Humber Teaching
NHS Foundation Trust

Opioid Dependence Assessment and Management within Specialist Addiction Community Services Guidelines

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VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*25 Apr 19*	*New Guideline. Approved at Drugs and Therapeutic Committee.*
1.1	*30 Mar 23*	*Reviewed - ONS statistics updated; References updated; Scope included; Formulation Buvidal included. Approved at Drugs & Therapeutic Committee (30 March 2023).*

Contents

1. INTRODUCTION

Disclaimer: This document has been prepared by copying some relevant text from the Department of Health (DH) 2017 Drug Misuse Guidelines. All clinicians treating patients with substance use disorders are advised to review the DH 2017 guidelines, relevant National Institute for Care and Health Excellence (NICE) guidelines and local policy N037 Identification of drug misuse (2022).

Heroin Dependence and Drug Related Deaths

Heroin dependence is a chronic, relapsing and remitting condition, with high morbidity and mortality (DH 2017). Internationally there has been an increase in heroin related deaths. In 2017 there were 4859 deaths related to drugs of which 2219 were related to any opiates.

In 2021 heroin and morphine continued to be the most frequently mentioned opiates with 1,213 drug poisoning deaths mentioning either one of these substances (ONS 2021). There were 663 deaths involving methadone, which is 28.5% higher than the previous year (516 deaths) and a statistically significantly higher rate than the previous year (11.7 deaths per million in 2021 compared with 9.1 in 2020).

Patients may have co-existing health disorders (physical and mental) and substance use disorders. Therefore, clinicians should be able to screen, assess and provide treatment according to complex needs.

2. SCOPE

These guidelines are aimed at the staff of East Riding Partnership, particularly the prescribers. However all staff need to be aware of the holistic assessment process as information required as part of the assessment process should start to be gathered from the point of initial contact. Staff need to make patients aware of what to expect for their treatment journey so that the patient can plan accordingly and receive safe prescribing care.

3. PROCEDURES

3.1. Management of Heroin/Opioid Dependence

The patient should have a full holistic comprehensive assessment including history and examination, drug testing and other testing as required. All this information is used to make the diagnosis and provide a patient centred recovery focussed management plan.

Oral opioid substitution treatment (OST) such as methadone is recommended as an effective treatment that reduces deaths by overdose, reduces heroin use, reduces crime and reduces Human Immunodeficiency Virus and Hepatitis C (DH 2017, NICE 2007). All pharmacological interventions are enhanced with psychosocial interventions (NICE 2007). This document does not cover psychosocial interventions.

The main goal for OST is complete cessation of heroin (and other illicit opioid) use.

3.2. Assessment

3.2.1. History and Examination

Before deciding to prescribe, the prescriber working within the Specialist Addictions Community Service must complete a full assessment to establish the diagnosis. The prescriber would need to assess the full history of the patient's drug and alcohol use, including duration of use, frequency of use, route of drug use administration, risk-taking, periods of abstinence, and response to previous treatments.

Central Nervous System (CNS) depressants are a major risk factor and so it is essential that the prescriber gets details of the drug use in the last three days (including prescribed and over-the-counter medication).

The assessment would include physical (including HIV and Hepatitis) and mental health, also medication prescribed. Patients should be asked to give an account of their typical daily activities and social functioning and should be asked about their offending history.

Corroborative evidence of opioid dependence should be sought, by physical examination, investigations (such as drug screens), and information from other people.

3.2.2. History

Current Substance Use

- Substance, route (smoked or injecting), dose/cost/units, frequency
- Substance use in last three days

Typical Day

- Substance use through day and why using then?
- **(Are there cravings or withdrawals?)**

Substance Use History

- First use, progression, did use increase? Why?
- **(Is there tolerance?)**
- Can you control your use? Have you tried to stop?
- **(Loss of control)**
- What happened when you reduced or stopped substance use? **(withdrawals)**
- Did the withdrawals go away when they took the substance?
- Past treatment/abstinence. What helped before?

Medical/Mental Health

- Any harms related to substance use?
- **(Persistent use despite harm)**
- Mental health
- Physical health – Hep C, Hep B, HIV
- Sexual health and contraception

Social

- Any other support?
- Work or any other interests?
- **(Neglect of other interests)**
- Driving? Kids? Safeguarding

Insight/Recovery Goals

- Is use a problem? What are your recovery goals? Do you want to stop? Why?

3.2.3. Physical Examination

- Look for signs of Intoxication and withdrawal (see Table 1 below)
- Injecting marks – needle tracks
- Liver damage

3.2.4. Investigations

- Withdrawal scales – Clinical Opiate withdrawals Scale (COWS) – see Appendix 1
- Urine drug testing – A urine drug screen is essential to confirm recent drug use. However, a positive test for opioids does not establish the diagnosis of dependence. See Drug Testing in Addictions (2021) guideline (G392) on the Trust intranet
- Breath Alcohol
- Other investigations: Bloods, Hep C, HIV, Hep B testing, pregnancy test (if female)

3.2.5. Collateral Information

- Confirm medication on summary care record
- Assess GP/Urgent care clinical journal entries if accessible
- Collateral information - Family/carer/other professionals

Table 1: Signs of opiate withdrawal

Objective signs of opiate withdrawal	Subjective signs of opiate withdrawal
Yawning	Restlessness
Coughing	Irritability
Sneezing	Anxiety
Runny nose	(The signs listed above may also be useful objective signs)
Lachrymation	Sleep disorders
Raised blood pressure	Depression
Increased pulse	Drug craving
Dilated pupils	Abdominal cramps
Cool, clammy skin	
Diarrhoea	
Nausea	
Fine muscle tremor	

3.2.6. Making a Diagnosis of Opioid Dependence

In order to prescribe, the prescriber must make a diagnosis.

According to ICD-10, you can make a diagnosis of dependence when three or more symptoms below are present together in the last year:

a) Cravings/thoughts about substance
b) Loss of control/Unable to stop using substance
c) Withdrawals when reduces or stops substance
d) Tolerance (needs more of the substance to have the same effect)
e) Neglect of other interests
f) Persistent use despite harm

3.2.7. The Responsibility of the Prescriber

Prescribing is the responsibility of the person signing the prescription. The prescriber should read relevant guidelines (DH 2017/NICE 2007) and review the BNF before prescribing.

3.3. Opioid Substitution Treatment (OST)

3.3.1. Choosing an Appropriate Opioid Substitute for Heroin Dependence

Please remember that opioid intoxication can kill a person and so always wait for withdrawals before starting opioid substitution treatment.

It is always advisable to inform the patient that you need to wait for withdrawals before starting treatment, so that they are aware if there is a delay to starting treatment.

Methadone and buprenorphine are both effective at achieving positive outcomes in heroin dependent individuals. Both are cost-effective and recommended by NICE (NICE 2007). According to NICE guidelines the drug choice is based on individual history and patient choice.

3.3.2. Patient Information

The prescriber must gain informed consent to start treatment for opioid dependence. The prescriber should explain the rationale for treatment, benefits of the medication, risks and side effects, ideally with a patient information leaflet (in a language they understand); see the Choice and Medication website for further details at https://www.choiceandmedication.org/humber/

The prescriber should explain that the medication needs to be collected daily, supervised at a nominated chemist and that they would need to attend appointments at the Addictions Service for ongoing prescriptions and psychosocial interventions.

3.3.3. Methadone

Please note the increased risk of opioid overdose death from respiratory depression during induction onto methadone treatment. Methadone has also been associated with heart rhythm QTc wave prolongation.

Methadone is a full opioid agonist which is recommended to be prescribed as a sugar-free 1mg per ml oral liquid. Methadone has a long half-life, and so is given as once daily dosing. Due to the long half-life, there is a risk of cumulative toxicity which can cause an overdose in the first few weeks of treatment. For people who are not tolerant to opioids, there have been incidents of fatal overdoses at 40mg methadone. Therefore starting methadone doses should always be 30mg or less. Patients need frequent observations during induction onto methadone and a prescriber review before each dose increase.

For patients totally naïve to methadone treatment, a Recovery Support Worker can accompany the patient to the chemist for the first dose and the patient return to the Hub afterwards for a period of observation – no more than one hour required (in most cases).

To receive the first dose, the pharmacist will require photographic ID from the patient.

3.3.4. Prescribing Methadone

- Methadone 1mg/ml solution sugar free (recommended)
- Wait for withdrawals (use COWS to assess withdrawals)
- Once withdrawals present COWS 5 and above, you can start methadone
- The first methadone dose should be no more than 30mg
- Subsequent day's methadone dose can be increased by 5-10mg per day
- **You must not increase the methadone dose more than 10mg per day**
- **You must not increase the methadone dose by more than 30mg from the first dose in the first week of treatment**
- **Dose increases during the second week should be avoided on consecutive days.**
- **There must be regular monitoring and review during the induction phase**
- You would aim to increase the dose until no withdrawals and cravings are present to an optimal dose range 60-120mg per day.

3.3.5. Buprenorphine

Buprenorphine is a partial opioid agonist with high affinity for opioid receptors. This is long acting and so has once daily dosing. This is taken as an oral sublingual tablet. Another formulation of Buprenorphine/naloxone (Suboxone) is available. There is also a rapidly absorbable oral wafer called Espranor and an injectable version, Buvidol.

For patients totally naïve to buprenorphine treatment, a Recovery Support Worker can accompany the patient to the chemist for the first dose and the patient return to the Hub afterwards for a period of observation – no more than one hour required (in most cases).

To receive the first dose, the pharmacist will require photographic ID from the patient.

3.3.6. Prescribing Buprenorphine

The patient must be in significant withdrawals before starting buprenorphine treatment due to the risks of precipitated withdrawal. Therefore the patient must have a COWS scale of 8 or more before starting treatment. Additionally they must have been at least 8-12hrs opiate free.

The formulation of buprenorphine is 2mg and 8 mg tablets. It is recommended that buprenorphine is started at 4mg on the first day, followed by 4mg increases on subsequent days. Optimal doses are between 12-24mg daily.

3.3.7. Opioid Overdose and Naloxone

A brief overview is provided below. See G387 Naloxone in Overdose Guideline and Procedures (2020) for full details.

3.3.8. Recognising an Opioid Overdose

- Unconscious – not responding to touch or noise
- Breathing difficulties – heavy snoring, rasping sounds or not breathing at all
- Pinpoint pupils
- Bluish tinge to lips, tip of nose, eye bags, fingertips or fingernails

3.3.9. Management of an Opioid Overdose

- Always make sure the environment is safe
- Try wake the person by shouting/shaking gently
- Call 999 and ask for an ambulance
- Place them in the recovery position
- Inject Naloxone or administer Naloxone nasal spray
- Stay with them and wait for the ambulance

4. REFERENCES/DEFINITIONS

Department of Health (2017) Drug Misuse and Dependence: UK guidelines and clinical management

Office of National Statistics (ONS) (2021) Deaths related to Drug Poisoning in England and Wales 2021Office of National Statistics (ONS) (2021) Deaths related to Drug Poisoning in England and Wales Available from:

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2021registrations

National Institute for Health and Care Excellence NICE (2007) Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance (TA114) Last updated 2014

National Institute for Health and Care Excellence NICE (2007) Drug misuse in over 16s: psychosocial interventions. NICE guidelines (CG51) Last updated 2020

National Institute for Health and Care Excellence NICE (2016) Coexisting severe mental illness and substance misuse: Community Health and Social care services (NG58) Last updated 2022

Wesson DR(1), Ling W. Journal Psychoactive Drugs. The Clinical Opiate Withdrawal Scale (COWS) (2003) Apr-Jun; 35(2):253-9

5. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Drug Testing in Addictions Guideline G392

Naloxone for Opioid Overdose Guidelines G387

Identification of Drug Misuse Policy N-037

APPENDIX 1 - Clinical Opiate Withdrawal Scale (COWS)

COWS Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.
Clinical Opiate Withdrawal Scale

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat on brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sifting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms 5 Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal