Humber Teaching
NHS Foundation Trust

OPIOID DEPENDENCE: ASSESSMENT AND MANAGEMENT ON THE WARDS GUIDELINE

Guideline currently under review – please continue to use this version until it is replaced by the next approved version

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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	*Nov 2022*	*New guideline document. Approved at DTG (24 November 2022).*

Contents

Background

Disclaimer - This document has been prepared by copying some relevant text from the DH 20117 Drug Misuse Guidelines. All clinicians treating patients with substance use disorders are advised to review the DH 2017 guidelines and relevant NICE guidelines.

Heroin dependence and drug related deaths

Heroin dependence is a chronic, relapsing, and remitting condition, with high morbidity and mortality (WHO 2018). Internationally there has been an increase in heroin related deaths. In 2017 there were 3756 deaths related to drugs of which 1985 were related to any opiates (e.g., heroin, oxycodone, methadone etc.) and 1164 were related to heroin and morphine (ONS 2018).

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

All patients admitted to the mental health unit should be screened for substance use disorders using the DAST/AUDIT and urine drug screening/breath alcohol test conducted. For patients with suspected heroin dependence a further assessment will be required.

It is important to be aware that prescribed opioids and over the counter opioids may also lead to opioid dependence. If this is suspected, a full assessment should also be completed.

You must always seek senior advice when considering a patient with opioid use disorders who has been admitted to the mental health unit.

Management of opioid dependence

Patients with opioid dependence should be offered biopsychosocial interventions to help stop heroin use and support recovery. Psychosocial interventions include a variety of psychosocial talking therapies such as motivational interviewing and social interventions such as peer support groups, housing, and rehabilitation support.

Medication management of opioid dependence is part of the biopsychosocial interventions. Oral opioid substitution treatment (OST) such as methadone or buprenorphine has a string evidence base and is a cost-effective intervention to help stop heroin an opioid use, which has been shown to be effective at reducing deaths by opioid overdose, reducing heroin use, improving health and wellbeing, and reducing crime and spread of blood borne virus' such as Hepatitis C (DH 2017, NICE 2007).

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

Assessment

1. For patients with an established diagnosis of opioid dependence and who are currently prescribed opioid substitution treatment with methadone or buprenorphine.

Confirm the last dose of methadone or buprenorphine and you can prescribe the same dose if there are no other concerns (e.g., not intoxicated) and the last dose was confirmed by the chemist to have been consumed in the last three days.

If you cannot confirm the last dose in the last three days, you will need to restart opioid substitution treatment by following the steps below.

2. For all patients who do not have an established diagnosis of opioid dependence or where you cannot confirm that opioid substitution treatment was consumed in the last three days by the chemist or previous provider.

You must complete a full assessment to establish the diagnosis of opioid dependence. This is a holistic assessment and would add a detailed substance use history and current substance use to the standard clerking. The prescriber must 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.
It is important to be aware that Central Nervous System 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 medications and check if there is co-prescription of opioids, zopiclone, benzodiazepines and pregabalin and gabapentin, over-the-counter medication, internet, and herbal remedies).
The clerking is a holistic assessment and includes substance use, mental health, medical health (including blood borne virus risks and tests), medications 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.

Clerking information

Current Substance Use

- Substance used e.g., heroin, illicit opioid medication etc
- Route (oral, smoked or injecting)
- Dose/cost in £/units
- Frequency per day
- Substance use in last 3 days

Typical Day

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

Substance Use History

- First use of opioids, progression, did use increase? Why?
- Is there tolerance? e.g., need more opioids to have the same effects
- Can the person control their use of opioids?
- Have they tried to stop? What happened?
- Can the person control their use of opioids?
- What happened when you reduced or stopped opioids?
- Did the person get withdrawals?
- Did the withdrawals go away when they took the substance?
- Past treatment/abstinence. What helped before?

Medical/Mental Health

- Any harms related to opioid 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? Children? Safeguarding

Insight/Recovery Goals:

- Does the patient think the opioid use is a problem?
- Do they feel like they are addicted to opioids?
- Why do they want to stop?
- What are their recovery goals?

Physical Examination

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

Investigations

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 policy for further details.

- Withdrawal scales – Clinical Opiate withdrawals Scale (COWS) – see appendix
- Breath Alcohol
- Other investigations: bloods, Hep C, HIV, Hep B testing, pregnancy test (if female)

Collateral Information

- Confirm medication on summary care record
- Confirm addictions medication with specialist addictions service
- Confirm when last consumed OST at chemist (very important)
- Collateral information – Family/carer/other professionals

Table 1: Signs of opiate withdrawal

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

Making a diagnosis of opioid dependence

To prescribe, the prescriber must make a diagnosis.

Diagnosis should be made using the ICD-10 (or ICD-11 when this is implemented nationally by 2024).

ICD 10 Diagnostic criteria:

Three of six symptoms below to be present together in the last year:

a) Cravings/thoughts about substance
b) Loss of control/Unable to stop 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

ICD 11 Diagnostic criteria:

Recurrent, episodic, or continuous opioid use, strong desire shown by 2 or more:

1. Impaired control
2. Increasing priority /persistent use despite harm
3. Physiological features - neuroadaptation to the substance
    - Withdrawals
    - Tolerance
    - Repeated use to prevent withdrawals

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.

Contacting the addictions specialist service

Before starting treatment, the prescriber/ward team should always try to contact the specialist addictions service who would be continuing treatment to plan.

For East Riding patients - East Riding Partnership 01482336675

For Hull patients - Renew CGL 01482 620013

If this was not possible e.g., after hours, contact should be made at the earliest opportunity, as the specialist addictions service will need to continue prescribing on discharge.

Choosing an appropriate opioid substitute for heroin dependence

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. At the mental health unit, methadone is available as stock and may be the only available choice.

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 – see choice and medication website for further details. https://www.choiceandmedication.org/humber/

The prescriber should explain that the medication would be started from a low dose to prevent overdose. The dose would gradually be increased to the dose that helps the patient stay off opioids. This is called the titration.

Once the patient is discharged from hospital, they would need to collect the medication daily and supervised at the chemist. The patient would also need to attend regular appointments at the addictions service for ongoing prescriptions, drug testing and psychosocial interventions.

Methadone

Please note the increased risk of opioid overdose death from respiratory depression during induction onto methadone treatment. Methadone has also been associated with QTc 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 40 mg methadone. Therefore, starting methadone doses should always be 30mg or less. Additionally, patients need frequent nursing observations during induction onto methadone and a prescriber review before each dose increase.

Prescribing methadone

- Make a diagnosis of opioid dependence as above
- Drug testing confirming the presence of opioids in urine
- Wait for withdrawals (use COWS to assess withdrawals)
- Once withdrawals present COWS 5 and above, you can start methadone
- Discuss with senior colleague or consultant
- Prescribe methadone 1mg/ml solution sugar free (recommended)
- The first methadone dose should be no more than 30mg
- The next day's methadone dose can be increased by up to 10mg per day e.g., 40mg
- **Do not increase the methadone dose more than 10mg per day**
- **Do not increase by more than 30mg from the start dose in a week**

Sample methadone titration

(Please note that this must be titrated according to the individual needs)

Day	Methadone dose
1	30mg
2	40mg
3	50mg
4	50mg
5	50mg
6	50mg
7	60mg

You should aim to increase the dose until no withdrawals and cravings were present to an optimal dose range 60–120 mg per day

Buprenorphine

Buprenorphine is a partial opioid agonist with high affinity for opioid receptors. There is an oral and injectable version of buprenorphine.

The oral version of buprenorphine lasts at least 24 hours a day, and has a few formulations: sublingual tablet, an orodispersible wafer (espranor) or buprenorphine/naloxone (suboxone). A long-acting injectable version of buprenorphine is also available, but this should never be newly started on a mental health unit and can only be started by a specialist.

Prescribing Buprenorphine

The patient must be in **MODERATE WITHDRAWAL** 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 not had a short acting opioid for at least 8-12 hours and a long-acting opioid for at least 24 hours.

Prescribing Buprenorphine:

The formulation of oral sublingual and orodispersible 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.

Sample buprenorphine titration

(Please note that this must be titrated according to the individual needs)

Day	Buprenorphine S/L
1	4mg
2	8mg
3	12mg
4	16mg

If a patient is already prescribed OST

- Before continuing the prescription, you need to confirm medical/medication history with summary care records.
- Confirm OST dose with drug service
- Confirm which chemist the patient last collected OST
- Confirm with chemist when the patient last collected OST (essential)
- If you can confirm with the chemist that the patient had the last dose within last three days – you can prescribe same dose, if no other concerns

Loss of tolerance or unable to confirm last consumed dose

A patient can lose tolerance to opioid after three days of stopping opiates. So, if you can't confirm the last dose was in the last three days or if the patient has missed three days of OST, the prescriber would need to restart from a low dose and titrate to previous dose as above (DH 2017).

Opioid overdose and Naloxone

Use immediate Life Support and see the opioid overdose and naloxone policy for further details.

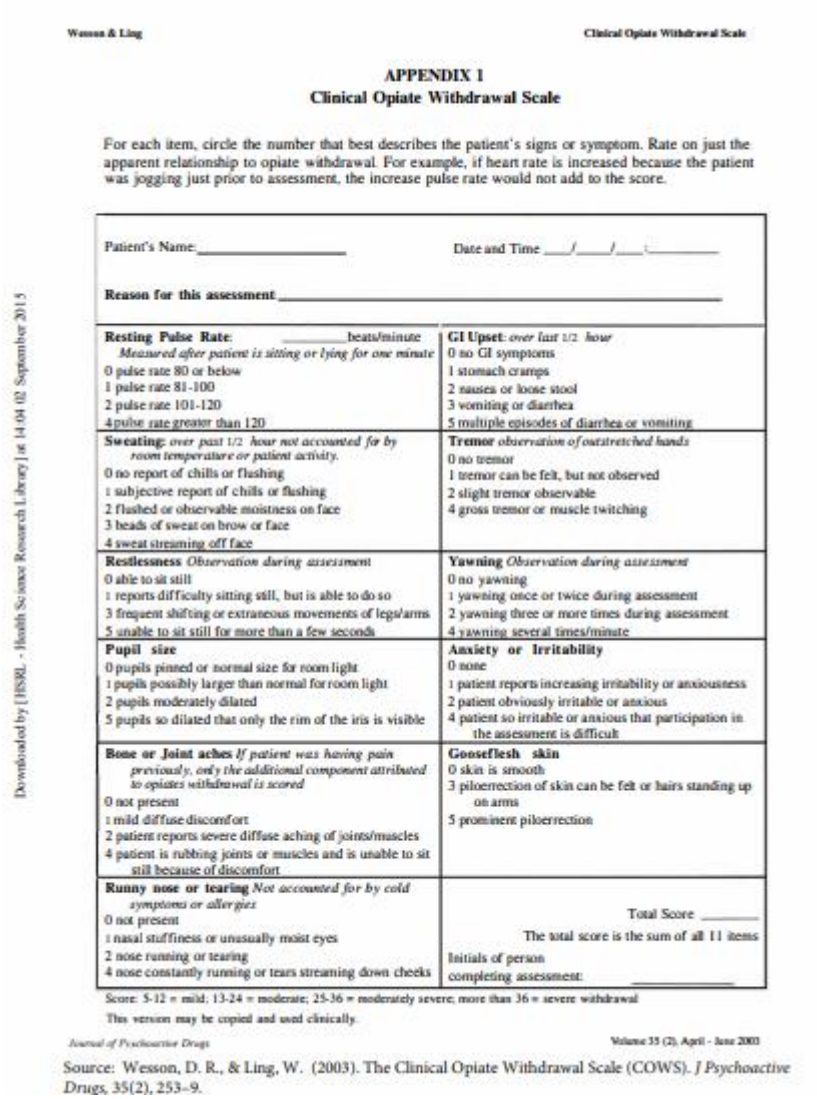
Recognising an opioid overdose

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

Management of an opioid overdose

1. Always make sure the environment is safe
2. Try wake the person by shouting/shaking gently
3. Call 999 and ask for an ambulance
4. Place them in the recovery position
5. Inject IM Naloxone
6. Stay with them and wait for the ambulance

Clinical Opiate Withdrawal Scale (COWS)



Wesson & Ling — Clinical Opiate Withdrawal Scale

APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment _____

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 sitting 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 or 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

This version may be copied and used clinically.

Journal of Psychoactive Drugs — Volume 35 (2), April - June 2003

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

References

DH 2017 Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

NICE 2007 Methadone and buprenorphine for the management of opioid dependence Technology appraisal guidance [TA114]Published: 24 January 2007