CLINICAL GUIDELINE

Acute management of people who use Drugs

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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Lead Author:	Samantha Perry
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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.

NHS Greater Glasgow and Clyde

Glasgow and Clyde Acute Services Division

Guidelines for the Acute Management of People Who Use Drugs

2024-2027

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

Approved – March 2024

Review – March 2027

Contents

Introduction

These guidelines are only intended for reference by Acute Service medical and nursing staff to aid in the management of patients admitted to hospital, principally for other reasons, who use drugs.

These are intended as guidelines only and cannot be comprehensive.

Referral should be made to **Acute Addiction Liaison as soon as possible following admission** who will support treatment interventions in line with Alcohol & Drug Recovery Service (ADRS) Guidelines. Please note this service is not available at weekends and bank holidays.

Operating Hours

- 9.00am -5.00pm, Monday to Friday (excluding public holidays)

Email Swinbox

- **AALNSED@ggc.scot.nhs.uk**

Telephone

- 0141 211 0231 or 0141 211 0238 (24 hour telephone answer service)

TrakCare

- Acute Inpatient Services, Emergency Department's & SATA can refer directly to the service by accessing **TrakCare - Referral Request – Others - Acute Addiction Liaison Team - Continue Order.** Acute staff should read service information to ensure referral meets the service referral criteria before confirming and ordering under usual TrakCare process.

If urgent advice is required outside normal office hours (Monday to Friday, 9am – 5pm) the **ADRS Crisis Outreach Service (Glasgow City)** can be contacted where there is a requirement to confirm Opiate Substitute Treatment or a patient is being discharged over a weekend / public holiday. Operating hours and contact details are:

Operating Hours

- 8.00am – 8.30pm, Monday to Sunday (including public holidays)

Email Swinbox

- **Ggc.Prog@ggc.scot.nhs.uk**

Telephone

- 0141 201 3102 (answer phone service available)

TrakCare

- Acute Inpatient Services, Emergency Department's & SATA can refer directly to the service by accessing **TrakCare - Referral Request – Others – ADRS Crisis Outreach Service - Continue Order.** Acute staff should read service information to ensure referral meets the service referral criteria before confirming and ordering under usual TrakCare process.

Opiates, cocaine and benzodiazepines are substances most commonly associated with harm across the Greater Glasgow & Clyde area. Many people who use drugs may also have a co-dependency or problematic use of alcohol.

This guideline provides advice on the short-term management of patients who use prescribed or non-prescribed Opiates and Benzodiazepines. Also included are those receiving Opiate Substitute Treatment (OST) or Diazepam prescribed by the Alcohol & Drug Recovery Services. (ADRS)

Acute staff should, where possible, confirm prescriptions with community pharmacies and/or ADRS Teams to ensure there is no break in treatment. **If difficulties are encountered obtaining confirmation of an active prescription, referral should be made to Acute Addiction Liaison Team to assist or the ADRS Crisis Outreach Service at weekends and public holidays.**

Regular prescriptions of Benzodiazepines or OST should not be discontinued without advice from the Acute Addiction Liaison unless clinically indicated.

Discharge support can be provided by the Acute Addiction Liaison team who have direct links with Alcohol and Drug Recovery Services.

Primary problematic alcohol is not covered by this document.

This guidance should be used in conjunction with **Appendices 1- 7**

Problematic stimulant use should be discussed on an individual basis with Acute Addiction Liaison.

For the diagnosis & management of **serotonin syndrome** related to New Psychoactive Substances (NPS's) **Appendix 6** .

Principles of Management

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
- **Persistent** drug use despite harmful consequences

Drug Misuse and Dependence: UK Guidelines on Clinical Management (Orange Guidelines) - **Drug misuse and dependence (publishing.service.gov.uk)**

History, Examination and Investigation

Admission to an acute hospital is an opportunity to engage individuals with drug treatment services. Be non-judgmental and accept others life-style choices.

There is evidence that treatment of co-existent substance use problems will increase an individuals' compliance, retention and the success of other medical and surgical interventions.

Early assessment and identification of need provides an opportunity to provide information about available treatments and recovery support options.

History

In addition to a full medical history the following should also be documented:

- Drugs used (current)
- Frequency and amount used
- Route of use e.g., injected, smoked, ingested
- Whether usage is increasing/decreasing
- Recent use: date & time of last drug use
- Previous use: timescale since last use
- Previous or current treatment
- Tetanus immunisation and Blood Borne Virus (BBV) status, including any current treatment.

Examination

All patients require a full physical examination.
In addition, the following should be documented:

- **Injection sites:** Frequent injectors may have multiple sites of different age and usage
- **Evidence of withdrawal:** requires Subjective Opiate Withdrawal Scale (SOWS) to be undertaken. **Appendix 3**

Investigations

- Routine blood investigations as directed by clinical presentation.

Blood Borne Viruses

https://rightdecisions.scot.nhs.uk/ggc-clinical-guideline-platform/adult-infection-management/blood-borne-viruses/

- Opportunistic screening for Hepatitis C & HIV should be offered at any healthcare contact.
- If a patient requires treatment for Hepatitis C refer to the treatment team specific to your hospital.
- **Failsafe** will be notified of all new HIV infections by the virology services and will link with the testing source.

- **CXR:** as directed by clinical presentation
- **Pregnancy testing:** Should be done for all women of childbearing age
- **ECG**

- This should be done for all patients, specifically to assess for a prolonged QTc interval. Especially those on higher doses of methadone.
- The upper limit of normal the QTc is 0.44s-(men) and 0.46s (women)
- Prolongation of the QTc interval can be associated with ventricular arrhythmias and death.
- Causes other than methadone should be considered and excluded e.g., genetic, adverse drug effects (prescribed and non-prescribed), anti-psychotics, endocrine and metabolic disturbances.
- If the QTc is consistently prolonged on repeat ECGs and reversible causes excluded, referral should be made to the **Acute Addiction Liaison** to discuss the treatment plan.

Drug urinalysis (near patient testing/laboratory)

This does not replace a full clinical assessment.
Positive urinalysis indicates a drug has been taken but does not indicate when.
Some of the newer drugs, including novel benzodiazepines, cannot be tested for using standard urine tests.
Requests for the laboratory testing to identify substances not detected by urine dip testing may be considered if clinically appropriate.
At the time of writing drug urinalysis and near patient testing is not available acutely.

Harm Reduction

Offer advice on harm reduction including:

- Overdose awareness
- Avoiding sharing needles, spoons, filters or other injecting paraphernalia
- Safe sex
- Naloxone
- Access to local care and treatment services
- Provision of contact details for Injecting Equipment Providers (IEP) within locality.
- Treatment options

Patients found in possession of illicit drugs

If small quantities are found these should be disposed of by the pharmacy
Larger quantities should be reported to the police.

Treatment Options

Opiates

Do not feel pressurised to prescribe Medication Assisted Treatment Opiate Substitute Treatment (MAT OST).

Opiate withdrawal can be distressing and can be a contributing factor to patients self-discharging from hospital against advice to remain. For the emergency management of opiate withdrawal symptoms refer to **Appendix 2**

Only prescribe OST when a full assessment, examination and investigations have been completed and refer to **Appendix 4.** Where indicated refer to Acute Addiction Liaison as soon as possible.

Most opiate dependent individuals will require maintenance treatment with psychosocial support

The following OST are prescribed in GG&C

- **Methadone –** usually 1mg/1ml
- **Buprenorphine –** tablet, espranor, suboxone & subutex
- **Buvidal -** long acting buprenorphine injection

Methadone

Methadone taken regularly 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 opiates, or opiate naive patients.

Caution should be exercised when commencing or re-introducing Methadone which should be done with the support of the Acute Addiction Liaison Nursing Team.

Buprenorphine (Espranor, Suboxone & Subutex)

Buprenorphine is a partial agonist, and will act as an antagonist in the presence of a competing agonist e.g., oral opiates or diamorphine will precipitate withdrawal and opiate blockade.

Buprenorphine is safer in overdose and may be less sedating than methadone.

Caution should be exercised when commencing or re-introducing Buprenorphine which should be done with the support of Acute Liaison Addiction.

Buvidal® (Long Acting Buprenorphine Injection)

Buvidal® is a long acting injectable formulation of buprenorphine which is available in either weekly or monthly depot- type preparations.

If a patient who is currently maintained on Buvidal® is admitted to an inpatient hospital site, it is important to ensure continuity of their treatment and care.

Caution should be exercised when commencing or re-introducing Buvidal® which should be done with the support of Acute Addiction Liaison

Alerts are placed on the clinical portal by the ADRS team to advise that a patient is prescribed Buvidal®.

Management Following Admission

Patients Prescribed Opiate Substitute Treatment (OST)

Contact the community dispenser / prescriber (if known) to inform them of the patient's hospital admission,

Confirm dosage and when last issued.

Caution is advised for patients prescribed take home MAT OST (>2 days), a collateral history should be taken from the patient, carer or relative to confirm the current dose and when last consumed.

Where MAT OST prescribing cannot be verified initiation of symptomatic relief is advised.

Refer to **Appendix 2**

Contact **Acute Addiction Liaison** who can liaise with prescriber and offer additional advice/support to medical/nursing staff and the patient.

Patients Not Prescribed Opiate Substitute Treatment (OST)

After a patient has been assessed and drug use (prescribed / non-prescribed) is confirmed a referral should be made to **Acute Addiction Liaison** for assessment and advice on further treatment options.

Where there is evidence of withdrawal symptoms initiation of symptomatic relief is advised. **Appendix 2**

Benzodiazepine / Hypnotic Withdrawal

Unlike Alcohol, there are no current recognised validated protocols for the management of acute withdrawal. Benzodiazepine withdrawal can cause potentially life-threatening seizures.
Other symptoms of acute benzodiazepine withdrawal include: anxiety; tremor; insomnia; nausea and vomiting.

Many patients attending Community ADRS Services are prescribed Benzodiazepines as a maintenance prescription. Long-term benzodiazepine prescriptions should not be abruptly stopped. Street bought benzodiazepines are of varying strength and patients should be treated based on symptoms. This may require the prescribing of benzodiazepines. Refer to ***Acute Addiction Liaison*** to discuss appropriate treatment options in the acute setting. **Appendix 5**

If urgent advice is required outside normal office hours (Monday to Friday, 9am – 5pm) the ***ADRS Crisis Outreach Service (Glasgow City)*** can be contacted where there is a requirement to confirm Opiate Substitute Treatment or a patient is being discharged over a weekend or public holiday. **Appendix 1**

Where patients develop mental health symptoms an additional referral to **Psychiatric Liaison Services** may be appropriate

Missed Opiate Substitute Treatments (OST)

Methadone/Buprenorphine

Where a patient has missed up to 3 days (72hrs) of OST but has continued to use opiates loss of tolerance may be minimal.

However, patients who have been physically unwell and completely abstinent, tolerance may be reduced and these patients are at increased risk of overdose. **Appendix 4**

Contact should be made with the **Acute Addiction Liaison** to discuss and agree treatment plan.

Buvidal®

It is important that missed doses are administered as soon as possible. The weekly dose may be given up to 2 days before or after the scheduled administration date. The monthly dose may be given up to 1 week before or after the scheduled administration date

Current GGC ADRS guidance advises that patients at steady state -who have been on monthly doses for 3 months or more- can be administered a planned dose up to 28 days after the scheduled administration date

Only 1 injection should be administered at any time point

Cumulative dosing is not permitted e.g.

- 1x24mg weekly injection & 1x24mg monthly injection is not equivalent to a 48mg monthly injection – 1x48mg monthly injection **should only be administered**
- 2 x 64mg monthly injections is not equivalent to 128mg monthly injection – 1x128mg injection must be administered.
- Weekly Buvidal injections are absorbed over a shorter period of time - the maximum dose per week for patients who are on weekly Buvidal treatment is 32 mg with an additional 8 mg dose.
- Monthly injections are absorbed much slower - the maximum dose per month for patients who are on monthly Buvidal treatment is 160 mg.
- If a patient is outside of usual dosing time frames please contact the **Acute Addiction Liaison** for further advice.

Buvidal Summary of Product Characteristics:
https://www.medicines.org.uk/emc/product/9706/smpc

Detoxification

Would rarely be recommended in the acute setting but may still be required for a person centred approach to care. Treatment is usually only suitable for highly motivated individuals with a short history of dependence and reasonably well preserved health and social functioning.

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** for further advice.

Enhanced Drug Treatment Service (EDTS)

There are patients within GG&C receiving injectable diamorphine treatment and OST, this is prescribed and dispensed within the EDTS premises. Diamorphine by injection, for the treatment of addiction, may only be prescribed by doctors holding a specialist license and can only be administered within EDTS premises.

Contact **Acute Addiction Liaison** for further advice. Monday to Friday 9am – 4.30pm.

At weekends / public holidays EDTS should be contacted directly.

Operating Hours

- 9.00am – 4.30pm, Monday to Sunday (including public holidays

Telephone

- 0141 553 2835 / 0141 553 2876

The service is open 7 days a week, staff are usually aware of admission to hospital and are keen to be involved in treatment planning.

Out-with these times patient's withdrawal symptoms should be managed using the emergency guidelines: **Appendix 2**

Under no circumstances should injectable diamorphine be continued in hospital as an OST. Opiates may still be given, however, for appropriate medical reasons.

Additional Considerations

Exercise extra caution when prescribing OST or Benzodiazepines in:

- Respiratory disease
- Head injury - do not attribute a reduced GCS to drug/alcohol intoxication - use clinical judgement and have a low threshold to perform a CT brain
- Liver disease/ Hepatitis
- Co-existent alcohol dependence
- Overdose/ decreased tolerance
- If receiving opiate analgesia or other sedating medication
- Interactions with other prescribed drugs - check if it will alter the effects of methadone or benzodiazepines e.g., rifampicin used in the treatment of tuberculosis reduces methadone plasma concentration by 30-65%.
- Pregnancy; unless indicated for the emergency management of medical conditions.
- Buprenorphine use in Liver Disease
- 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, contact **Acute Addiction Liaison**.

Home Respite Patients (pass up to 3 days)

On occasions where a patient on Opiate Substitute Treatment (OST) is discharged from hospital for a short period e.g. on weekend pass, it is the responsibility of the hospital to ensure continuation of OST prescribing during this period.
Do not give a supply of home.

Early referral to the **Acute Addiction Liaison** should be made.

The team will link with the community prescriber for a short term prescription to be lodged with an agreed community pharmacy.

Further discussion will be undertaken with the patient and community prescriber to review current OST prescription to consider alternative treatment plans.

Discharge Planning

The **Acute Addiction Liaison** Team will provide input and support to ensure a safe and robust discharge plan is in place for all patient's referred to the service.

No patients on Opiate Substitute Treatment should be discharged from hospital without confirmation on continuation of treatment in the community

Consider increased risks at weekends / public holidays.

If a patient requires to be discharged on opiate analgesia this should be the lowest effective dosage

Remember, GP's can facilitate daily pick up of analgesia with OST.

Routine Discharge

- Ensure all OST prescriptions are in place prior to discharge (liaise with **Acute Addiction Liaison)**
- Confirm date of last dose with community pharmacy.
- Communicate and confirm discharge plan with patient.
- Ensure the IDL is completed and authorised.

Delayed Discharge

- Identify barriers to discharge
- Discuss support options with patient with focus on discharge home being the first option.
- Agree discharge plan.

Weekend Discharge

- Should be avoided if possible, unless agreed discharge plan is in place for continuation of OST.

The Pregnant Patient

Drug use in pregnancy results in a high-risk pregnancy and management should have a multidisciplinary approach

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)** to ensure that they receive the appropriate maternity care during and following their pregnancy.

For pregnant women, OST has additional complexities and all cases should be discussed with **Special Needs in Pregnancy Service (SNIPs). SnipsGlasgow@ggc.scot.nhs.uk**

There is evidence to suggest that maternal withdrawal, even mild, is associated with 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 for emergency treatment.

However long-term benzodiazepine prescriptions should not be abruptly stopped.

Patients at high risk of benzodiazepine withdrawals due to illicit use should be referred to **Special Needs in Pregnancy Service (SNIPs). SnipsGlasgow@ggc.scot.nhs.uk**

New Psychoactive Substances

For the diagnosis and management of serotonin toxicity, **Appendix 6**
https://rightdecisions.scot.nhs.uk/media/2338/serotoninfp.pdf

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 Cathinone’s

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 NPS toxicity.

Drug Concealment

- Up to date information on the management of the management drug concealment be provided on
  www.toxbase.org

Naloxone

Take Home Naloxone (Prenoxad®)

Opiates such as heroin and methadone are 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, their friends and family 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 the GGC - Staffnet Hub by searching for Naloxone. GGC - Clinical Guideline Platform | Right Decisions (scot.nhs.uk)

Training and Supply

- Referral to **Acute Addiction Liaison** whilst in hospital
- Community Pharmacy
- Navigator Service
- Self-referral via any Community Alcohol and Drug Recovery Service **Appendix 1b**
- The Glasgow Alcohol and Drug Crisis Centre, 123 West St, Glasgow, G5 8BA. Telephone 0141 420 6969.
- A supply of “take home” naloxone can be dispensed by the ward on discharge.

Pharmacy Naloxone Dispensing
Prenoxad® stock should be ordered via the **Pharmacy Distribution Centre (PDC)**.

All hospital pharmacy sites with **Acute Addiction Liaison** support will hold a designated minimum number of supplies of Prenoxad®.

Prenoxad® should be labelled ‘Inject 0.4ml (400micrograms) into the outer thigh muscle. If no response repeat at 2 – 3 minute intervals’.

The cellophane should not be removed from the packaging.

Patients are instructed during training to keep the pack unopened until required in an emergency situation.

Police may remove open packs from individuals.

Management of pain for patients on Opiate Substitute Treatment

DO NOT WITHOLD ANALGESIA IF PATIENTS ARE IN PAIN

Introduction

Patients on OST expect that their pain will be badly managed and are frequently anxious about the possibility of drug withdrawal.

This Guideline is to be used where non opiate analgesics have failed or are inappropriate.

Consider alternatives e.g. paracetamol, nerve blocks or splints

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

Contact the Acute Addiction Liaison Service for additional advice and support

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 anesthetist

They may require 10-20mg of morphine 4-6 hourly thereafter, IV preferably. Morphine requirement should be titrated to pain.

Buprenorphine

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

- Where the patient is prescribed Buprenorphine as an Opiate Substitute Treatment this should be continued until day of surgery and further advice sought from the responsible anesthetic team.
- As Buprenorphine is a partial agonist, opiate withdrawal may be precipitated in the presence of a competing agonist such as diamorphine.
- Following the procedure, patients may require 10-20mg of morphine 4-6 hourly preferably IV.
- A gap of 12-16 hours after the last dose of morphine is recommended before restarting Buprenorphine to prevent precipitated withdrawal
- Restart Buprenorphine

Buvidal®

The general principles of pain management for a patient on Buvidal® are as per trans-mucosal buprenorphine treatment.

Buvidal treatment should be continued and pain managed where possible using non-opiate analgesia. Regional anaesthesia may be considered.

If titration of short-acting opiates is required, higher doses of opiate may be needed. Patients should be monitored carefully during treatment and referral to the specialist pain service considered.

Discharge Arrangements

Acute Addiction Liaison will assist in facilitating this.

If a patient requires to be discharged on opiate analgesia, the dose should be the lowest effective dosage.

Remember GP's can facilitate daily pick up of their analgesia with their OST prescription.

Unanticipated Pain (EMERGENCY)

Do not withhold analgesia if a patient is in pain

Methadone

If on methadone, there is no direct conversion to morphine initially.

Give 10-20mg morphine 4-6 hourly, preferably IV and then titrate according to response.

If in ITU the sedative and opiates commonly used 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 service.

To restart methadone, contact Acute Addiction Liaison for advice.

Buprenorphine

If on Buprenorphine, no further doses should be given following admission

Patients should receive 20-40mg morphine 4-6 hourly IV preferably and titrate according to response.

Monitor for signs of Acute Withdrawal using SOWS rating scale **Appendix 3**

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 contact Acute Addiction Liaison for advice.

Buvidal®

The general principles of pain management for a patient on Buvidal® are as per transmucosal buprenorphine treatment.

Buvidal treatment should be continued and pain managed where possible using non-opiate analgesia. Regional anaesthesia may be considered.

If short-acting opiates are required for pain relief, higher doses than expected may be needed.

Patients should be monitored carefully during treatment and referral to specialist pain services considered.

Discharge Arrangements

Discharge planning should be done in conjunction with Acute Addiction Liaison.

Contact patient's GP / local prescribing team and pharmacy prior to discharge to ensure continuation of prescription, or acute addiction liaison service.

If patient requires to be discharged on opiate analgesia this should be the lowest effective dosage

Remember their GP can facilitate daily pick up of their analgesia with their OST prescription

Buvidal must only be administered by healthcare professionals. Patients must not be provided with doses on discharge for self-administration.

Summary

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 “Hyper Analgesic 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

Preferably non opiate analgesics should be used if suitable and safe to do so.

Appendix 1 (a)

Alcohol & Drug Recovery Services (ADRS) Contact Information

Acute Addiction Liaison Service (Glasgow City)

The Acute Addiction Liaison Nursing Service provides specialist Alcohol & Drug Recovery in-reach to the two main acute hospital sites within Glasgow City: Glasgow Royal Infirmary and Queen Elizabeth University Hospital. The service is also available to provide input to Gartnavel General Hospital & Beatson Oncology Centre, Princess Royal Maternity, Stobhill ACH, Vale of Leven Hospital and Victoria ACH.

Operating Hours

- 9.00am -5.00pm, Monday to Friday (excluding public holidays)

Email Swinbox

- **AALNSED@ggc.scot.nhs.uk**

Telephone

- 0141 211 0231 or 0141 211 0238 (24 hour telephone answer service)

TrakCare

- Acute Inpatient Services, Emergency Department's & SATA can refer directly to the service by accessing **TrakCare - Referral Request – Others - Acute Addiction Liaison Team - Continue Order.** Acute staff should read service information to ensure referral meets the service referral criteria before confirming and ordering under usual TrakCare process.

ADRS Crisis Outreach Service (COS) (Glasgow City)

Where a patient is identified as at increased risk of further drug / alcohol crisis post-discharge a referral can be made for community follow up when statutory, voluntary or third sector services are not available across Glasgow City. Referrals will be followed up the same day or within 24 hours of receipt. Please refer to Acute Addiction Liaison 9.00am -5.00pm, Monday to Friday (excluding public holidays)

Operating Hours

- 8.00am – 8.30pm, Monday to Sunday (including public holidays)

Email Swinbox

- **Ggc.Prog@ggc.scot.nhs.uk**

Telephone

- 0141 201 3102 (answer phone service available)

TrakCare

- Acute Inpatient Services, Emergency Department's & SATA can refer directly to the service by accessing **TrakCare - Referral Request – Others – ADRS Crisis Outreach Service - Continue Order.** Acute staff should read service information to ensure referral meets the service referral criteria before confirming and ordering under usual TrakCare process.

Service	Address	Tel. No.	Email & Operating Hours
Acute Addiction Liaison	Based GRI / QEUH	0141 211 0231 or 0141 211 0238 (24 hour answer phone service available)	**New Referrals & Existing Casework:** AALNSED@ggc.scot.nhs.uk **TrakCare** **Referral Request – Others - Acute Addiction Liaison Team - Continue Order** **Operating Hours** 9.00am -5.00pm, Monday to Friday (excluding public holidays)
Alcohol & Drug Recovery Service (ADRS) Crisis Outreach Service (Glasgow City)	Nevis Building, Stobhill Hospital, 133 Balornock Road, G21 3UW	0141 201 3102 (24 hour answer phone service available)	**New Referrals & Existing Casework:** Ggc.Prog@ggc.scot.nhs.uk **TrakCare** **Referral Request – Others- ADRS Crisis Outreach Service – Continue Order** **Operating Hours:** 8.00am – 8.30pm, Monday to Sunday (including public holidays)
ADRS Pharmacy Team (Glasgow City)			**Please contact the ADRS Pharmacy Team for additional advice on MAT prescribing.** **Operating Hours** 9.00am -5.00pm, Monday to Friday (excluding public holidays)
Enhanced Drug Treatment Service (EDTS)	55 Hunter Street, G4 0UP	0141 553 2835 0141 553 2876	**Existing Casework Only:** **Operating Hours:** 8.30am – 4.30pm, Monday to Sunday (including public holidays)
East Dunbartonshire ADRS	Kirkintilloch Health & Care Centre, Saramago Street, G66 3BF	0141 232 8211	**New Referrals & Existing Casework:** EDADSAdmin@ggc.scot.nhs.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
East Renfrewshire ADRS	St Andrews House, 113 Cross Arthurlie Street, G78 1EE	0141 577 3368 0141 577/4027	**New Referrals & Existing Casework:** Addiction.referrals@eastrenfrewshire.gov.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
Inverclyde ADRS	Wellpark Centre, 30 Regent Street,	01475 715 353	**New Referrals & Existing Casework:** Alcohol.allocations@inverclyde.gov.uk

	Greenock, PA15 4PB		**Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
Lanarkshire	East Kilbride Camglen Clydesdale Hamilton	01355 597 456 0141 584 2515 01555 777 431 01698 368 711	**New Referrals & Existing Casework:** cares.ek@lanarkshire.scot.nhs.uk cares.camglen@lanarkshire.scot.nhs.uk cares.hamilton@lanarkshire.scot.nhs.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
North East ADRS	Newlands Centre, 871 Springsfield Road, G31 4HZ 1250 Westerhouse Road, G34 9EA	0141 565 0200 0141 276 3420	**New Referrals:** SW_NEAddictionsAdmin1@glasgow.gov.uk **Existing Casework:** SW_NEAddictionsAdmin2@glasgow.gov.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
North West ADRS	Mercat 2, 35 Hecla Avenue, G15 8NA Possilpark Health & Care Centre, 99 Saracen Street, G22 5AP Woodside Health & Care Centre, 891 Garscube Road, G20 7LR	0141 276 4330 0141 276 4580 0141 800 0670	**New Referrals & Existing Casework:** SW_NWCommunityAddictionTeam@glasgow.gov.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
Renfrewshire ADRS	20 Back Sneddon Street, Paisley, PA3 2DJ	0141 618 2585	**New Referrals & Existing Casework:** Addictions.sw@renfrewshire.gov.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
South Ayrshire			**New Referrals & Existing Casework:**

			Clinical_AddictionServices-SouthAyrshire@aapct.scot.nhs.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
South ADRS	10 Ardencraig Place, Glasgow, G45 9US Gorbals Health & Care Centre, 2 Sandiefield Road, Glasgow, G5 9AB 130 Langton Road, Glasgow, G53 5DP Pavilion One, Rowanpark Business Centre, 5 Ardlaw Street, Glasgow, G51 3RX	0141 276 5040 0141 420 8100 0141 276 3010 0141 276 8740	**New Referrals:** SouthADRSNewReferrals@glasgow.gov.uk **Existing Casework:** SouthADRSDuty@glasgow.gov.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)
Tier 4 Inpatient Services	Eriskay House, Stobhill Hospital, 133 Balornock Road, G21 3UW Kershaw Unit, Gartnavel Royal Hospital, 1055 Great Western Road, G12 0XH	0141 232 0600	**Operating Hours:** 24 hour care Monday to Sunday (including public holidays)
West Dumbartonshire ADRS	120 Dumbarton Road, Glasgow, G81 1UG Dumbarton Joint Hospital, Cardross Road, G82 5JA	0141 562 2311 01389 812 018	**New Referrals & Existing Casework:** Addictions.clydebank@west-dunbarton.gov.uk Addictions.dumbarton@wdc.gcsx.gov.uk **Operating Hours:** 8.45am – 5.00pm, Monday to Friday (excluding public holidays)

Appendix 1 (b)

Appendix 2

Emergency Management of Opiate & Benzodiazepine Withdrawal Symptoms

Refer to Acute Addiction Liaison as soon as possible after admission

For Patients:

- **Awaiting further assessment**
- **Awaiting confirmation of OST Prescription**
- **Who use prescribed / non-prescribed Opiates**
- **Awaiting confirmation of Benzodiazepine Prescription**
- **Who use prescribed / non-prescribed Benzodiazepines**
- **Short term admissions for whom no through care is possible.**

Opiate Withdrawal

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

Benzodiazepine Withdrawal

Diazepam / Lorazepam can be prescribed in equal doses up to:

Diazepam 10mg - 20mg four times daily

Lorazepam 1mg - 2mg three times daily (caution in older patients)

This dose can be reduced or maintained during short admissions depending on the clinical condition of the patient.

Do not supply on discharge

Appendix 3

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

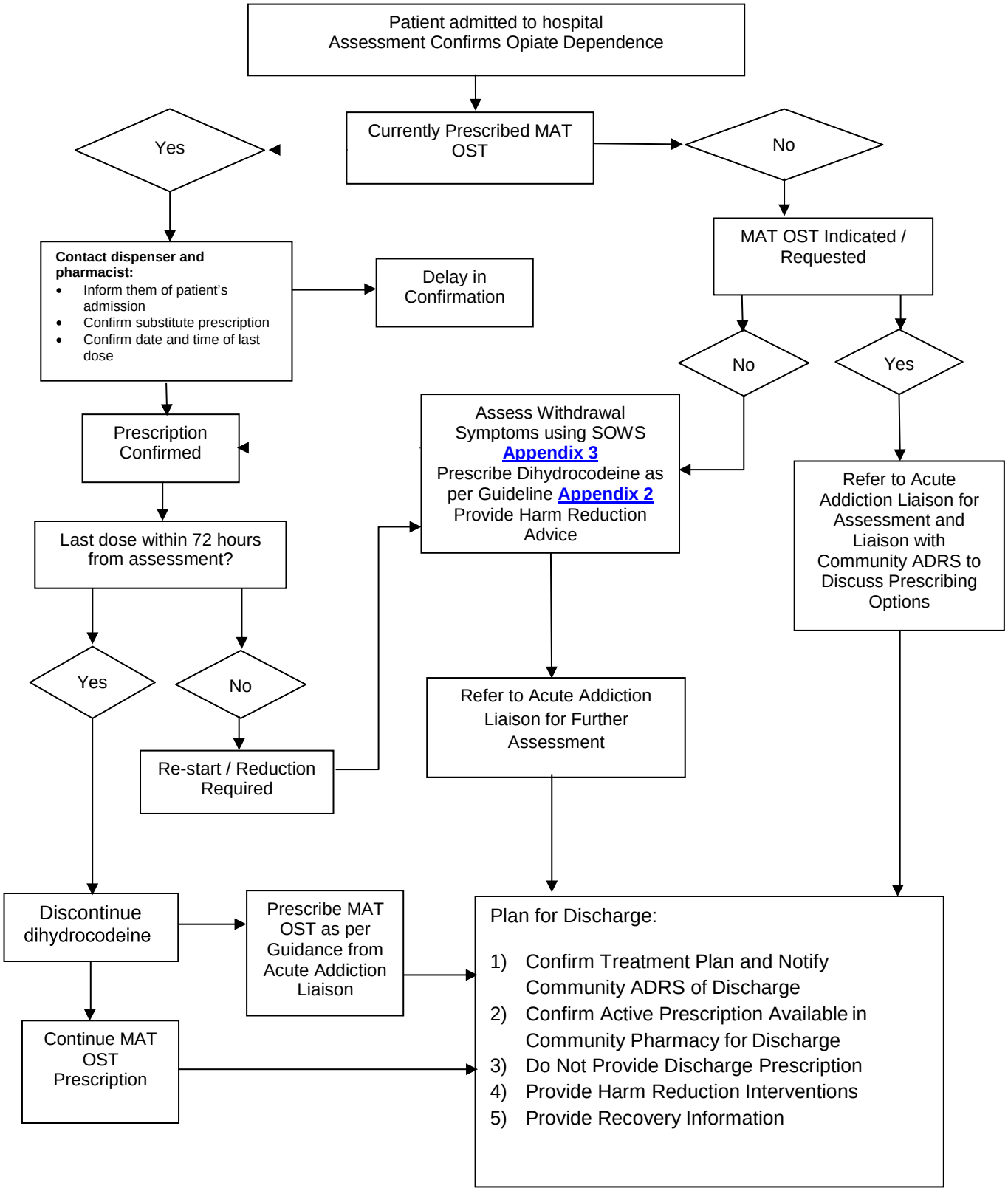
Observe the patient and score accordingly. A score of more than 5 is strongly suggestive of opiate withdrawal in a dependent patient.

	2	1	0
Pupil size	**Wide**	**Normal**	**Pinpoint**
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 4

Management of People who use Opiates

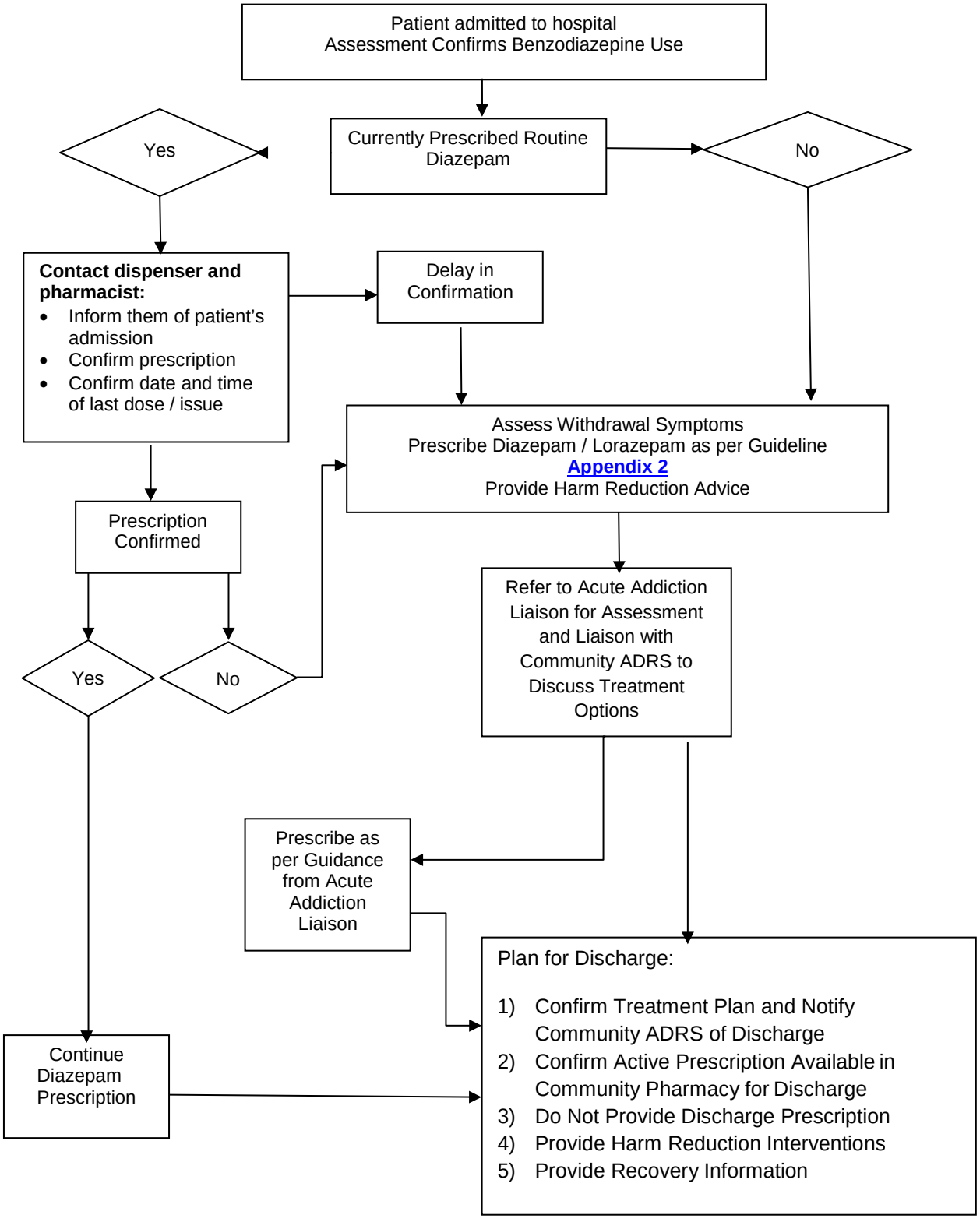
MAT OST Pathway



Appendix 5

Management of People who use Benzodiazepines

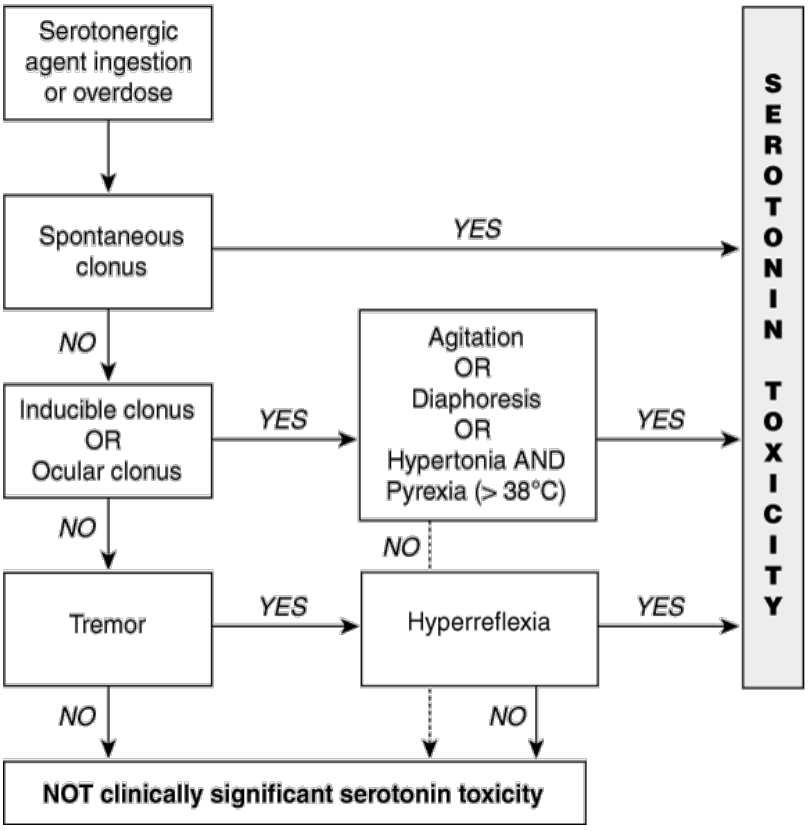
Assessment Pathway



Appendix 6

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’

Acknowledgements & Contributors

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These guidelines were originally produced by the GDPS, and were updated by Glasgow Addiction Services in February 2009 in consultation with the Acute Services Directorate, and the Acute Addiction Action Plan Drug Misuse and Withdrawal Sub Group; they may not be altered, or reproduced without permission.