Essex Partnership University
NHS Foundation Trust

SECTION 10: MANAGEMENT OF ALCOHOL, OPIOID AND BENZODIAZEPINE DEPENDENCE

Formulary and Prescribing Guidelines

10.1 Introduction

This document covers the safe prescribing and management for service users with alcohol, opioid or benzodiazepine dependence who come under the care of EPUT psychiatric services in inpatient settings, prison settings and community settings.

This guidance is intended only as a quick-reference guide and must be used in conjunction with other resources when making treatment decisions.

Reference should be made to:

- NICE CG115: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence[1].
- NICE CG52: Drug misuse in over 16s: opioid detoxification[2].
- NICE NG64: Drug misuse prevention: targeted interventions.[11]
- NICE NG58: Coexisting severe mental illness and substance misuse: community health and social care services.[12]
- NICE CG120: Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings.[13]
- Drug misuse and dependence: UK guidelines on clinical management. Update 2017. Independent Expert Working Group. London: Department of Health[3] (the "Orange" Book). This describes the principles underlying treatment for drug misuse and dependence in the UK.
- Trust procedures for management of substance dependence in particular settings, e.g. community, prison.

This is not an exhaustive list.

There are some general principles applicable to all service users:

Prolonged use of opioid medicines for non-cancer pain

The MHRA have published recommendations[17] following a review of the risks of dependence and addiction associated with prolonged (>3 months) use of opioid medicines (opioids) for non-cancer pain:

- discuss with patients that prolonged use of opioids may lead to drug dependence and addiction, even at therapeutic doses
- before starting treatment with opioids, agree with the patient a treatment strategy and plan for end of treatment
- explain the risks of tolerance and potentially fatal unintentional overdose, and counsel patients and caregivers on signs and symptoms of opioid overdose to be aware of (see opioids safety information leaflet).[18] Healthcare professionals are

encouraged to use this information alongside the statutory patient information leaflet supplied with opioid medicines.

- provide regular monitoring and support especially to individuals at increased risk, such as those with current or past history of substance use disorder (including alcohol misuse) or mental health disorder

- at the end of treatment, taper dosage slowly to reduce the risk of withdrawal effects associated with sudden cessation of opioids; tapering from a high dose may take weeks or months

- consider the possibility of hyperalgesia if a patient on long-term opioid therapy presents with increased sensitivity to pain

Acute Kidney Injury (AKI)

Patients who misuse drugs and alcohol are at risk of AKI via a number of mechanisms including: dehydration due to sedation, muscle breakdown from immobilisation, thrombosis (especially for intravenous drug misuse), amyloidosis from “skin popping” and the direct effects of stimulant drugs. For further information refer to Guidance for Mental Health Professionals on the management of Acute Kidney Injury[4]

Driving

Reference should be made to the documents published by the DVLA, and the new law[5] on fitness to drive while taking prescribed drugs https://www.gov.uk/drug-driving-law .

Ask about use of alcohol and drugs

Healthcare professionals in all settings, including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people, including those with known or suspected psychosis, about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs (examples include illegal drugs such as cannabis, cocaine, crack cocaine and heroin, prescribed drugs that have not been prescribed to the person using them or are not taken in the way that was intended such as diazepam, pregabalin and 'over-the-counter' medicines that can be bought from a pharmacy such as codeine.)

Also ask about their use of new psychoactive substances. The level of detail obtained depends on the setting and how much information the person wishes to provide at that time.

If the person has used substances ask them about all of the following:

- particular substance(s) used
- quantity, frequency and pattern of use
- route of administration
- duration of current level of use.

Healthcare professionals should also conduct an assessment of dependency and also seek corroborative evidence from families, carers or significant others, where this is possible and permission is given.

Coexisting mental illness and substance misuse

Identify and provide support to people with coexisting severe mental illness and substance misuse. Severe mental illness includes a clinical diagnosis of schizophrenia, schizotypal and delusional disorders, bipolar affective disorder, or severe depressive episodes with or without psychosis.

Offer information

Offer adults who are assessed as vulnerable to drug misuse the following:

- clear information on drugs and their effects
- advice and feedback on any existing drug use, to help people assess their own drug use
- information on local services and where to find further advice and support

This information should be provided at the same time as the assessment.

10.2 ALCOHOL DEPENDENCE

Approved drugs for the management of alcohol dependence (detoxification or abstinence)

Drug[6]	Formulations	Comments
Chlordiazepoxide	Capsules 5mg, 10mg;	Detoxification.
Lorazepam	Tabs 1mg, 2.5mg	Detoxification in patients with liver impairment
Oxazepam	Tab 10mg, 15mg	Detoxification in patients with liver impairment
Acamprosate	Tabs (gastro-resistant) 333mg;	Acamprosate is indicated as therapy to maintain abstinence in alcohol-dependent patients. It should be combined with counselling. Stop if patient starts drinking again.
Disulfiram	Tabs 200mg	Alcohol deterrent compound. Disulfiram may be indicated as an adjuvant in the treatment of carefully selected and co-operative patients with drinking problems. Its use must be accompanied by appropriate supportive treatment.
Naltrexone	Tabs 50mg	Used as part of a comprehensive programme of treatment against alcoholism to reduce the risk of relapse, as support treatment in abstinence and to reduce the craving for alcohol.

Drug[6]	Formulations	Comments
Nalmefene	Tabs 18mg	For the reduction of alcohol consumption in adult patients with alcohol dependence who have a high drinking risk level without physical withdrawal symptoms and who do not require immediate detoxification.
Pabrinex	Intramuscular High Potency solution for injection 5ml and 2ml ampoules	Prophylaxis of Wernicke's encephalopathy in alcohol dependence.
Thiamine	Tabs 50mg, 100g	Treatment of deficiency, and prevention of Wernicke's Encephalopathy[14]
Vitamin B Compound Strong	Tablets contain: Nicotinamide 20 mg, Pyridoxine hydrochloride 2 mg, Riboflavin 2 mg, Thiamine hydrochloride 5 mg	Treatment of deficiency. Due to a lack of evidence of their efficacy and safety, vitamin B complex preparations (vitamin B compound and vitamin B compound strong tablets) should not be prescribed for prevention of Wernicke's Encephalopathy in alcoholism.[14] Vitamin B complex preparations should not be prescribed for preventing deficiency or for maintenance treatment following treatment for deficiency.[14] Vitamin B complex preparations should not be prescribed as dietary supplements. Patients who wish to use them for dietary supplementation should be advised to purchase them over the counter.[14] Vitamin B compound strong tablets may be prescribed on a short-term basis (10 days) for patients at risk of refeeding syndrome. This also applies to patients who are not harmful or dependent drinkers.[14] In rare cases where there might be a justifiable reason for prescribing vitamin B complex e.g. medically diagnosed deficiency or chronic malabsorption, vitamin B compound strong and not vitamin B compound should be prescribed (lower cost).[14]

10.2.1 ALCOHOL DEPENDENCE – EVALUATION OF THE SERVICE USER

Acute alcohol withdrawal syndrome

Following periods of excessive alcohol consumption a drop in blood-alcohol concentration may precipitate withdrawal syndrome. The first symptoms of alcohol withdrawal usually appear within hours (5 - 8) of the last intake of alcohol and peak over 24 - 48 hours. The alcohol withdrawal syndrome may be a continuum from simple tremor with relatively mild signs/symptoms through to hallucinations, seizures or the life threatening delirium tremens. All antipsychotics have the additional risk of lowering the seizure threshold, which is a particular concern in alcohol withdrawal[7].

Signs and symptoms of alcohol withdrawal

Symptoms may be seen within hours of the last drink and may develop before the blood alcohol level has fallen to zero. Symptoms outlined below may vary in severity, commonly peaking at 10 to 30 hours and usually subsiding by 40 to 50 hours.

Common features of alcohol withdrawal include:

- Tremor of hands, tongue, eyelids
- Nausea, vomiting, diarrhoea
- Fever, sweating, flushing
- Anxiety, agitation, irritability
- Tachycardia
- Fleeting hallucinations
- Insomnia
- Convulsions

Less common features include:

- Hypertension
- Arrhythmias
- Paraesthesia
- Suicidal ideation

Delirium Tremens (DTs)

DTs occur in about 5% of individuals during alcohol withdrawal but account for the highest level of morbidity and mortality[7]. Onset of symptoms usually occurs 2 - 3 days following cessation or reduction in alcohol consumption and this represents a medical emergency. Prevention and treatment is through prompt diagnosis, admission and the administration of high dose benzodiazepines (chlordiazepoxide).

DTs are fatal in 15 - 20% of inappropriately managed cases, usually due to respiratory and cardiovascular collapse or cardiac arrhythmias. Patients most at risk are those with tachycardia, a high fever (> 39.9°C/ 104°F), dehydration with an associated illness (pneumonia/pancreatitis), general debility or where the diagnosis is delayed. Appropriate management reduces mortality to about 1%.

Patients suspected of having Delirium Tremens or Wernicke's syndrome should be transferred to an acute medical hospital. Mental Health wards / Prison healthcare units do not have the facilities for administering IV fluids and these conditions are

also often associated with inter-current illnesses such as electrolyte imbalances and chest infections.

Common features of delirium tremens include:

- Severe tremor
- Systolic hypertension
- Tachycardia: > 100/min
- Fever, with or without infection: temp > 38.3°C/ 101°F
- Sometimes convulsions
- Severe hallucinations which often evoke extreme fear (usually visual but may be tactile or auditory)
- Clouding of consciousness
- Confusion, disorientation
- Agitation, violent behaviour
- Delusions
- Delirium
- Insomnia

Assisted withdrawal should be considered if a service user meets one or more of the following criteria:

- drinking over 30 units of alcohol per day
- have a score of more than 30 on the SADQ (Annex 1)
- have a score of 9 and over on the CIWA-Ar (Annex 2)
- have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
- need concurrent withdrawal from alcohol and benzodiazepines

The presence of significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or a significant learning disability or cognitive impairment should warrant inpatient detoxification even at lower levels of alcohol use (between 15 and 20 units of alcohol per day). A lower threshold should also be considered for vulnerable groups, for example, homeless and older adults.

10.2.2 ALCOHOL DEPENDENCE – MANAGEMENT

Fixed-dose or symptom-triggered medication regimens can be used in assisted withdrawal programmes. A symptom-triggered approach involves tailoring the drug regimen according to the severity of withdrawal and any complications. The service user is monitored on a regular basis and pharmacotherapy only continues as long as the service user is showing withdrawal symptoms. If a symptom-triggered regimen is used, all staff should be competent in monitoring symptoms effectively and the unit should have sufficient resources to allow them to do so frequently and safely (Annex 2). In a fixed-dose regimen, the initial dose of medication should be titrated to the severity of alcohol dependence and/or regular daily level of alcohol consumption.

In severe alcohol dependence, higher doses will be required to adequately control withdrawal and should be prescribed according to the SPC. There should be adequate

supervision if high doses are administered. A gradual reduction of the dose of the benzodiazepine over seven to ten days is advised to avoid alcohol withdrawal recurring.

Benzodiazepine doses may need to be reduced for children and young people, older people and people with liver impairment.

All clients with a recent history of excessive alcohol consumption should have routine blood tests to check liver function (LFTs), including GGTs and a full blood count (FBC), at assessment.

Choice of Benzodiazepine

Chlordiazepoxide has a lower potential of abuse than diazepam and is therefore the benzodiazepine of choice for the management of alcohol withdrawal. Intravenous diazepam or lorazepam has a more rapid onset of effect so may be preferred where urgent control is required. Oral equivalences for common benzodiazepines can be found in the most current edition of the BNF.

Algorithm for management of acute alcohol withdrawal symptoms[7]

(See also, the Algorithm for the Management of Wernicke's encephalopathy, if necessary)

Levels of dependence can be estimated according to the daily units of alcohol used and the scores in the Severity of Alcohol Dependence Questionnaire[9] (SADQ), (Annex 1), or the scores in the Clinical Institute Withdrawal Assessment Alcohol Revised Scale[10] (CIWA-Ar), (Annex 2).

People with mild dependence usually do not need assisted alcohol withdrawal. People with moderate dependence (with a SADQ score of between 20 and 30, or CIWA-Ar 9 - 14) usually need assisted alcohol withdrawal. People who are severely alcohol dependent (with a SADQ score of more than 30, or CIWA-Ar more than 14) will need assisted alcohol withdrawal, typically in an inpatient or residential setting.

Severity	Number of units/day	SADQ score	CIWA-Ar	Chlordiazepoxide (estimated starting dose)
Moderate	15 – 30	20- 30	9-14 (Moderate)	15 – 30 mg QDS
Severe	30 – 40	31 – 44	15-20 (High)	30 – 40 mg QDS
Very severe	40 – 60	>45	>20 (Severe)	> 40 mg QDS

The guidance above is for prescribers. If chlordiazepoxide is to be administered under a Patient Group Direction the doses shown in the PGD should be followed.

Mild dependence

Requires small doses of chlordiazepoxide or may even be managed without medication.

Moderate dependence 15-30 units/day

A typical regimen might be 15-30mg QDS, reducing gradually over 5 - 7 days. Note that 5 - 7 days treatment is adequate and longer treatment is rarely helpful or necessary. The table below is an example of an outpatient regimen.

Day	Dose
1	20mg QDS
2	15mg QDS
3	10mg QDS
4	10mg BD
5	10mg OD

A service user may be on the same dose for a day or two depending on clinical need, presentation and therapeutic response. In cases of more severe objective withdrawal up to 20mg PRN (split across the doses if needed) can be given in the first 48 hours if required.

Thiamine 100mg TDS may be prescribed for the prevention of Wernicke's Encephalopathy.[14]

Severe dependence > 30 units/day (inpatient)

Severely dependent patients should get 7 - 10 days treatment with the flexibility of 'as required' medication for the first two days. If symptoms are controlled within the first two days it will be easier to implement the reducing regimen. Patients who have DTs, head injury or cognitive impairment may need lengthier withdrawal regimens. Intensive daily monitoring is advised for the first three days. The intention of flexible dosing is to titrate dosage against symptoms.

The following are examples of a fixed-dose regimen for severe (7-10 days) and very severe dependence (9 -14 days).

Severe	
Day	**Dose**
1	30mg QDS
2	25mg QDS
3	20mg QDS
4	15 mg QDS
5	10mg QDS
6	10mg TDS
7	10 mg BD
8	10 mg OD

Very Severe	
Day	**Dose**
1	40mg QDS + 40mg PRN divided
2	40mg QDS
3	35mg QDS
4	30mg QDS
5	25mg QDS
6	20mg QDS
7	15mg QDS
8	10mg QDS
9	10 mg TDS
10	10mg BD
11	10mg OD

Starting the treatment

If the patient appears intoxicated or sedated, the first dose of benzodiazepine must be withheld until it is clinically safe to begin treatment.

Patients who give a recent history of consuming 10-15 units of alcohol daily MUST be given a stat dose of chlordiazepoxide 20 mg as soon as possible following assessment and as long as they are not intoxicated.

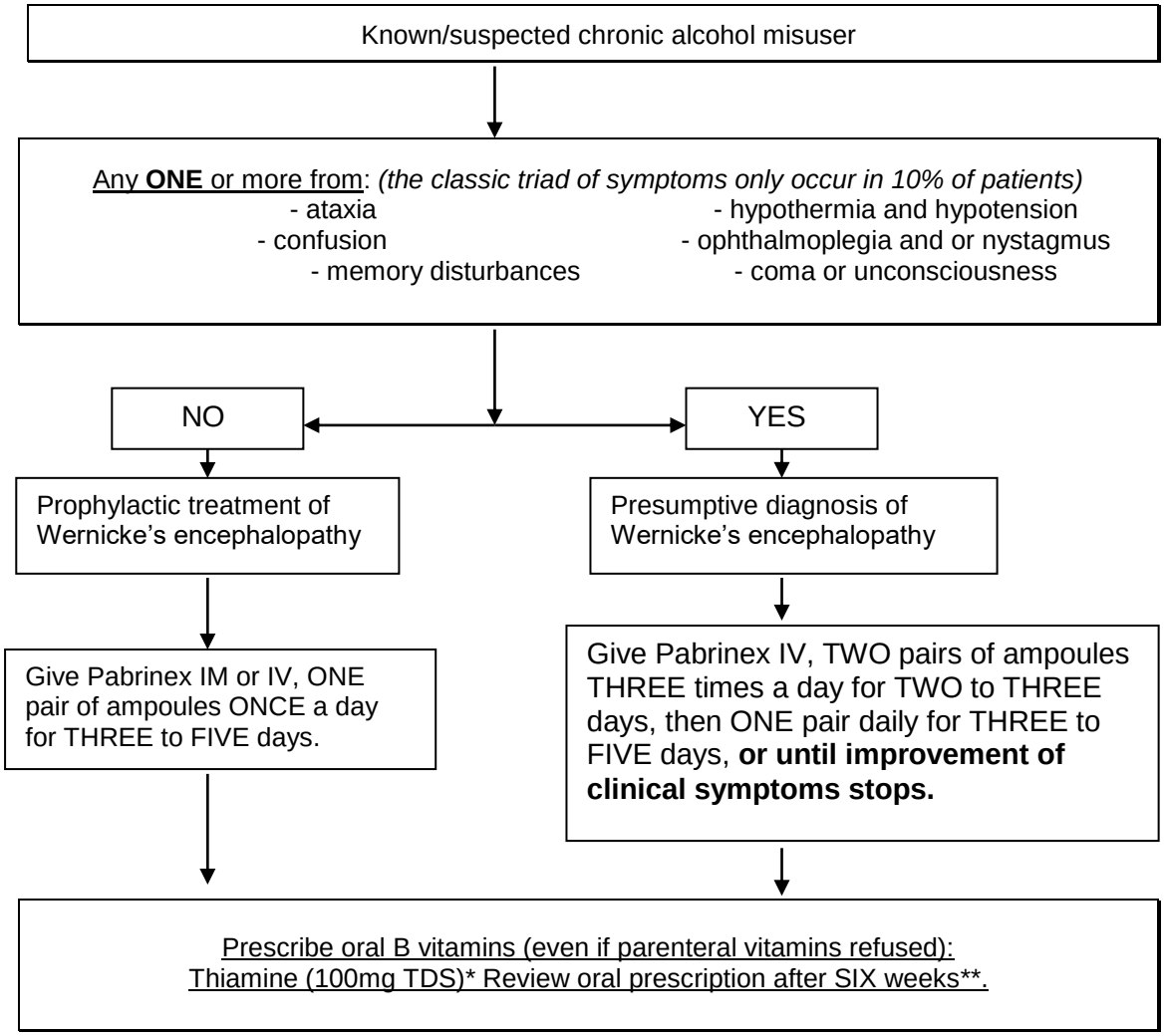
The time of administering the first dose must be recorded on the drug chart in order that the staff can then give the second dose after a **minimum** 3 hour interval.

If a patient shows any signs of alcohol withdrawal during any 24 hour period it would suggest that the dose of chlordiazepoxide is insufficient. In this event, revert to the level at which the withdrawal symptoms were controlled and maintain for a further two days. The remainder of the regimen should also be extended, each dose being maintained for 2 - 3 days depending on the severity of the symptoms.

Wernicke's Encephalopathy

Wernicke's encephalopathy (WE) occurs in approximately 12.5% of alcohol misusers and is fatal in approximately 17% of untreated cases. Permanent brain damage (Korsakoff's psychosis) occurs in approximately 85% of inappropriately managed survivors, 25% of whom require long-term institutionalisation. WE and Korsakoff's psychosis can be prevented through the identification of those at risk, and the administration of parenteral B vitamins. Failure to treat WE may constitute negligence. Damages of £500,000 and more have been awarded to cover long-term care costs in patients who have developed Korsakoff's psychosis as a result of inappropriate management of WE. Patients suspected of having Delirium Tremens or Wernicke's syndrome should be transferred to an acute medical hospital.

Algorithm for the management of Wernicke's encephalopathy



*Thiamine should be prescribed as split daily dose rather than a single dose to increase absorption. Vitamin B complex preparations (vitamin B compound and vitamin B compound strong tablets) should not be prescribed for prevention of Wernicke's Encephalopathy (see section 10.2)[14]

**Review patients prescribed thiamine with a view to stopping if the patient has been abstinent for 6 weeks or more and has regained adequate nutritional status.[14]

Before administering Pabrinex

The administration of glucose for the treatment of hypoglycaemia may exacerbate the acute loss of thiamine even further in the detoxifying alcoholic patient, and it is essential that parenteral thiamine is administered **before** the glucose load.

Intramuscular Administration of Pabrinex

The contents of one ampoule number 1 and one ampoule number 2 of Pabrinex Intramuscular High Potency (total 7ml) are drawn up into a syringe to mix them just before use, then injected slowly high into the gluteal muscle, 5cm below the iliac crest. IM administration is therefore only suitable for prophylactic treatment.

The injection can be given at a single site however, this exceeds the normal maximum volume of injections advised to be injected into the gluteal muscle of 5ml (halved for children or those with low muscle mass), that is within EPUT medicines policy CLP13 SOP 11, procedure for the preparation and administration of injectable medicines. It is common practice to split the injection, once mixed, across two sites and this can be considered as an alternative, and should be used in patients with low muscle mass. When making a decision as to whether to split the dose it is important to consider whether a large volume of injection is suitable for the patient and to discuss the risks and benefits of administering a single injection or split injection with the patient.

There is a small risk of anaphylaxis when Pabrinex is administered. Facilities to manage anaphylaxis must be available. The incidence of anaphylactic reactions to IM Pabrinex is estimated to be 1 in 5 million pairs of ampoules. Given the nature of Wernicke's encephalopathy, the benefit to risk ratio favours parenteral thiamine, and fears about using it should not result in inappropriate use of oral thiamine.

OBSERVATIONS DURING THE DETOXIFICATION PERIOD (INPATIENT SETTING)

Observations should be performed:

- Immediately before the start of the detoxification,
- Six hourly throughout the detoxification until the CIWA-Ar score has been < 9 for 24 hours,
- and additionally at 1 hour after the last dose of chlordiazepoxide administered.

Each set of observations should include:

- Alcohol withdrawal scale (CIWA-Ar),
- Observation of level of consciousness and orientation,
- Pulse, blood pressure and temperature,
- Respiratory rate,
- Observation for dehydration & marked tremor.

If the patient is asleep, they should not be woken for observations. However, it should be recorded that they were asleep.

The first 24 hours

Observations should be carried out at least four times daily during the first 24 hours. This is also to determine the dose of chlordiazepoxide that should be administered. In complicated patients (e.g. those with DTs), consider monitoring and dosing at this frequency beyond the first 24 hours.

Contact the prescriber if tachycardia or hypertensive.

Nutritional support and close monitoring of fluid balance are important. Nutrition is especially important within a few hours following parenteral thiamine administration (i.e. Pabrinex).

Urea and electrolytes (including magnesium) should be regularly checked.

Days 2 to 6

Observations should be carried out twice daily from days 2 to 6. This may be more frequent if any complications are seen. These observations are solely for the purpose of

monitoring the patient and not for the administration of chlordiazepoxide. The patient should be on a set reducing regimen from Day 2.

Stabilisation

The service user should remain on the unit/ward until the alcohol detoxification is complete. It is important that they are monitored (e.g. CIWA-Ar) for the first seven days of their management, as they may suddenly deteriorate or may suffer withdrawal seizure. This means no leave is to be granted until day 7 or 8 of the detoxification.

In certain circumstances alcohol related withdrawal seizures have been known to be near fatal or fatal.

An extended stay on the unit/ward is advised if the client:

- has experienced confusion or hallucinations during the detoxification
- has a history of previously complicated withdrawal
- has epilepsy or a history of fits
- is undernourished
- has severe vomiting or diarrhoea (this should be controlled within 24 hours or patient transferred to hospital).
- is at risk of suicide
- has severe dependence coupled with unwillingness to be observed daily
- has uncontrollable withdrawal symptoms
- has an acute physical or psychiatric illness
- has multiple substance misuse

In the treatment of concurrent opiate and alcohol dependence, no reduction in the opiate agonist should be attempted until the alcohol detoxification is complete.

10.2.3 DRUGS FOR MAINTAINING ABSTINENCE

After a successful withdrawal in people with moderate and severe alcohol dependence, consider offering acamprosate, disulfiram, oral naltrexone, or nalmefene, in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.

Behavioural couple's therapy should be offered to service users who have a regular partner and whose partner is willing to participate in treatment. Before starting treatment conduct a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including gamma glutamyl transferase [GGT]). In particular, consider any contraindications or cautions (see the SPC), and discuss these with the service user.

Acamprosate

Acamprosate has been shown to increase abstinence rates in people receiving treatment for alcohol dependence by 10-20% (40% at best). Evidence suggests the intended actions of acamprosate are maintained over 1 year but not beyond. It should be initiated as soon as possible after abstinence has been achieved and should be maintained if the patient relapses. Contraindications include severe renal or hepatic failure so function tests should be performed prior to initiation. Avoid in those who are pregnant or breastfeeding. Refer to BNF/SPC for full details.

Acamprosate is usually prescribed at a dose of 1998mg (666mg three times a day) unless the service user weighs less than 60 kg, and then a maximum of 1332mg should be prescribed per day.

Acamprosate should usually be prescribed for up to 6 months, or longer for those benefiting from the drug who want to continue with it. It should be stopped if drinking persists 4 - 6 weeks after starting the drug.

Service users taking acamprosate should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months.

Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement.

Disulfiram

Disulfiram inhibits aldehyde dehydrogenase, leading to an acetaldehyde (ethanol) accumulation after drinking alcohol which can cause unpleasant physical effects. Continued drinking can lead to arrhythmias, hypotension and collapse. Disulfiram appears to reduce the number of drinking days but not to increase abstinence. Supervised consumption may improve efficacy. Contra-indications for using disulfiram include cardiac failure, coronary artery disease, and history of cerebrovascular accident, hypertension, psychosis, severe personality disorder and suicide risk. Disulfiram should not be continued for more than six months without a review. Refer to BNF/SPC for full details.

After a successful withdrawal in people with moderate and severe alcohol dependence, consider offering disulfiram in combination with a psychological intervention to service users who have a goal of abstinence but for whom acamprosate and oral naltrexone are not suitable, or prefer disulfiram and understand the relative risks of taking the drug.

If using disulfiram start treatment at least 24 hours after the last alcoholic drink consumed. Usually prescribe at a dose of 200 mg per day. For service users who continue to drink, if a dose of 200 mg (taken regularly for at least 1 week) does not cause a sufficiently unpleasant reaction to deter drinking, consider increasing the dose in consultation with the service user.

Before starting treatment with disulfiram, test liver function, urea and electrolytes to assess for liver or renal impairment. Check the SPC for warnings and contraindications in pregnancy.

Make sure that service users taking disulfiram stay under supervision, at least every 2 weeks for the first 2 months, then monthly for the following 4 months. If possible, they should have a family member or carer, who is properly informed about the use of disulfiram, oversee the administration of the drug. Service users on disulfiram should be

medically monitored at least every 6 months after the initial 6 months of treatment and monitoring.

Warn service users taking disulfiram, and their families and carers, about:

- The interaction between disulfiram and alcohol (which may also be found in food, perfume, mouthwash etc.), the symptoms of which may include flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension and collapse.

- The rapid and unpredictable onset of the rare complication of hepatotoxicity; advise service users that if they feel unwell or develop a fever or jaundice that they should stop taking disulfiram and seek urgent medical attention.

Naltrexone

Naltrexone is a non-selective opioid antagonist and has UK marketing authorisation for treatment of alcohol dependence Naltrexone is thought to reduce pleasurable effects of alcohol due to its propensity to block the release of endogenous opioids and reduce dopaminergic activity. Thus naltrexone reduces alcohol's rewarding effects and motivation to drink or "cravings". Naltrexone is shown to reduce the number of drinking days and the amount of alcohol consumed in those who are still drinking or have just relapsed. Naltrexone should not be stopped if drinking resumes unless drinking persists for longer than 4 - 6 weeks. It should not be started in patients known or suspected of being dependent on opiates including heroin, methadone or buprenorphine, and analgesia such as tramadol, codeine or other opiate containing agents. Naltrexone will precipitate acute opiate withdrawal in these patients.

It is usually prescribed after alcohol detoxification though patients who are less dependent or drinking harmfully also benefit. Start prescribing at a dose of 25 mg per day and aim for a maintenance dose of 50 mg per day. It can also be prescribed on an as needed basis to reduce heavy drinking in those patients who do not require immediate detoxification. LFTs should be monitored monthly with this administration. Draw the service user's attention to the information card that is issued with oral naltrexone about its impact on opioid-based analgesics.

Oral naltrexone should usually be prescribed for up to 6 months or longer for those benefiting from the drug who wish to continue with it. It should be stopped if drinking persists 4 - 6 weeks after starting the drug.

Service users taking oral naltrexone should stay under supervision, at least monthly for 6 months and at reduced but regular intervals if the drug is continued after 6 months. Do not use blood tests routinely, but consider them for older people, for people with obesity, for monitoring recovery of liver function and as a motivational aid for service users to show improvement. If the service user feels unwell advise them to stop the oral naltrexone immediately.

Nalmefene

Refer to NICE TA325. [8]

Nalmefene is an opioid receptor antagonist with a different pharmacological profile to naltrexone at the three opioid receptor subtypes. Nalmefene exhibits antagonist activity at the mu and delta opioid receptors, and partial agonist activity at the kappa opioid receptors. Nalmefene has a marketing authorisation in the UK for 'the reduction of alcohol consumption in adult patients with alcohol dependence who have a high drinking risk level

without physical withdrawal symptoms and who do not require immediate detoxification'. It may have a better safety profile than Naltrexone with less risk of liver toxicity.

Nalmefene is recommended within its marketing authorisation, as an option for **reducing alcohol consumption,** for people with a milder form of alcohol dependence, who have a high drinking risk level (between 5-10 units/daily for women and 7-12units/daily for men), are without physical withdrawal symptoms **and therefore do not** require alcohol detoxification.

The marketing authorisation states that nalmefene should only be prescribed in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption **and** be initiated only in patients who continue to have a high drinking risk level 2 weeks after initial assessment. It therefore should not be prescribed for inpatients. Any prescribing by trust community teams should be in consultation with CDAS.

Other medications:
Benzodiazepines should only be used for managing alcohol withdrawal and not as ongoing treatment for alcohol dependence.

Do not use antidepressants routinely for the treatment of alcohol misuse alone.

Do not use gammahydroxybutyrate (GHB / sodium oxybate) for the treatment of alcohol misuse.

10.3 OPIOID DEPENDENCE – MAINTENANCE TREATMENT WITH OPIOID SUBSTITUTION

10.3.1 Approved drugs for the maintenance treatment of opioid dependence with opioid substitution

Methadone and buprenorphine using flexible dosing regimens are recommended as options for maintenance therapy in the management of opioid dependence.

Drug[2]	Formulations[2]
Methadone	1mg/ml Sugar Solution 1mg/ml Sugar Free Solution Tablets 5mg – only to be prescribed if liquid is unsuitable (e.g. holiday prescriptions) Capsules 5mg – unlicensed, only to be prescribed if tablets are unavailable
Buprenorphine	S/L tabs 0.4mg, 2mg, 8mg
Buprenorphine oral lyophilisate (Espranor)	Oral lyophilisate 2mg, 8mg
Buprenorphine + Naloxone (Suboxone)	S/L tabs (2mg + 0.5mg), (8mg + 2mg)

Note

ESPRANOR: [16]
The therapeutic indication for Espranor is substitution treatment for opioid drug dependence, within a framework of medical, social and psychological treatment.

Treatment is intended for use in adults and adolescents aged 15 years or over who have agreed to be treated for addiction. Treatment should be under the supervision of a clinician experienced in the management of opiate dependence/addiction. Espranor is not interchangeable with other buprenorphine products. Different buprenorphine products have different bioavailability. Therefore, the dose in mg can differ between products. Once the appropriate dose has been identified for a patient with a certain product (brand), the product cannot readily be exchanged with another product.

The route of administration for Espranor is **on** the tongue, not under it. Administration is oromucosal. The oral lyophilisate should be taken from the blister unit with dry fingers, and placed whole on the tongue until dispersed, which usually occurs within 15 seconds, and then absorbed through the oromucosa. Swallowing should be avoided for 2 minutes. The oral lyophilisate should be taken immediately after opening the blister. Patients should not consume food or drink for 5 minutes after administration.

Prescribers must advise patients that the oromucosal route of administration is the only effective and safe route of administration for Espranor. If the oral lyophilisate, or saliva containing buprenorphine are swallowed, the buprenorphine will be metabolised and excreted and have minimal effect.

New initiations - Buprenorphine lyophilisate for de novo patients starting opiate substitution treatments can be initiated by consultants and lead NMPS within STaRS.

Continuation of script - Any buprenorphine lyophilisate scripts that were either initiated by the STaRS consultants or transferred from an externally agency can be continued by all NMPS or doctors in STaRS .

Conversions - buprenorphine sublingual to oral lyophilisate conversions and vice versa are only to be undertaken by the consultants in STaRS.

10.3.2 OPIOID DEPENDENCE – MAINTENANCE TREATMENT WITH OPIOID SUBSTITUTION IN THE INPATIENT SETTING

If an opioid dependent patient is admitted to a ward and is currently receiving opioid substitution drug treatment from a Community Drug and Alcohol Service (CDAS) this should not be prescribed without first consulting the CDAS.

The quick reference guide to prescribing Methadone and Buprenorphine (inpatients) should be used (Annex 3).

If the patient requires opioid substitution treatment but is not under any CDAS the appropriate CDAS should be contacted for advice / referral.

Treatment should not be changed, e.g. dose reduction/ detoxification, unless under the guidance of CDAS.

10.3.3 OPIOID DEPENDENCE - MAINTENANCE TREATMENT WITH OPIOID SUBSTITUTION IN THE COMMUNITY / PRISON SETTING

Provision of CDAS varies across Essex. Service providers are:

Area	Provider
North Essex	Essex STaRS (Colchester, Harlow, Chelmsford)
Basildon, South Essex	Essex STaRS (Basildon)
Southend on Sea	Southend Treatment and Recovery Service (Southend)
Thurrock	Inclusion Visions (Grays)
HMP Chelmsford	Forward Trust

Providers will follow their local procedures, which are not included here.

10.4 OPIOID DEPENDENCE - DETOXIFICATION

10.4.1 Approved drugs for the treatment of opioid detoxification

Drug[2]	Formulations[2]
Methadone	1mg/ml Sugar Solution 1mg/ml Sugar Free Solution Tablets 5mg – only to be prescribed if liquid is unsuitable (e.g. holiday prescriptions) Capsules 5mg – unlicensed, only to be prescribed if tablets are unavailable
Buprenorphine	S/L tabs 0.4mg, 2mg, 8mg
Buprenorphine + Naloxone (Suboxone)	S/L tabs (2mg + 0.5mg), (8mg + 2mg)

Detoxification refers to a planned dose reduction of the opioid drug.

This is done as a reduction of the maintenance dose of the opioid drug after induction onto a stabilisation dose. The reduction is usually part of the long-term plan for the patient.

10.4.2 OPIOID DEPENDENCE - DETOXIFICATION IN THE INPATIENT SETTING

This should only be done under the direction of CDAS.

10.4.3 OPIOID DEPENDENCE - DETOXIFICATION IN THE COMMUNITY SETTING

CDAS providers will follow their local procedures, which are not included here.

10.5 OPIOID DEPENDENCE – MANAGEMENT OF OPIOID OVERDOSE

Approved drugs for the management of opioid overdose

Drug	Formulation	Comments
Naloxone	Injection 1mg/ml solution for injection for intramuscular administration Injection 1mg/ml prefilled syringe (Prenoxad) for intramuscular administration Nasal spray 1.8mg (Nyxoid) for intranasal administration	Prenoxad and Nyxoid for use by CDAS staff for administration and supply to service users/carers under the Naloxone Take Home Programme

A primary cause of mortality after an overdose of natural and synthetic opioid drugs is respiratory depression, for which naloxone is indicated. It is an opioid antagonist and can rapidly reverse the life-threatening effects of opioid overdose and improve respiratory function. It has no psychoactive properties and no intoxicating effects or misuse potential. . It is licensed for use in the treatment of suspected acute opioid overdose or intoxication.

The naloxone take home programme is an overdose mortality prevention strategy developed by CDAS that involves supplying naloxone directly to patients and carers along with opioid overdose prevention training. This works by eliminating the time delay before the arrival of emergency services, which contributes to the high mortality rates associated with accidental opioid overdose.

Naloxone 1mg/ml solution for intramuscular injection is the preferred option of naloxone formulation for use within the Trust and should be considered first line. Its absorption is not affected by nasal mucosa and septal defects.

Naloxone 1.8mg nasal spray should be considered for targeted cohort of patients in the following circumstances:

- For its licensed age group outside the current licensed age group for Prenoxad i.e. 14 to 17 years of age inclusive.
- Where the service user/carer, following training and support, declines Prenoxad due to serious concerns in using an injection.
- Where the staff facilitating training considers that the service user/carer is unable to demonstrate competency in using Prenoxad, which increases the risk of injury e.g. use by adolescent or young adult carers.
- In certain exceptional circumstance such as patient travelling abroad and unable to carry Prenoxad due to needles being prohibited.

Refer to Trust Clinical Guideline for the administration of Naloxone for known or suspected opioid overdose and the clinical management of the Naloxone Take Home Programme (CG82) for more information.

10.6 BENZODIAZEPINE DEPENDENCE

For the purposes of dose reduction programmes the BNF lists doses approximately equivalent to **diazepam 5 mg**:

≡ alprazolam 250 micrograms

≡ clobazam 10 mg

≡ clonazepam 250 micrograms

≡ flurazepam 7.5–15 mg

≡ chlordiazepoxide 12.5 mg

≡ loprazolam 0.5–1 mg

≡ lorazepam 500 micrograms

≡ lormetazepam 0.5–1 mg

≡ nitrazepam 5 mg

≡ oxazepam 10 mg

≡ temazepam 10 mg

Inpatient and Community MH&LD:

Prescribers are recommended to follow the latest advice published in the BNF, in the section “Hypnotics and Anxiolytics - Dependence and withdrawal”.

A suggested protocol for withdrawal for prescribed long-term benzodiazepine patients is as follows:

1. Transfer patient stepwise, one dose at a time over about a week, to an equivalent daily dose of diazepam preferably taken at night.
2. Reduce diazepam dose, usually by 1–2 mg every 2– 4 weeks (in patients taking high doses of benzodiazepines, initially it may be appropriate to reduce the dose by up to one-tenth every 1–2 weeks). If uncomfortable withdrawal symptoms occur, maintain this dose until symptoms lessen.
3. Reduce diazepam dose further, if necessary in smaller steps; steps of 500 micrograms may be appropriate towards the end of withdrawal. Then stop completely.
4. For long-term patients, the period needed for complete withdrawal may vary from several months to a year or more.

CDAS and Prison:

CDAS providers will follow their local procedures, which are not included here.

References

1. NICE CG115: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. February 2011.
2. NICE CG52: Drug misuse in over 16s: opioid detoxification. July 2007.
3. Drug misuse and dependence: UK guidelines on clinical management. Independent Expert Working Group. London: Department of Health. https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management Accessed 17/11/2017.
4. Guidance for Mental Health Professionals on the management of Acute Kidney Injury NHS England. June 2016. Accessed 17/11/2017.
5. Drugs and driving: the law. HM Government. https://www.gov.uk/drug-driving-law Accessed 17/11/2017.
6. BNF online, current edition. Accessed 17/11/2017.
7. South London & Maudsley NHS Foundation Trust Prescribing Guidelines 12th edition, Wiley Blackwell 2015.
8. NICE TA 325. Nalmefene for reducing alcohol consumption for people with alcohol dependence. November 2014.
9. Severity of alcohol dependence questionnaire. https://www.alcohollearningcentre.org.uk/Topics/Latest/Severity-of-Alcohol-Dependence-Questionnaire-SADQ/ Accessed 17/11/2017.
10. Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf Accessed 17/11/2017.
11. NICE NG64: Drug misuse prevention: targeted interventions. Published date: February 2017.

12. NICE NG58: Coexisting severe mental illness and substance misuse: community health and social care services (2016).

13. NICE CG120: Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2011).

14. Regional Medicines Optimisation Committee (RMOC) Position Statement: Oral vitamin B supplementation in alcoholism. November 2019. https://www.sps.nhs.uk/wp-content/uploads/2019/12/RMOC-position-statement-oral-vitamin-B-supplementation-in-alcoholism-v1.0-1.pdf Accessed 27/1/2020.

15. GOV.UK Guidance – Widening the availability of naloxone. Updated 18 February 2019. Available at: https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone [Accessed 22/06/20]

16. Summary of product characteristics, Espranor. www.medicines.org.uk/ Accessed 24/9/2020.

17. Opioids: risk of dependence and addiction. Drug Safety Update volume 14, issue 2: September 2020: 5.

18. Opioid medicines and the risk of addiction. Safety leaflet on opioid medicines to help patients and their families reduce the risks of harm. https://www.gov.uk/guidance/opioid-medicines-and-the-risk-of-addiction

Annex 1

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE
(Stockwell et al, 1979)

We would like to recall a recent month when you were drinking in a way, which for you was fairly typical of a heavy drinking period. Please fill in the month and the year: -

MONTH: ……YEAR: .....

We want to know more about your drinking during this time and how often you experienced certain feelings. Please put a tick to show how frequently each of the following statements applied to you during this typical period of drinking.

		Score	**0**	**1**	**2**	**3**
			Almost Never	**Some-times**	**Often**	**Nearly Always**
1)	I wake up feeling sweaty					
2)	My hands shaking first thing in the morning					
3)	My whole body shakes violently first thing in the morning, if I don't have a drink					
4)	I wake up absolutely drenched in sweat					
5)	I dread waking up in the morning					
6)	I am frightened of meeting people first					
7)	I feel on the edge of despair when I wake up					
8)	I feel very frightened when I wake up					
9)	I like to have a morning drink					
10)	I always gulp down my morning drink as quickly as possible					
11)	I drink in the morning to get rid of the shakes					
12)	I have a very strong craving for a drink when I wake up					
13)	I drink more than 1/4 bottle of spirits or 4 pints beer/1 bottle wine per day					
14)	I drink more than 1/2 bottle of spirits or 8 pints beer/2 bottles wine per day					
15)	I drink more than 1 bottle of spirits or 15 pints beer/4 bottles of wine per day					
16)	I drink more than 2 bottles of spirits or 30 pints beer/8 bottles wine per day					

Imagine the following situation:

> You have been completely off drink for a few weeks and you then drink very heavily for two days

HOW WOULD YOU FEEL THE MORNING AFTER THOSE TWO DAYS OF DRINKING?

Score	**0**	**1**	**2**	**3**
	Almost Never	**Some-times**	**Often**	**Nearly Always**
17) I would start to sweat				
18) My hands would shake				
19) My body would shake				
20) I would be craving a drink				
Totals				
SEVERITY OF ALCOHOL DEPENDENCE QUOTIENT				

Re: Questions 17 – 20

(If the patient has not been abstinent for a period of two weeks then score maximum for Q17–20)

TOTAL SADQ SCORE =

(Score 0-3 no dependence, 4-19 mild dependence, 20-30 moderate dependence, 31-44+ severe dependence, 45+ very severe dependence)

Annex 2

Clinical Institute Withdrawal Assessment Alcohol Revised Scale (CIWA-Ar)

Nausea/Vomiting – Rate on scale 0 – 7
0 – None
1 – Mild nausea with no vomiting
2
3
4 – Intermittent nausea
5
6
7 – Constant nausea and frequent dry heaves and vomiting

Tremors – have patient extend arms & spread fingers. Rate on scale 0 - 7
0 – No tremor
1 – Not viable, but can be felt fingertip to fingertip
2
3
4 – Moderate, with patient's arms extended
5
6
7 – severe, even w/arms not extended

Anxiety – Rate on scale 0 – 7
0 – no anxiety, patient at ease
1 – mildly anxious
2
3
4 – moderately anxious or guarded, so anxiety is inferred
5
6
7 – equivalent to acute panic states seen in severe delirium or acute schizophrenia reactions

Agitation - Rate on scale 0 – 7
0 – normal activity
1 – somewhat normal activity
2
3
4 – moderately fidgety and restless
5
6
7 – paces back and forth, or constantly thrashes about

Paroxysmal Sweats – Rate on Scale 0 – 7
0 – no sweats
1 – barely perceptible sweating, palms moist
2
3
4 – beads of sweat obvious on forehead
5
6
7 – drenching sweats

Orientation and clouding of sensorium – Ask, "What day is this? Where are you? Who am I?" Rate scale 0 – 4
0 – Orientated
1 – cannot do serial additions or is uncertain about date
2 – disorientated to date by no more than 2 calendar days
3 – disorientated to date by more than 2 calendar days
4 – disoriented to place and/or person

Tactile disturbances – Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 – none
1 – very mild itching, pins & needles, burning, or numbness
2 – mild itching, pins & needles, burning, or numbness
3 – moderate itching, pins & needles, burning, or numbness
4 – moderate hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Auditory Disturbances – Ask "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 – not present
1 – Very mild harshness or ability to startle
2 – mild harshness or ability to startle
3 – moderate harshness or ability to startle
4 – moderate hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Visual disturbances – Ask "Does the light appear to be too bright? Is its colour different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 – not present
1 – very mild sensitivity
2 – mild sensitivity
3 – moderate sensitivity
4 – moderate hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Headache – Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or light headiness.
0 – not present
1 – very mild
2 – mild
3 – moderate
4 – moderately severe
5 – severe
6 – very severe
7 – extremely severe

Procedure:

1. Assess and rate of each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (i.e. Start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

Assessment Protocol a. Vitals, Assessment Now. b. If initial score ≥ 8 repeat q1h x 8hrs, then if stable q2h x 8 hrs, then if stable q4h. c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hours, d/c assessment. If score ≥ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer pm medications as ordered and record on MAR and below.	**Date**												
	Time												
	Pulse												
	RR												
	O_2 sat												
	BP												

Assess and rate each of the following (CIWA-Ar Scale):	**Refer to reverse for details instructions in use of the CIWA-Ar scale.**											
Nausea/vomiting (0 – 7) 0 – none, 1 – mild nausea no vomiting; 4 – intermittent nausea; 7 – constant nausea, frequent dry heaves and vomiting												
Tremors (0 – 7) 0 – no tremor, 1 – not viable but can be felt; 4 – moderate w/arms ex tended, 7 – severe even w/arms not extended												
Anxiety (0 – 7) 0 – none, at ease; 1 – mildly anxious; 4 – moderately anxious or guarded; 7 – equivalent to acute panic state												
Agitation (0 – 7) 0 – normal activity; 1 – somewhat normal activity; 4 – moderately fidgety/restless; 7 – paces or continuously thrashes about												
Paroxysmal Sweats (0 – 7) 0 – no sweats; 1 – barely perceptible sweating, palms moist; 4 – heads of sweat obvious to forehead; 7 – drenching sweat												
Orientation (0 – 4) 0 – orientated; 1 – uncertain about date; 2 – disorientated to date by no more than 2 days; 3 – disorientated by > 2 days; 4 – disorientated to place and/or person												
Tactile Disturbances (0 – 7) 0 – none; 1 – very mild itch, P&N, numbness; 2 – mild itch, P&N, burning, numbness; 3 – moderate itch, P&N, burning, numbness; 4 – moderate hallucinations; 5 –severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations												
Auditory Disturbances (0 – 7) 0 – not present; 1 – very middle harshness/ability to startle; 2 – mild harshness/ability to startle; 3 – moderate harshness/ ability to startle; 4 – moderate hallucinations; 5 severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations												
Visual Disturbances (0 – 7) 0 – not present; 1 – very mild sensitivity, 2 – mild sensitivity; 3 – moderate sensitivity; 4 – moderate hallucinations; 5 – severe hallucinations; 6 – extremely severe hallucinations; 7 – continuous hallucinations												
Headache (0 -7) 0 – not present; 1 – very mild; 2 – mild; 3 – moderate; 4 – moderately severe; 5 – severe; 6 – very severe; 7 – extremely severe												
Total CIWA-Ar score:												

Scale for Scoring: Total Score:= 0 – 9: absent or minimal withdrawal 10 – 19: mild to moderate withdrawal more than 20: severe withdrawal	**Indication for PRN medication:** a. Total CIWA- AR score 8 or higher if ordered PRN only (Symptom triggered method) b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + pm method)

Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)												
Assessor initials												

Patient Identification (Addressograph)

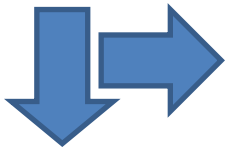
Annex 3

Methadone and Buprenorphine: Quick Reference Guide for Prescribing and Supply for Inpatients

Working Hours (9am-5pm)

Admission of a suspected opioid dependent patient

Confirm if patient is currently under the care of a Community Drug and Alcohol Service (CDAS). Local pharmacy staff can assist during office hours or direct contact with CDAS.



Also confirm use with urine screen (with approved test kit).

Obtain printed evidence (e.g. fax or secure email) of current treatment regimen from appropriate CDAS or dispensing pharmacy before prescribing on drug chart. Inform community prescriber of admission and have them cancel any active prescription at the community pharmacy.

If urine screen is opiate negative and/or you are not able to obtain prescribing information ask for advice from CDAS on an individual patient basis to prevent withdrawal on ward and document agreed management plan (see notes 1 and 2).

Notes 1

a) No substance replacement drug should be prescribed based solely on information obtained from a patient or out of date documentation.

b) Patients who miss three days or more of their regular prescribed dose of opioid maintenance therapy are at risk of overdose because of loss of tolerance. Dose reduction must be considered in these patients (BNF online, accessed 10 Oct 2017).

c) If the patient misses five or more days of treatment, an assessment of illicit drug use is required before restarting substitution therapy. This is particularly important for patients taking buprenorphine because of the risk of precipitated withdrawal (BNF online, accessed 10 Oct 2017).

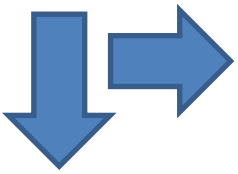
d) Ensure the community prescriber is informed of the patient's leave arrangements and discharge. TTA opiate substitute medication should not be dispensed routinely. Ideally any TTA opiate substitute medication should be prescribed by the local CDAS with specific agreed time frames and an identified community pharmacy that will dispense. Fax or send details of opiate substitution dose to community prescriber.

e) EPUT medicines policies (CLPG 13- Appendix 3) provide detailed instructions on how to manage CDs.

Methadone and Buprenorphine: Quick Reference Guide for Prescribing and Supply for Inpatients

Out of Hours (after 5pm till 9am of next working day)

Admission of a suspected opioid dependent patient



Confirm use with urine screen (with approved test kit).

Necessary steps should be taken to confirm treatment regimen (if possible check Community Drug and Alcohol Service (CDAS) electronic records (see notes 1a) and/or local dispensing pharmacy. Update CDAS as soon as possible and cancel active prescription at community pharmacy.

Assess for signs of opiate withdrawal using a validated withdrawal scale (objective signs could start 4 -24hrs after last dose of opiate and can include yawning, lacrimation, sneezing, runny nose, raised pulse/BP, dilated pupils, diarrhoea, nausea, fine muscle tremor & clammy skin).

Provide symptomatic relief if non-severe (see notes 2).

If severe and in absence of appropriate advice follow protocol for emergency substitution. Document & report via DATIX, see also notes 1b-e.

Notes 2

Adjunctive therapy and symptomatic relief for non-severe withdrawal symptoms:

Symptom	***Treatment***
Diarrhoea	Loperamide as per BNF regimen
Stomach cramps	Mebeverine as per BNF regimen
Nausea & vomiting	Metoclopramide or Prochlorperazine as per BNF regimen
Muscular pains and headaches	Paracetamol/NSAIDs as per BNF regimen
Anxiety/agitation	Diazepam as per BNF regimen
Insomnia	Zopiclone 3.75mg-7.5mg ON

Protocol for emergency substitution

Methadone: initial dose 10mg orally (SF mixture 1mg/1mL).
An additional 5mg can be given 4-hourly if objective withdrawal symptoms persist within first 8 hours. For following two days give total previous day dose as a single dose each morning. All consumption must be supervised.
Dose can be adjusted up or down depending on patient response.
No more than 50mg daily should be prescribed unless advised otherwise by specialist service (CDAS).