates. They will seek drugs, they will have signs of dependency such as self-neglect, neglect of responsibilities due to focussing on drug use, signs of recent drug use including opiate positive urine drug tests (note: a positive urine test means the person has used the drug within the previous 5 days so it is not a definitive indictor of dependency alone). Use the short opiate withdrawal scale to assess symptom severity.
- Extra caution is needed in patients who are using or abusing other sedatives. Alcohol misuse and benzodiazepine misuse are common in this group of patients. Withhold methadone or buprenorphine doses if there is a suspicion of secondary sedative use.
- Patients will often use crack cocaine with heroin. They use crack first which stimulates them then use heroin to reverse any overstimulation from the crack
- If you are unsure whether it is safe to prescribe then do not prescribe and contact the local drug service for advice. If it is out of office hours they can be contacted when open.
- The drug services in Newham and Hackney are not provided by ELFT addiction services so referral to these services will be through their pathways.
- If you require further information contact your local drug service using one of the numbers below.
- In cases of pregnancy – methadone is licenced for use in pregnancy. The woman should be made aware that her baby may have neonatal withdrawal syndrome but this is not usually life threatening and can be treated. In reality if a expecting woman continues using drugs throughout her pregnancy the baby will be born with opiate dependency in any case.it is generally accepted that stable methadone has better outcomes and is less of a risk than adulterated street heroin. Buprenorphine is not licensed in pregnancy and should not be initiated in pregnant woman due to the risk of precipitated withdrawal. Maternal withdrawal will cause neonatal distress.
- Patients on doses of 100mg or more of methadone or on methadone plus another QT prolonging drugs (like citalopram) will need ECG monitoring. QTc interval is prolonged if it is 440ms in males and 460ms in women. QTc over 500ms is associated with increased risk of Torsades De Pointe. If the patient is on other QT prolonging drugs they should be changed to non QT prolonging drugs. If QT is prolonged due to methadone contact the local drug service for advice. QT prolongation is not a problem with buprenorphine.
- Methadone is metabolised by the cytochrome P450 system. Drugs which inhibit cytochrome P450 will increase methadone blood levels and drugs that induce cytochrome P450 will reduce methadone blood levels

Useful contact numbers:
Tower Hamlets – RESET, drug and alcohol service CGL: **0203 889 9510**
Bedford P2R: 0333 332 4019
Dunstable P2R: 0333 332 4019
Newham – Newham CGL / CRI: 0800 652 3879
City and Hackney – CNWL/WDP The Hackney Recovery Centre: 0300 303 2611

SHORT OPIATE WITHDRAWAL SCALE

CLIENT: ……DATE OF COMMENCEMENT:

Day	PD	1	2	3	4	5	6
Feeling sick							
Stomach cramps							
Muscle spasms or twitching							
Feelings of coldness							
Heart pounding							
Aches and Pains							
Yawning							
Runny eyes							
Difficulty sleeping							
Muscle tension							
Weakness							
Headache							
Diarrhoea							
Irritability/Agitation							
Runny nose or sneezing							
Any opiate drugs (y/n)							
Any other drug (y/n)							
Name & amount of drug used							
Blood Pressure							
Pulse (per min)							

Please rate withdrawal symptoms each day: 0 = None 1 = Mild 2 = Moderate 3 = Severe

Adapted from Gossop M., Darke S., Griffiths P. et al Addiction 1995; 90: 607-614

Objective Opioid Withdrawal Scale (OOWS)

Patient name: Date …… Time …….

OBSERVE THE PATIENT DURING A 5 MINUTE OBSERVATION PERIOD THEN INDICATE A SCORE FOR EACH OF THE OPIOID WITHDRAWAL SIGNS LISTED BELOW (ITEMS 1-13). ADD THE SCORES FOR EACH ITEM TO OBTAIN THE TOTAL SCORE

	SIGN	MEASURES		SCORE
1	Yawning	0 = no yawns	1 = ≥ 1 yawn	
2	Rhinorrhoea	0 = < 3 sniffs	1 = ≥3 sniffs	
3	Piloerection (observe arm)	0 = absent	1 = present	
4	Perspiration	0 = absent	1 = present	
5	Lacrimation	0 = absent	1 = present	
6	Tremor (hands)	0 = absent	1 = present	
7	Mydriasis (dilated pupils)	0 = absent	1 = ≥3 mm	
8	Hot and Cold flushes	0 = absent	1 = shivering / huddling for warmth	
9	Restlessness	0 = absent	1 = frequent shifts of position	
10	Vomiting	0 = absent	1 = present	
11	Muscle twitches	0 = absent	1 = present	
12	Abdominal cramps	0 = absent	1 = Holding stomach	
13	Anxiety	0 = absent	1 = mild – severe	
	TOTAL SCORE	Range 0-13		

Notes / observations

Handelsman, L., Cochrane, K. J., Aronson, M. J. et al. (1987) Two New Rating Scales for Opiate Withdrawal, *American Journal of Alcohol Abuse,* 13, 293-308