NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Problematic Drug Users In GGC, Acute Hospitals - Adult Inpatients (Management of)

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Acute Services Division

GUIDELINES ON THE MANAGEMENT OF PROBLEMATIC DRUG USERS IN GLASGOW AND CLYDE ACUTE HOSPITALS

2019-2022

Ratified by: NHS Greater Glasgow & Clyde Drug and Therapeutics Committee

Approved November 2019
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INTRODUCTION

These guidelines relate to the management of patients who have problematic drug use admitted to hospital principally for other reasons than primary drug use.

Opiates (heroin) and benzodiazepines are the substances most associated with problematic drug use in Greater Glasgow & Clyde (GGC) and therefore feature most prominently in this guidance. The diagnosis of serotonin syndrome related to New Psychoactive Substances (NPSs) is included on page 15 / **Appendix 9**. Primary problematic alcohol use is not covered by these guidelines, but in co-dependent users (heroin +/- benzodiazepines + alcohol) **Appendix 3** can be used to cover alcohol withdrawal. Patients admitted with problematic stimulant use should be discussed on an individual case basis with GGC Acute Addiction Liaison Nurses or Alcohol & Drug Recovery Services medical staff, contact details in **Appendix 1**. These Guidelines also advise on the management of individuals on Methadone, or Buprenorphine treatment who are admitted to Glasgow and Clyde acute hospitals.

These are intended as Guidelines only and cannot be comprehensive. Patients with complex needs and challenging behaviour should also be discussed on a case by case basis with appropriately experienced and trained staff. This guidance should be best used in conjunction with **Appendices 1-9** and the flow chart in **Appendix 6**.

PRINCIPLES OF MANAGEMENT

Admission to an acute hospital can be an ideal opportunity for engagement and retention in treatment for individuals who have problematic drug use. There is a current and increasing body of evidence that concurrent treatment of their substance use problems will increase compliance, retention and success of their other medical and surgical regimes.

Acute Addiction Liaison Nurses are available in all acute hospitals in Glasgow and Clyde, please contact them for advice.

THE PREGNANT PATIENT

The principles of medical practice are not different in this patient group. The immediate management of pregnant women is clearly described in each section. The different management issues in pregnancy are described on page 15. For longer term management additional specialist advice and support is also available from both Senior Addiction Specialists and Special Needs in Pregnancy Service (SNIPS) for GGC (see contact details at **Appendix 1**). This service is not available 24/7 so if specialist advice is not available, initial management should follow generic guidelines.

HISTORY, EXAMINATION AND INVESTIGATION

DEFINITION

Dependent users will most likely require medical interventions. In GGC, drug dependence is defined by the ICD-10 classification of mental and behavioral disorders where 3 or more of the following have been present together in the past year:

- A strong desire or sense of **compulsion** to take the substance
- **Loss of control** of substance-taking behaviour
- A characteristic **withdrawal syndrome** for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms
- Evidence of **tolerance**, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses
- **Salience over** alternative pleasures or interests
- **Persisting drug use despite harmful consequences**

In addition to the usual medical history the following should be documented:

- Drugs used
- Frequency and amount used
- Route of use e.g. IV, smoked, ingested
- Whether usage is increasing/decreasing
- Recent use
- Previous use
- Previous or current treatment
- Tetanus immunisation status

Examination

- **Injection sites** (Frequent injectors will have multiple sites of different age and usage)
- **Evidence of withdrawal** (requires Subjective Opiate Withdrawal Scale (SOWS) to be undertaken see **Appendix 4**)

Investigations

- **Drug urinalysis (if available):** This does not replace full clinical assessment. Positive urinalysis indicates a drug has been taken but does not indicate when. Some of the new type drugs on the street, including novel benzodiazepines, cannot be tested for using standard urine tests
- **ECG**: Most patients will have a routine ECG, however this should be done for all patients prescribed methadone to assess for prolonged QT interval (http://www.ggcprescribing.org.uk/blog/mue-08-drug-induced-qt-prolongation)

  (The QT interval is corrected for heart rate by the QTc, in men the upper limit of normal is 0.44s and in women 0.46s)

  Prolongation of the QT interval can be associated with ventricular arrhythmias and death. Causes other than methadone should be considered and excluded eg genetic, adverse drug effects (anti-psychotics), endocrine and metabolic disturbances.

  If during admission QTc is prolonged on repeated ECG and all other reversible causes are excluded, a risk assessment of altering methadone dose or switching to buprenorphine should be discussed with Alcohol and Drug Recovery Service medical staff. Consideration should be given that the risk of relapse to heroin outweighs cardiac risk in most patients.

  For more information please refer to National Orange guidelines. Drug Misuse and Dependence: UK Guidelines on Clinical Management

- **Blood Borne Viruses**
  Especially, Hepatitis C & HIV

  Opportunistic screening for blood borne viruses should be offered at any healthcare contact. The HIV Failsafe team will ensure follow up; it is the duty of the testing clinician to inform the patient of the hepatitis screening results unless other systems are in place.

For treatment / support advice for staff the HIV Failsafe team can be contacted on – 0141 211 0097

TREATMENT OPTIONS

Heroin dependency can be treated with symptomatic relief as described in **Appendix 2** detoxification regimens or maintenance programmes. Detoxification is usually only suitable for highly motivated individuals with a short history of dependence and reasonably well preserved health and social functioning. A strong body of evidence now supports the view that most opiate dependent individuals require maintenance treatment with psychosocial support using methadone or buprenorphine.

Patients on a Methadone or Buprenorphine substitute prescription

Patients may take 24-36 hours to develop symptoms and signs of withdrawal, so may not need a dose within the first hours of admission unless they are pregnant see Page 15.

Telephone their care manager to inform them of admission and community dispenser to inform them of patient's hospitalisation, to confirm dosage and when last consumed. If all is confirmed and their assessment is satisfactory then continue their present dose, if not, contact acute addiction liaison for advice.

Do not feel pressurised to prescribe. Only prescribe when assessment (Appendix 4), examination and investigations have been completed and indicate that prescription is appropriate.

Enhanced Drug Treatment Service (EDTS)

These patients will be receiving injectable diamorphine treatment and opiate replacement therapy (ORT) in the form of methadone. These are prescribed and dispensed in the EDTS premises. **DIAMORPHINE BY INJECTION FOR THE TREATMENT OF ADDICTION MAY ONLY BE PRESCRIBED BY DOCTORS HOLDING A SPECIALIST LICENCE AND ONLY ADMINISTERED WITHIN EDTS PREMISES. DIAMORPHINE TREATMENT MUST NOT, UNDER ANY CIRCUMSTANCES, BE CONTINUED WHILST A PATIENT IS IN HOSPITAL.**

EDTS is open 9am-5pm seven days including public holidays – Tel: 0141 533 2835 or 0141 553 2876

Outwith this time patients should be treated in line with the principles detailed in this guideline. See **Appendix 6**

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Length of stay in Hospital

1. Short stay (<7days)

- if on a methadone or buprenorphine prescription in the community check last date and dose with the community dispenser before continuing (Appendix 6). If not on methadone or buprenorphine refer to **Appendix 2** for crisis management
- if a poly drug user not on treatment presents in withdrawal and requires overnight admission, a crisis management regimen (see **Appendix 2** and **Appendix 3**) may be appropriate. Refer to acute addiction liaison nurses to arrange longer term assessment and treatment
- if pregnant see relevant section on Page 16

2. Longer stay (>7days)

- if on a prescription check last date and dose with the community dispenser before continuing (Appendix 6), if not, care planning and management is possible. Please discuss the patient with Acute Addiction Liaison Nurses or appropriate Senior Alcohol & Drug Recovery Service Medical Officer if liaison nurses are not available. (**Appendix 1**).
- if someone has a condition requiring admission for weeks or longer then stabilisation with methadone may be indicated.

***Do not initiate Methadone or Buprenorphine treatment without advice from specialist addiction services and without arranging continuation of treatment on discharge*.**

In pregnancy there should be a low threshold to initiate Methadone or Buprenorphine.

CAUTION - Methadone

Methadone has a long half-life (range from 14 to 72 hours - mean about 24).

It may be lethal in overdose or when given to patients who have lost their tolerance to opioids, or opioid naive patients.

Extra caution should be exercised when re-introducing Methadone/ Buprenorphine following a period of abstinence. e.g post intubation following an ITU admission

For the management of patients on Methadone / Buprenorphine please refer to **Appendix 5** and **Appendix 6**

Please consult Acute Addiction Liaison Nurses or SNIPs GGC if the patient is pregnant. Please refer to **Appendix 1**

MISSED DOSES

If a patient has missed up to 3 days (72hrs) of methadone but has continued to use heroin or other opiates loss of opiate tolerance is unlikely and may not require a reduction in their prescribed methadone dose (see **Appendix 6**)

However, if a patient has been physically unwell and completely abstinent a more cautious approach may be required. Contact acute addiction liaison service (see **Appendix 1**).

CAUTIONS

Exercise extra caution when prescribing Methadone or Benzodiazepines in:

- Respiratory disease
- Head injury – in head injury the Glasgow Coma Scale is not sensitive enough to assess opioid intoxication
- Liver disease/ Hepatitis
- Co-existent alcohol dependence
- Overdose/ decreased tolerance
- If receiving opiate analgesia or other sedating medications
- Patients with severe pain (in this group titrated IV/subcutaneous morphine is the regimen of choice, avoid **pethidine**)
- Interactions with other prescribed drugs, check if it will alter the effects of methadone or benzodiazepines eg rifampicin used in the treatment of tuberculosis reduces methadone plasma concentration by 30-65%
- Pregnancy; unless indicated for emergency treatment of seizure activity please refer to pregnancy section page 16
- Methadone Dose in Renal Impairment
  Glomerular Filtration Rate (GFR)
  ≥10 ml/minute/1.73m² no change
  <10 ml/ minute/1.73m² reduce by 50% and titrate according to response

If oral doses of methadone or benzodiazepines cannot be given, reduced intravenous doses of benzodiazepines or subcutaneous methadone may be given. Typically dose conversion from oral to subcutaneous methadone is half, which can be given as 2 separate doses, 12 hours apart. The patient should be monitored closely and the dose adjusted accordingly.

When returning to oral methadone recommence original oral dose if there is no risk of overdose.

Advice must be sought from addiction specialists on an individual patient basis for conversion.

If methadone has not been consumed and the patient has been completely abstinent for more than 48 hours see **Appendix 6** and contact acute addiction liaison nurse service for advice.

In pregnancy, there are increased risks associated with opiate withdrawals. Urgent advice must be sought from local senior alcohol & drug recovery service medical staff and maternity specialists (SNIPS). See **Appendix 1** for contact details

Buprenorphine

Buprenorphine is a partial agonist, and will act as an antagonist in the presence of a competing agonist such as strong oral opiates or diamorphine. This will result in precipitated withdrawal or opiate blockade. It also means Buprenorphine is safer in overdose and may be less sedating than methadone.

Care must always be taken when titrating or re-titrating Buprenorphine see **Appendix 5**. Care must be taken with missed doses of >48 hours plus see **Appendix 6**, contact acute addiction liaison nurse services for advice.

Buprenorphine is restricted to initiation by alcohol & drug recovery services or GPs who have received appropriate training and authorisation from addiction services for those patients for whom methadone is not suitable and for whom the use of Buprenorphine is considered appropriate.

PATIENTS LIKELY TO SUFFER BENZODIAZEPINE / HYPNOTIC WITHDRAWAL

These guidelines give pragmatic guidance for the hospital management of problematic benzodiazepine use and dependency.

Benzodiazepine withdrawal can cause potentially life threatening seizures.

Other symptoms of acute benzodiazepine withdrawal:

anxiety; tremor; insomnia; nausea and vomiting

Street bought benzodiazepines are of varying strength and patients should be treated based on symptoms.

Small doses of diazepam (5-10mg) should be prescribed in the “once only” section of the prescription kardex and patients re-assessed at regular intervals. If they are not drowsy or intoxicated then this may be repeated 6 hourly. Seek advice from acute addiction liaison nurse service.

ALL THESE MEDICATIONS SHOULD BE DISPENSED UNDER SUPERVISION

Patients not on a substitute prescription contact acute addiction liaison nurses

Decide whether short stay (crisis management) or longer stay (care planning) is required.

Complete assessment (history, examination and investigation) and exclude other illnesses, which may cause symptoms similar to opiate withdrawal.

Always seek advice in pregnancy and breast feeding from local senior alcohol & drug recovery services medical staff and maternity specialists **the Special Needs in Pregnancy Service (SNIPS) in Glasgow and Clyde as appropriate. See Appendix 1.**

If patients develop objective signs of withdrawal (**Appendix 4**), begin treatment to alleviate the withdrawals in line with **Appendix 2**.

Remember symptoms of opiate withdrawal may be subjectively severe but objectively mild.

If stabilisation with methadone or buprenorphine is appropriate then contact the acute addiction liaison nurse service who can give further advice and assistance, and facilitate arrangements with GPs, local Community Alcohol and Drug Recovery Services (**Appendix 1**), and through care planning. Treatment options at this point would be to proceed to emergency treatment of acute withdrawal if maintenance will not be possible, but this should be a last resort. See **Appendix 2** and **Appendix 3**.

Buprenorphine should only be initiated by an addictions specialist.

Problematic Use of Drugs and Alcohol

Primary problematic alcohol use is not covered by these guidelines, please refer to the Glasgow Modified Alcohol Withdrawal Scale (GMAWS) and contact acute addiction liaison nurse services for further advice. (**Appendix 1**)

Patients on weekend pass / short periods up to 3 days

On occasions where a patient on a substitute prescribing programme is discharged from hospital for a short period, for example, on weekend pass, it is the responsibility of the **discharging hospital** to continue Methadone / Buprenorphine prescribing during this period, and also advise the community prescriber / dispenser of this arrangement. The patient should be advised prior to leaving hospital to return to the ward for daily dispensing of their substitute prescription.

Do not give a supply of Methadone / Buprenorphine home

Prior to the patient leaving the ward the community team and dispenser must be made aware of this arrangement.

PATIENT DISCHARGE PROCEDURE

No patient on a Methadone or Buprenorphine prescription should be discharged without arrangements being made for continuity of their substitute prescription. This is particularly important for weekend discharges. If the acute addiction liaison nurses are involved they may be able to make appropriate arrangements.

Inform community dispenser of last dose of Methadone / Buprenorphine providing time and date given in hospital. Prior to discharge phone GP or Community Alcohol and Drug Recovery Service prescriber to inform of discharge and dosage of Methadone / Buprenorphine prescribed. Ensure IDL is completed and authorised.

Do not give a supply of Methadone / Buprenorphine home

If a patient requires to be discharged on opiate analgesia, the dose should be the lowest effective dosage as per WHO pain guidelines. Remember their GP can facilitate daily pick up of their analgesia with their Methadone / Buprenorphine prescription.

HARM REDUCTION

Offer advice on harm reduction including:

- Overdose awareness
- Avoiding sharing needles, spoons, filters or other injecting paraphernalia
- Safe sex

Contact details are available from Community Alcohol and Drug Recovery Services for all Injecting Equipment Providers in GGC. See **Appendix 1**

TAKE HOME NALOXONE (PRENOXAD)

Opiates such as heroin and methadone are most commonly implicated in drug related deaths, especially when taken in combination with other central nervous system depressants such as alcohol and benzodiazepines. The Take Home Naloxone programme within NHS GGC allows individuals at risk of opiate overdose to access Overdose Awareness Training and be issued with a supply of Take Home Naloxone. An individual does not need to be in structured treatment to be able to access Take Home Naloxone. Up to date guidelines can be found in the Clinical Guideline Repository on Staffnet by searching for Naloxone.

Training and supply can be accessed by:

- Referral to the acute addiction liaison nurses whilst in hospital (see **Appendix 1** for contact details)

- Self referral via any Drug Service (**Appendix 1**) or Community Alcohol and Drug Recovery Service (**Appendix 10**).

- The Glasgow Drug Crisis Centre, 123 West St, Glasgow, G5 8BA. Telephone 0141 420 6969.

Patients who are considered to be at risk of overdose should be offered naloxone training by the acute addiction liaison nurses whilst in hospital and a supply of "take home" naloxone dispensed by the ward on discharge. Contact details and further information is shown in **Appendices 1 and 10**.

PROBLEMATIC DRUG USE IN PREGNANCY

Drug use in pregnancy results in a high risk pregnancy and management should be multidisciplinary, with particular importance placed on communication between all professionals involved.

In Greater Glasgow and Clyde it is recommended that all drug using pregnant women, including those on substitute prescribed medication are referred to the Special Needs in Pregnancy Service (SNIPs) as the best way to ensure that they receive the appropriate maternity care during and following their pregnancy.

For pregnant women, ORT has additional complexities and all cases should be discussed with Senior Alcohol & Drug Recovery Service Medical Staff.

There is evidence to suggest that maternal withdrawal, even mild, is associated with foetal stress, foetal distress and even stillbirth, particularly in the third trimester. Abrupt withdrawal of opiates is best avoided as it carries a risk of miscarriage, foetal distress and premature labour.

Benzodiazepines should not be prescribed to pregnant women unless indicated as emergency treatment however long term benzodiazepine prescriptions should not be abruptly stopped. Benzodiazepines should be rationalised and converted to diazepam and reduced. Patients at high risk of benzodiazepine withdrawals due to illicit use should be referred to acute addiction liaison nurse service, **Appendix 1**.

NEW PSYCHOACTIVE SUBSTANCES

For the diagnosis and management of serotonin toxicity, see **Appendix 9**

New psychoactive substances (NPS) represent a diverse group of drugs that can be classified according to their pharmacological activity. There have been nearly 500 different compounds identified, however only a handful are found to be in circulation. Such drugs may or may not be detected by urine toxicology screens, and the utilisation of such testing will neither confirm nor exclude their use. The mainstay of treatment is supportive, with the use of sedation in agitated individuals, and monitoring of blood glucose.

Synthetic Cannabinoids

These represent the most diverse class of compounds, and are the most commonly consumed products, predominantly by smoking. They are sold in foil packets with names such as “exodus damnation,” “sweet leaf obliteration,” and “annihilation.” They act as full agonists on the endogenous cannabinoid receptors in the brain.
Clinical features associated with their use are nausea, vomiting, and induced dissociative state. Case reports in the literature have identified acute ischaemic stroke, and acute kidney injury following daily consumption. The synthetic cannabinoids appear to be a significant trigger in the development of acute mental health presentations.

Novel Benzodiazepines

There has been an increase in the number of potent novel benzodiazepines on the market, many of which have not undergone formal pharmacological testing. They may or may not be identified on urine toxicological testing. These benzodiazepines may be used in significant quantities along with other street drugs; withdrawal may lead to seizures or fits. Patients may also use them to ‘self-medicate’ when consuming stimulants.

Synthetic Cathinones

These chemicals represent the synthetic analogues of the natural stimulant cathinone found in the Khat plant. They act as stimulants similar to amphetamines, but have varying activities on neurotransmitters, with some more potent at inducing serotonin toxicity.

Stimulants

Most stimulants are sold as alternatives to cocaine or amphetamines. They predominantly act on dopamine and noradrenaline transport system within the CNS.

Hallucinogens

Sold on blotters like LSD, these compounds have a prolonged duration of action, with much greater potency. Unlike LSD, they may have intensive vasoconstrictive properties, and case reports have identified acute digital ischaemia with their use.

Cocaine

Cocaine is a stimulant, it increases levels of several neurotransmitters and exerts sodium and potassium blocking effects. As a result multiple body systems are affected and intoxication may present in a multitude of ways.

Please refer to guidelines at www.toxbase.org for the detailed management of cocaine toxicity.

For the diagnosis and management of serotonin toxicity see **Appendix 9**.

MANAGEMENT OF PAIN IN PATIENTS ON SUBSTITUTE PRESCRIPTIONS METHADONE & BUPRENORPHINE

DO NOT WITHOLD ANALGESIA IF PATIENTS ARE IN PAIN

Introduction

- Patients on Methadone / Buprenorphine expect that their pain will be badly managed and are frequently anxious about the possibility of drug withdrawals
- This Guideline is to be used where non opiate analgesics have failed or are inappropriate, as per WHO Pain Ladder **Appendix 7**
- There is no direct conversion between methadone and morphine
- Methadone is a very poor analgesic and should not be relied upon in this patient group
- Buprenorphine should not be used as analgesia in patients taking full agonists, such as codeine or morphine based drugs
- Consider alternatives eg paracetamol, nerve blocks or splints

Anticipated Pain (Elective)

METHADONE

- Where a patient on methadone is to undergo a procedure resulting in moderate to severe pain, they should continue on their normal dose until the day of surgery
- Whether patients should take their normal dose of methadone on day of the procedure will be dependent on the timing of surgery and ultimately decided by the anaesthetist
- They will require 10-20mg of morphine 4-6 hourly thereafter, IV preferably. Morphine requirement should be re-titrated to pain.
- Patients should recommence methadone on their current dose if this can be achieved in less than 48hrs, if this is not possible contact acute addiction liaison nurse service. Outwith the hours of 9am-5pm Monday-Friday please refer to **Appendix 6**.

Buprenorphine

These guidelines are considered optimal, however each case should be considered on an individual basis with the responsible anaesthetic team.

- Where the patient is on Buprenorphine, they will need to stop their tablets **24 hours before surgery**
- This is because it is a partial agonist, and as such, can act as an antagonist in the presence of a competing agonist such as diamorphine, resulting in precipitated withdrawal or opiate blockade
- Following the procedure, they will require 10-20mg of morphine 4-6 hourly IV preferably
- A gap of 12-16 hours after the last dose of morphine is recommended before restarting Buprenorphine to prevent precipitated withdrawal
- Restart Buprenorphine as per **Appendix 5**
- Seek specialist advice from acute addiction liaison nurse service

Discharge Arrangements

- Contact patient's GP / local prescribing team and pharmacist prior to discharge to ensure continuation of prescription, or acute addiction liaison nurse service (see **Appendix 1)**
- If patient requires to be discharged on opiate analgesia, the dose should be the lowest effective dosage as per WHO pain guidelines. Remember their GP can facilitate daily pick up of their analgesia with their Methadone / Buprenorphine prescription

Unanticipated Pain (EMERGENCY)

Methadone

- If on methadone, there is no direct conversion to morphine. Give 10-20mg morphine 4-6 hourly, preferably IV
- If in ITU and ventilated, the propofol and morphine should be adequate without the immediate reintroduction of methadone
- If a patient is on pain control analgesia (PCA) or regular IV morphine seek advice from Acute Addiction Liaison Nurses or Alcohol & Drug Recovery Services Medical staff as to dose of methadone to be prescribed **Appendix 1**
- To restart methadone, start at 20mg and increase dose of methadone as dose of morphine decreases. On day 1, patient can have further 10mg methadone if required to stop withdrawal. Dose would then be titrated in the usual way, as per guidelines **Appendix 5**

Buprenorphine

- If on Buprenorphine, no further doses should be given following admission
- Patients should receive 20-40mg morphine 4-6 hourly IV preferably
- Monitor for signs of Acute Withdrawal using SOWS rating scale **Appendix 4**
- Over next 72 hours, reduce to 10-20mg morphine
- Continue to observe for signs of withdrawal but do not confuse with signs of inadequate pain relief
- To restart, no opiates for 12-16 hours and re-titrate as per Prescribing Guidelines **Appendix 5**

Discharge Arrangements

- Contact patient's GP / local prescribing team and pharmacy prior to discharge to ensure continuation of prescription, or acute addiction liaison nurses see **Appendix 1**

- If patient requires to be discharged on opiate analgesia, the dose should be the lowest effective dosage as per WHO pain guidelines. Remember their GP can facilitate daily pick up of their analgesia with their Methadone / Buprenorphine prescription

Summary **Appendix 8**

- Patients who continue to show objective signs of acute pain, such as sweating, dilated pupils and rapid respiratory rate, may require higher doses of opiate analgesia than those mentioned above

- However, this should not be confused with "Hyperanalgesic Syndrome", where pain is increased following opiate administration. A patient, who has increased pain as a result of tolerance, would be expected to improve with further opiate administration

- Patients with problematic drug use have frequent episodes of intoxication / withdrawal which may alter the intensity of their pain experience

- When suitable and safe, non opiate analgesics should be used

Contacts

Useful phone numbers and contacts see **Appendix 1**

APPENDIX 1

Useful Phone Numbers & Contacts During Working Hours

ACUTE ADDICTION LIAISON NURSE SERVICES

Glasgow	Queen Elizabeth University Hospital / Gartnavel General Hospital / Glasgow Royal Infirmary / Stobhill Hospital Victoria Hospital / Vale of Leven	0141 211 0231 0141 211 0238
Renfrewshire	Royal Alexandra Hospital	0141 314 4472
Inverclyde	Inverclyde Royal Hospital	01475 715 353

GGC ALCOHOL & DRUG RECOVERY SERVICES SENIOR MEDICAL STAFF / CONSULTANT PSYCHIATRIST

Glasgow - Main switchboard – 0141 303 8971

Leven - Main switchboard – 01389 812 018

Renfrewshire - Main switchboard – 0300 300 1199

Inverclyde - Main switchboard – 01475 715 353

GLASGOW SPECIAL NEEDS IN PREGNANCY SERVICE (SNIPS)

Specialist obstetric addictions advice is not available 24/7. In the absence of specialist advice pregnant women using alcohol or other drugs should be managed according to general guideline and specialist advice sought at the earliest opportunity.

Dr Ellis – 0141 211 5132 or page – 2255 via main switchboard – 0141 211 5400

A SNIPS midwife is on duty 8.30am – 4.00pm 7 days / week and can be contacted by leaving a message on answer phone in the SNIPS midwifery office, checked twice daily:

SNIPS midwifery office – 0141 211 5366

NB – In addition, advice on obstetric management should always be sought from the unit where the woman is booked or closest obstetric unit as appropriate

CLYDE SPECIAL NEEDS IN PREGNANCY SERVICE (SNIPS)

Royal Alexandra Hospital – 0141 314 6199
Inverclyde Royal Hospital – 01475 504 833
Vale of Leven Hospital – 01389 817 270

GGC ADDICTION PHARMACY SERVICES

Main switchboard - 0141 303 8971

FAMILY SUPPORT SERVICE

Scottish Families Affected by Alcohol & Drugs – 08080 10 10 11 - www.sfad.org.uk

FOR OUT OF HOURS

Please contact The Drug Crisis Centre, 123 West St, Glasgow, G5 8BA. Telephone 0141 420 6969.

APPENDIX 2

Suggested emergency management of withdrawal symptoms, as per the Subjective Opioid Withdrawal Scale (SOWS) (Appendix 4) for those patients:

- Awaiting further assessment

- Awaiting confirmation of patients Methadone / Buprenorphine dose

- Short term admissions for whom no through care is possible

- Dihydrocodeine to be prescribed in doses of up to 60mgs four times daily
- This dose can be reduced or maintained during short admissions depending on the clinical condition of the patient.
- **Do not supply on discharge**

If required, incremental reductions can be daily or every other day.

Note: *Although this is established practice supported by some evidence base, this is an unlicensed use of dihydrocodeine. Liquid preparations are the preferred formulation to enable supervised administration*.

For further advice contact acute addiction liaison nurse service (**Appendix 1**)

APPENDIX 3

Suggested detoxification or maintenance regimen for short term admissions for a problematic benzodiazepine use and seizures. Please discuss with acute addiction liaison nurses.

It is recognised that the doses of diazepam used in treating these patients is well in excess of those normally prescribed.

Oral Diazepam could be prescribed as follows:

20mg three times daily for 3 days	(Days 1-3)
15mg three times daily for 3 days	(Days 4-6)
10mg three times daily for 3 days	(Days 7-9)
5mg three times daily for 3 days	(Days 10-12)
5mg twice daily for 3 days	(Days 13-15)
5mg once daily for 3 days	(Days 16-18)

Diazepam detoxes should be agreed on an individual basis according to level of use and length of hospitalisation and discussed with **acute addiction liaison nurses**.

If required, incremental reductions can be daily or every other day.

Notes

1. For those abusing opiates plus benzodiazepines and / or alcohol, for whom no through care is possible, a combination of **Appendix 2** and **Appendix 3** can be prescribed, please also refer to the Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

   It is recognized that the doses of diazepam for this patient group are well above those normally prescribed and patients should have their physical observations closely monitored

2. If the patient presents with signs of sedation or intoxication, the dose can be withheld until clinical condition is satisfactory. Then proceed with a reduced dosage

3. Do not assume if a patient becomes unusually drowsy they have had illicit drugs. There may be an underlying medical reason that requires further investigation and patient should be closely monitored

4. On discharge continuation of a hospital initiated benzodiazepine prescription is **not** recommended

APPENDIX 4

Assessment of Opiate Withdrawal – Subjective Opioid Withdrawal Scale (SOWS)

Observe the patient and score accordingly. A score of more than 5 is strongly suggestive of opiate withdrawal in a dependent patient.

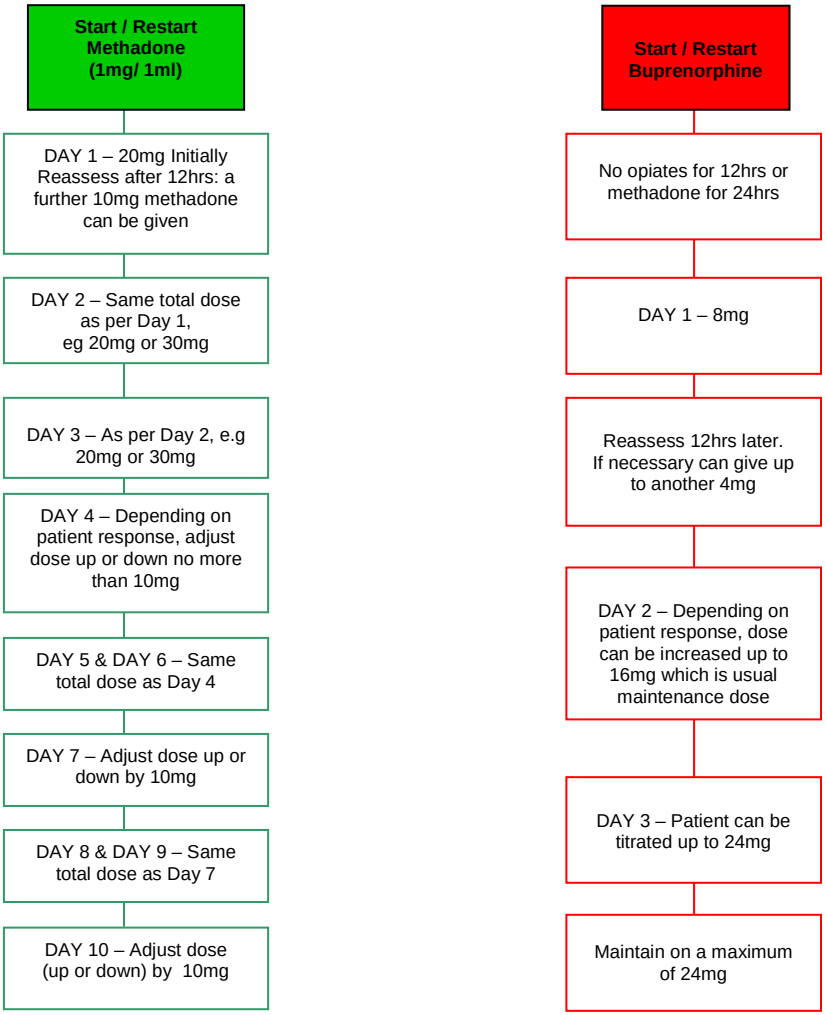
	2	1	0
Pupil size	**Wide**	**Normal**	**Pin point**
Palms	**Wet**	**Moist**	**Dry**
Skin	**Goosed**	**Cold**	**Warm**
Nasal	**Running**	**Sniffing**	**Dry**
Agitation	**Can't sit**	**Agitated**	**Calm**
GIT	**Vomiting**	**Nausea**	**Normal**
Pulse	**>100**	**80-100**	**<80**
TOTAL			

APPENDIX 5

Flow Chart for Titration / Re-titration of Methadone / Buprenorphine

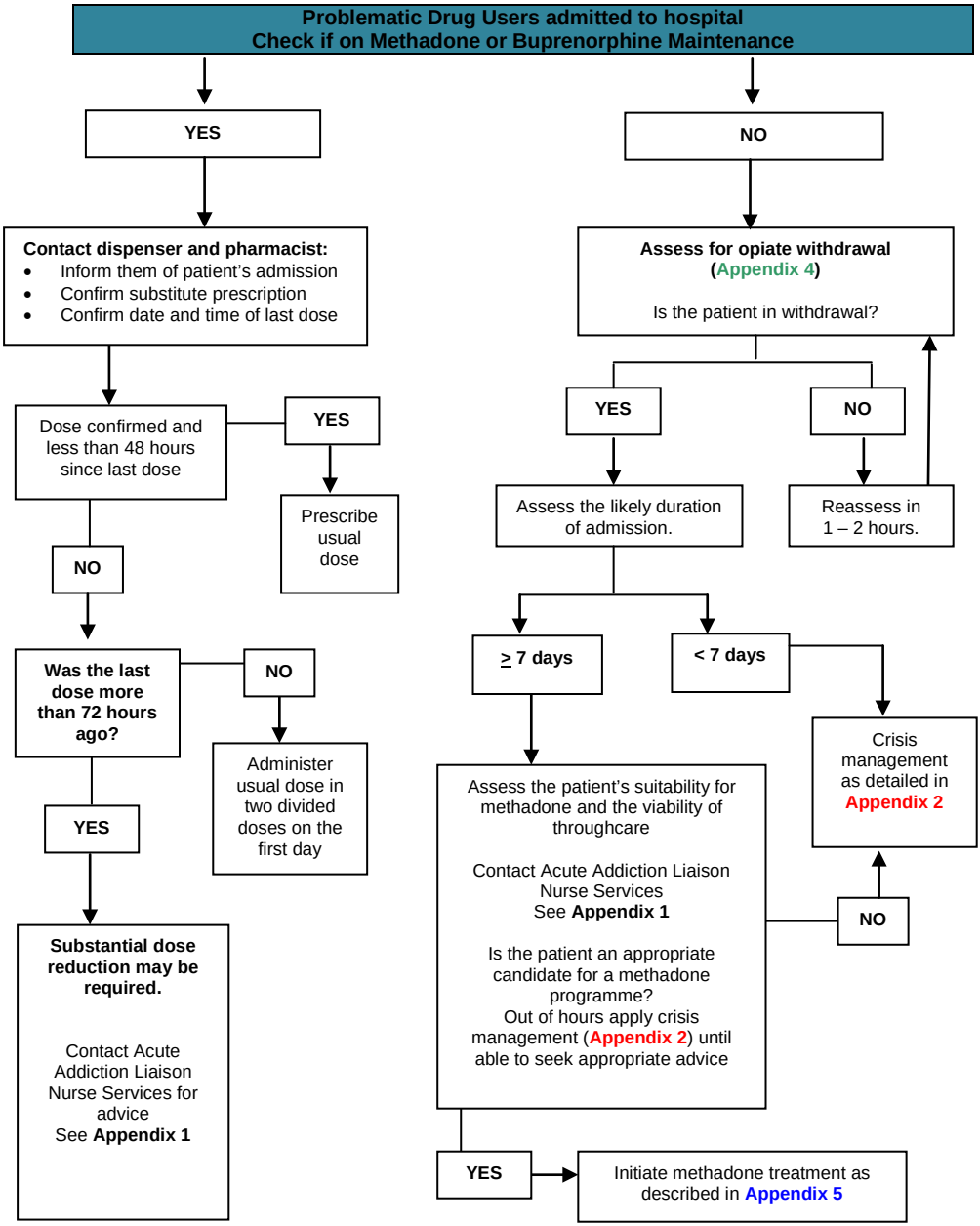
Initiating substitute prescriptions

Do not initiate substitute prescription treatment without advice from Acute Addiction Liaison Nurses and / or GGC Addictions Senior Medical Staff (appendix 1) and without arranging continuation of treatment on discharge with Glasgow Alcohol and Drug Recovery Services or Clyde Community Drug Services

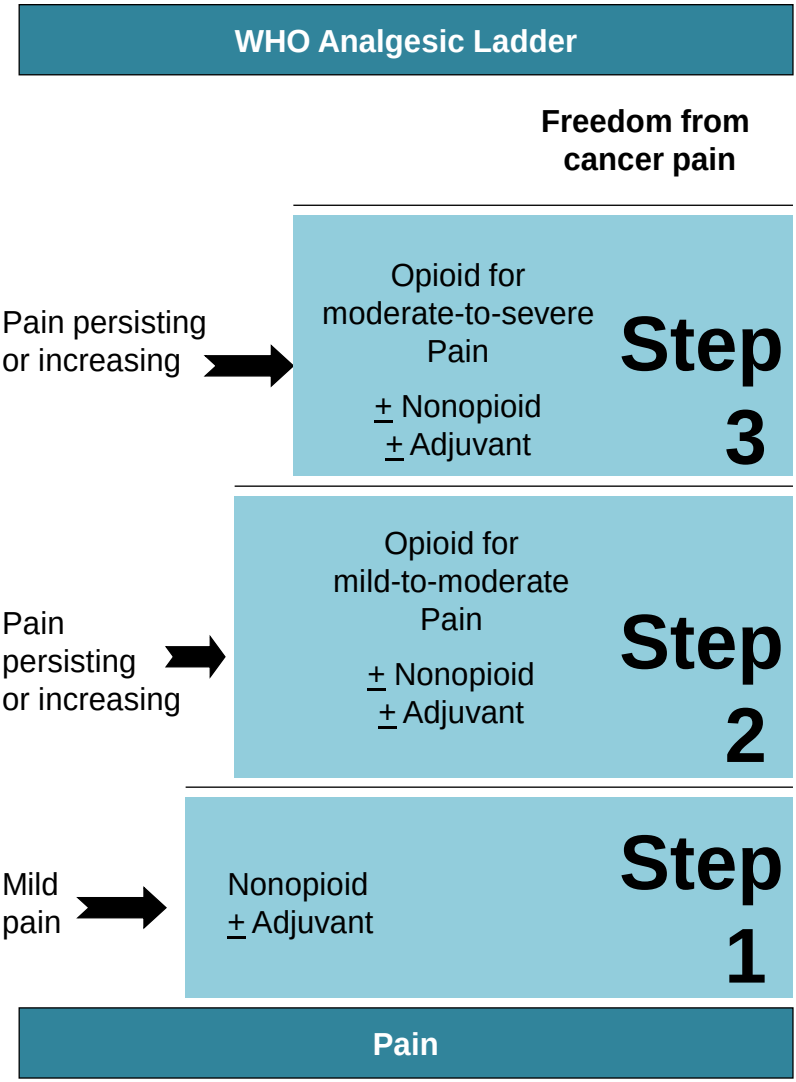


APPENDIX 6

Flow Chart for use with Hospital Guidelines on the Management of Problematic Opiate users in Hospital



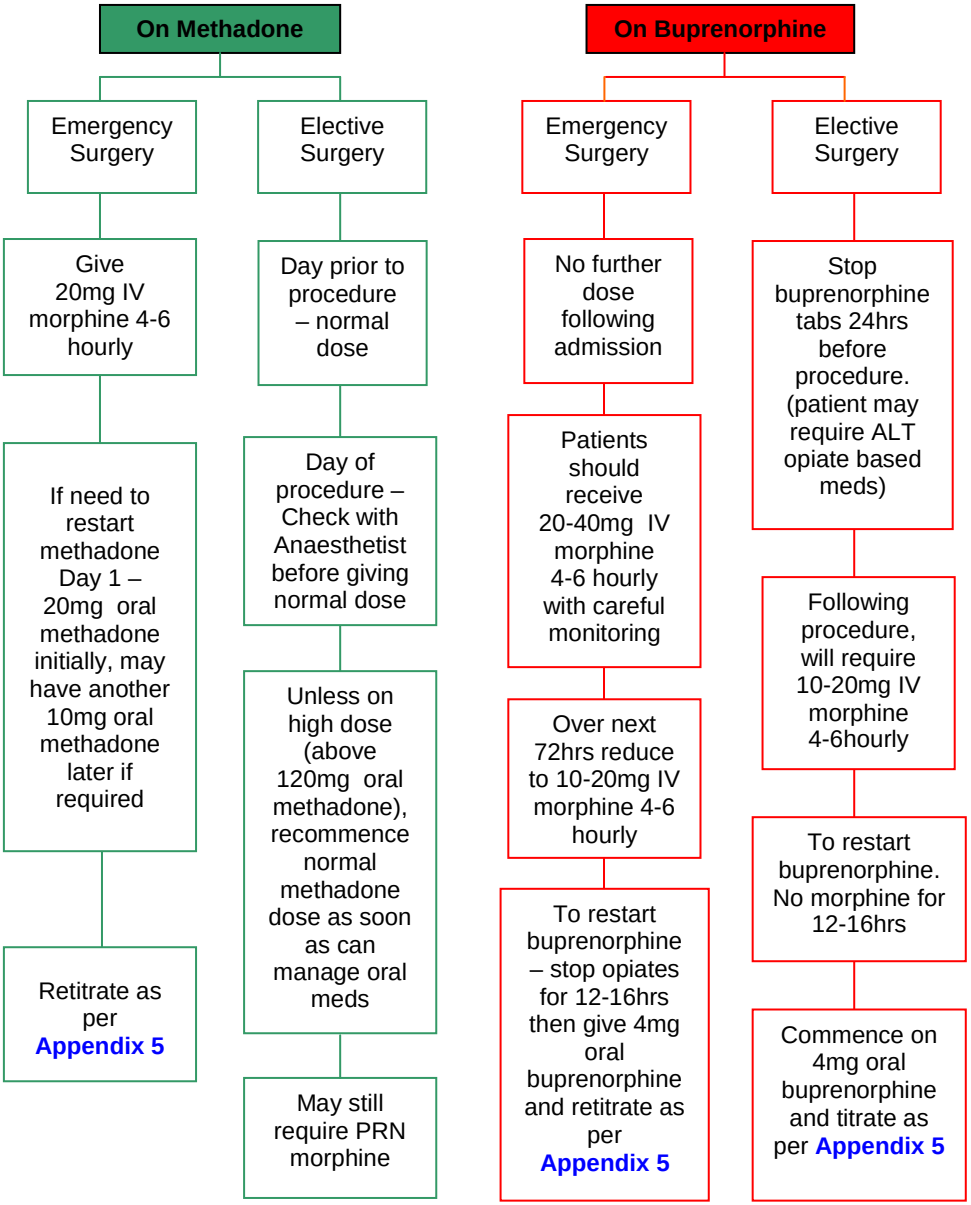
APPENDIX 7



Adapted from: World Health Organisation. *Cancer pain relief and palliative care*. Geneva: WHO; 1996. Used with permission

APPENDIX 8

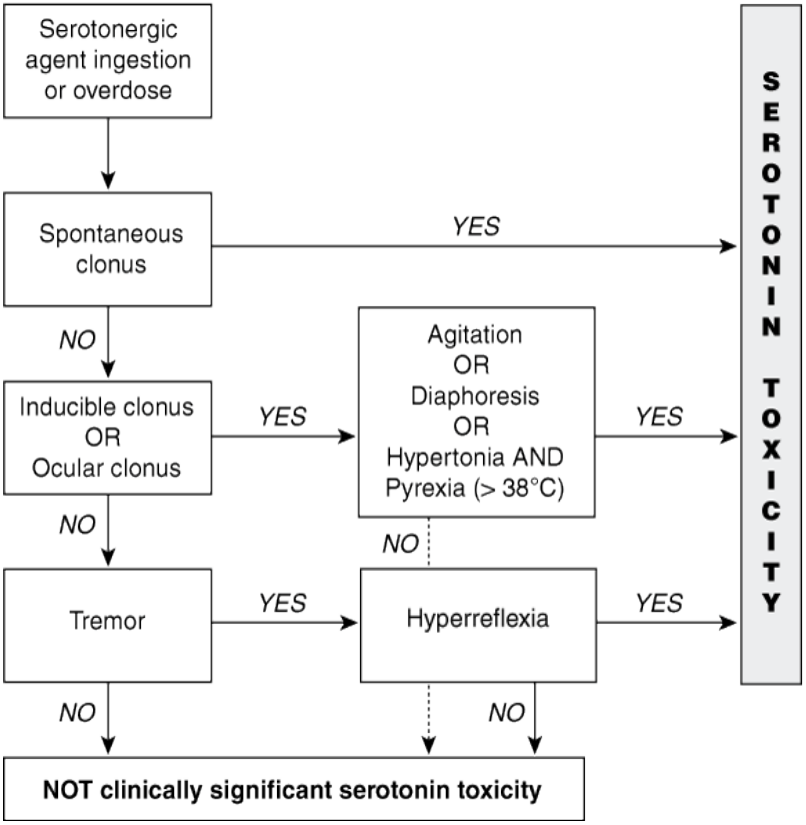
Patients admitted on Substitute Prescription who require Opiate Pain Relief



APPENDIX 9

Diagnosis of Serotonin Toxicity

www.toxbase.org



For guidance on the treatment of serotonin toxicity, click on link below for Clinical Guidelines Repository on StaffNet and search 'serotonin toxicity recognition'
http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/PoliciesProcedures/GGCClinicalGuidelines/Pages/home_page.aspx

APPENDIX 10

For further information / advice on Naloxone please contact the relevant team listed below.

For Out of Hours please contact The Drug Crisis Centre, 123 West St, Glasgow, G5 8BA. Telephone 0141 420 6969

Community Alcohol & Drug Recovery Services

East	**Newlands Centre, 871 Springfield Rd, G31 4HZ**	**0141 565 0200**
North East	**1250 Westerhouse Rd, G34 9EA**	**0141 276 3420**
South	**Gorbals Health & Care Centre, 2 Sandiefield Rd, G5 9AB**	**0141 420 8100**
South East	**10 Ardencraig Place, G45 9US**	**0141 276 5040**
South West	**Pavilion One, Rowanpark Business Centre, 5 Ardlaw Street, G51 3RX**	**0141 276 8740**
Pollok	**130 Langton Rd, G53 5DP**	**0141 276 3010**
North West (Possilpark)	**Possilpark Health & Care Centre, 99 Saracen St, G22 5AP**	**0141 800 0670**
North West (Drumchapel)	**7-19 Hecla Square, G15 8NH**	**0141 276 4330**
North West	**Woodside Health & Care Centre, 891 Garscube Rd, G20 7LR**	**0141 276 4580**
Homeless Health Service (Glasgow)	**55 Hunter Street, G4 0UP**	**0141 553 2801 0141 553 2807**
Enhanced Drug Treatment Service	**55 Hunter St, G4 0UP**	**0141 533 2835 0141 553 2876**
East Renfrewshire	**St Andrews House, 113 Cross Arthurlie St, G78 1EE**	**0141 577 3368**
East Dumbarton	**Kirkintilloch Health & Care Centre, Saramago St, G66 3BF**	**0141 232 8211**
Leven	**Dumbarton Joint Hospital, Cardross Rd, G82 5JA**	**01389 812 018**
West Dumbarton	**120 Dumbarton Road, G81 1UG**	**0141 562 2311**
Inverclyde	**Wellpark Centre, 30 Regent St, Greenock, PA15 4PB**	**01475 715 353**
Renfrewshire	**Renfrewshire Drug Service 20 Back Sneddon St, Paisley, PA3 2DJ**	**0141 618 2585**

For further information on the take home naloxone programme within NHS GG&C please contact: GGC Addiction Pharmacy Service on: 0141 303 8971

APPENDIX 11

Acknowledgements & Contributors

In memory of George Benson who sadly passed away July 2019. George was a valued member of the group and a key contributor to these Guidelines. For many years he was integral in driving forward developments across acute and community services to improve the treatment and care of people with addictions.
R.I.P. George

This guideline was reviewed and updated by the Acute Problem Drug Use Group

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