## METHADONE IN OPIATE DEPENDENT PATIENTS

### GUIDELINES

<table>
<thead>
<tr>
<th>Edition No:</th>
<th>1</th>
<th>ID Number:</th>
<th>GUDLMM003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dated:</td>
<td>January 2016</td>
<td>Review Date:</td>
<td>January 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Document ID:</th>
<th>Guideline</th>
<th>Document Type:</th>
<th>Local</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate:</td>
<td>Acute &amp; Continuing Care Directorate</td>
<td>Category:</td>
<td>Medicines Management</td>
</tr>
<tr>
<td>Department(s):</td>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Author/Reviewer:</th>
<th>Sponsor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title</td>
<td>Job Title</td>
</tr>
<tr>
<td>Principal Clinical Pharmacist ED and AMU</td>
<td>Head of Pharmacy</td>
</tr>
</tbody>
</table>

### Policy Dissemination

Trust and Turning Point staff

### Policy Consultation

Turning Point Team

### Corporate Approval and Ratification

<table>
<thead>
<tr>
<th>Name of Committee</th>
<th>Date: 29/01/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and Therapeutics Committee</td>
<td></td>
</tr>
</tbody>
</table>

### Document Control / History

<table>
<thead>
<tr>
<th>Edition No</th>
<th>Reason for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>New Policy</td>
</tr>
</tbody>
</table>

### Document References:

- BNF No 68 September - March 2015; Pharmaceutical Press, Bedfordshire.
- NICE Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal 114, 2007.
- Imperial College Healthcare NHS Trust – St Mary’s Hospital Guidelines for the Management of Drug Dependent Patients 2008.
METHADONE IN OPIATE DEPENDENT PATIENTS
GUIDELINES

Kings College Hospital NHS Foundation Trust, Clinical Guidelines
The pharmacological management of adult inpatients who
are opioid drug users. The management of adult methadone
programme clients admitted as an inpatient.

<table>
<thead>
<tr>
<th>Trust Associated Documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

© Medway NHS Foundation Trust [2016]
1 Document Summary
The following guidelines have been prepared to assist all medical, pharmacy and nursing staff in the management of drug dependent patients who are currently using substances of misuse. The Department of Health Guidelines advise that appropriate communication and transfer of information between a healthcare professionals coming into contact with or providing interventions for drug misusers is vital to ensure seamless care. These guidelines apply to all drug dependent patients regardless of the reason for their admission. The Trust’s policy should be made clear to the patient at the earliest opportunity so that (s)he has the choice of accepting inpatient treatment.

2 Introduction
Department of Health guidelines state “Assessment and evidence-based care provided by liaison or a multidisciplinary team is appropriate in many clinical situations, including, for example, with pregnant women, young people, older drug misusers, those with a dual diagnosis, drug misusers with acute and chronic pain, and drug misusers being admitted to or discharged from hospital. Drug misusers may attend A&E or be admitted to hospital for treatment of conditions common to other patients or directly related to their drug misuse. In either case, hospital medical staff should take proper account of any drug misuse and any treatment being provided in the community”. (DoH, 2007)

This policy has been written in conjunction with Substance Misuse Liaison Team (Turning Point) to ensure the safer management of opiate substitutes between primary and secondary care settings.

3 Purpose / Aim and Objective
- To ensure the safe and effective management of adult patients admitted to hospital that are dependent on heroin or on an opioid substitution treatment.
- To minimise the risk of opioid withdrawal and the risk of using illicit substances in the inpatient setting.
- This guideline is only intended for inpatients. People presenting to ED in opioid withdrawal who do not require admission for other medical reasons should be referred to Turning Point. Turning Point are available 24 hours a day.
- It is not within the scope of these guidelines to advise patients on withdrawal or rehabilitation programme. Any patient who expresses the desire to start on a drug withdrawal or rehabilitation programme should be referred Turning Point for assessment and support. Their contact details can be found at the end of this document.

4 (Duties) Roles & Responsibilities
It is the responsibility of all staff to read this policy and follow the guideline when managing patients who require management of opiate dependent patients.
Flowchart for the management of opioid dependent patients and patients on opioid substitution programmes

Patient known or suspected to be opioid dependent

Patient is on registered substance misuse programme

Patient is using illicit substances

Confirm usual prescription: Name of medication, dose, formulation, frequency and date last collected. All should be confirmed with a reliable source (e.g. Turning point, community pharmacy, GP)

Unable to confirm dose

Exhibiting signs of withdrawal? (see full guideline for scale)

Yes

Do not prescribe methadone

No

Rx 10mg methadone stat

May need to reduce usual dose (as tolerance may have decreased) and titrate as below

Four hours later: if still showing signs of withdrawal, give 10-20mg Methadone prn up to maximum 40mg total per 24 hrs until assessment.

Note: Methadone should be prescribed as the 1mg/mL oral solution.

Verbal communication with prescribers is acceptable if written confirmation about the current prescription cannot be made.

For further information contact your ward pharmacist or contact Turning Point on: 0300 123 1560
PRN Methadone Regime

DAY1 (For the first 24 hours only): If not intoxicated prescribe:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone liquid 1mg/ml</td>
<td>10mg</td>
<td>oral</td>
<td>STAT</td>
<td>FIRST dose ONLY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone liquid 1mg/ml</td>
<td>5-10mg</td>
<td>oral</td>
<td>Every 4 hours when required</td>
<td>Give dose if Objective Opioid Withdrawal score (OOWS) greater than 4. (See Appendix 1) Maximum dose (including STAT dose) 40mg/24 hours</td>
</tr>
</tbody>
</table>

Monitor the patient every hour until objective opioid withdrawal signs subside, wait 4 hours between doses to allow the full effect of methadone to develop.

DAY2 onwards: Stop PRN dosing. Give the total amount of methadone determined on day 1 as a ONCE daily dose. The PRN prescription must be discontinued.

REMEMBER: OPIOID WITHDRAWAL IS NOT A LIFE-THREATENING CONDITION; OPIOID TOXICITY IS.

6 Opioid Withdrawal and substitution therapy

6.1 General Principle

Opioids are potentially toxic drugs. The principle of management when a heroin user is admitted to hospital is to prevent opioid withdrawal and minimise the risk of continued use of illicit substances while an inpatient. This can be complex as it is impossible from the patient’s history to know the level of opioid tolerance. Careful titration of oral methadone against signs of withdrawal is the recommended approach. Ideally, commencing methadone in hospital will provide the opportunity to continue treatment in the community post-discharge.

Patients already on opioid substitution treatment should have their treatment continued while hospitalised, unless there is a medical contraindication to doing so. It is important to verify the dose patients are receiving in the community and when the last dose was given. If the dose by a reliable source cannot be confirmed, patients must be titrated according to the flowchart in section 5.

In all patients known or suspected to be using opioid drugs; A relevant history should be taken from patient, including physical health, psychiatric health, prescribed medication and
allergies. Non-judgmental, empathic history taking is most likely to elicit accurate information. Patients should be asked about other drug use and examined for:

a. Signs of injecting drug use.

b. Signs and symptoms of withdrawal.

c. Signs and symptoms of intoxication.

There are two possible scenarios:

- The patient is receiving substitute pharmacotherapy (for example a methadone or buprenorphine programme) in the community.

- The patient is not on a programme and is abusing illicit substances.

During the first 48 hours of hospitalisation, irrespective of whether patient is on a registered programme or not, patients should be monitored for signs of opioid toxicity (daytime drowsiness, euphoria, drooling and/or heavy snoring at night). If signs are observed, patients should be monitored with pulse oximetry and further methadone withheld until symptoms resolve and the patient is reviewed by the substance misuse team. The Substance Misuse Liaison Team (Turning Point) are available for advice 24 hours a day.

6.2 Prescribing for patients currently on an opioid substitute programme in community

If a patient is receiving substitute therapy in the community, it is vital that a reliable drug history is obtained before prescribing ANY substitute therapy. This should be confirmed using one of the following sources:

- Turning Point (OPEN 24 Hours a day)
- Patient’s GP
- Dispensing pharmacist
- If patient from a care home or another hospital, from a medication administration record sheet or drug chart if available. If not, verbal confirmation must be sought from place of transfer.

The following information must be confirmed for all patients:

- Name of medication
- Dose
- Formulation
- Frequency of administration
- Date last prescribed
- Date and quantity of prescription which was last picked up
- Date of last supervised administration
- Frequency of collection and type i.e. supervised or not
- Other analgesic or benzodiazepine medicines

Only once the details of the substitute therapy are confirmed (as above) should the drug be prescribed.
• The same dose can be continued if the last dose taken is within 48 hours of admission.
• If the patient has missed greater than 3 days of more of opioid substitution therapy they MUST be started on the PRN regimen and titrated accordingly.

REMEMBER: OPIOID WITHDRAWAL IS NOT A LIFE-THREATENING CONDITION; OPIOID TOXICITY IS.

It is important to let the prescribing agency know that the patient has been admitted to hospital and they must also be informed when the patient is discharged. Document this information and any correspondence clearly in the patient’s medical notes and on the relevant section of the drug chart.

6.3 Prescribing for patients NOT currently on an opioid substitute programme in community (i.e. illicit use of methadone and/or heroin or other opiates) and patients where confirmation of dose has not been possible

Consider prescribing a titration regime of methadone if:
• The patient is not receiving substitute therapy in the community
• It has not been possible to confirm the patients regular dose or last date of dosing
• The patient reports recent regular opioid use
• There is convincing clinical evidence of opioid dependence - including clinical history and/or examination findings of opioid dependence
• The patient provides informed consent to treatment.

Always refer these patients to Turning Point.

Methadone is the drug of choice for opiate substitute therapy. Buprenorphine should only be prescribed as substitute therapy if a patient has been admitted on it. Methadone, is a long acting opioid agonist, and should always be prescribed as a liquid. It is a full agonist at opiate receptors. It will therefore effectively prevent physical withdrawal from opiate drugs, but also carries a risk of respiratory arrest and coma. Its long half-life means it will outlast the effects of the opiate antagonist naloxone, often requiring repeated administrations of naloxone following an overdose. The half-life of methadone is typically 24 to 36 hours, thus leading to a stable drug plasma concentration over time and allowing for once daily dosing. The long half-life also means that the development of a steady state after a dose change may take several days (approximately 5 half-lives) to achieve. The same is true for the time required for elimination of the drug. Changes in methadone dosage should therefore be made in small steps; usually less than 10-20mg per day. The peak serum plasma concentration is reached after 2 to 4 hours. During symptom triggered assessment, subsequent doses must be given at least 4 hours apart.

It is a controlled drug with a high dependency potential and a low lethal dose (deaths have been reported following the commencement of a daily dose of 40mg). It is important that
appropriate assessment, titration and monitoring are performed during the initiation of methadone. The effects of methadone are enhanced by other CNS depressant drugs such as alcohol, benzodiazepines and by other opiates which may lead to a higher incidence of overdose. Therefore methadone should NOT be prescribed to any patient showing signs of intoxication due to alcohol or other CNS depressant.

Note:
Untreated heroin withdrawal symptoms typically reach their peak 32-72 hours after the last dose and symptoms will have subsided substantially after 5 days.
Untreated methadone withdrawal typically reaches its peak 4-6 days after the last dose and symptoms do not substantially subside for 10-12 days.

6.4 Titration Regime
After assessment of patients, prescribe the initial (day 1) methadone regimen.

DAY1 (First 24 hours only): If not intoxicated prescribe:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone liquid 1mg/ml</td>
<td>10mg</td>
<td>oral</td>
<td>STAT</td>
<td>FIRST dose ONLY</td>
</tr>
<tr>
<td>Methadone liquid 1mg/ml</td>
<td>5-10mg</td>
<td>oral</td>
<td>Every 4 hours when required</td>
<td>Give dose if Objective Opioid Withdrawal score (OOWS) greater than 4. (See Appendix 1) Maximum dose (including STAT dose) 40mg/24 hours</td>
</tr>
</tbody>
</table>

Monitor patient every hour until objective withdrawal signs subside, wait 4 hours between doses to allow full effect of methadone given to develop.

DAY2 onwards: Stop PRN dosing. Give the total amount of methadone determined on day 1 as a ONCE daily dose. The PRN prescription must be discontinued. OOWS should be scored regularly. If the patient is still in withdrawal then methadone can be increased but this must be done gradually with increments of not more than 10mg. A maximum of 30mg increase per week should not be exceeded. Ensure these patients are reviewed DAILY by the substance misuse team until stabilized.

6.5 Reversal of opioids
Reversal agents must be available on all wards where this guideline is used. Naloxone for opioid reversal should be used in small titrated doses to prevent the risk of acute withdrawal syndrome. 100micrograms via IV route should be administered over a few seconds. If no response is seen after a full two minutes, repeat to a maximum total dose of 400
micrograms (i.e. 1mL of 100 micrograms on 4 occasions). If no IV route is available, it can be administered by an IM injection (NB If IM used onset is potentially slower than IV so should not be repeated until after 3 minutes). It is important to remember the amount administered should be titrated against respiratory rate and not the level of consciousness.

Since naloxone has a shorter duration of action than many opioids, dose monitoring and repeated injections may be necessary according to the respiratory rate and depth of coma. In immediately life threatening situations due to suspected opiate overdose the senior clinician present may make a decision to give a higher bolus of naloxone i.e. 400 micrograms at each occasion every two minutes up to a maximum of 10mg. The effects of some opioids, such as buprenorphine, are only partially reversed by naloxone. Where repeated administrations of naloxone are required, it may be given as a continuous infusion adjusted according to vital signs. For more detailed information refer to the ‘Safer Use of Naloxone Policy’

7 Discharge of patients with methadone

For patients not currently on a methadone programme - supplies should NEVER be made on discharge. Turning Point should be contacted for further supplies on discharge.

Patients should NOT routinely be discharged with supplies of methadone. Turning Point should be contacted at the point of discharge and the time of last dose and dose received in hospital should be communicated to the team. Turning Point may request written confirmation of the information communicated verbally.

In exceptional circumstances where the patient cannot collect their usual methadone prescription, limited supplies (for example 24-48 hours) can be made. The relevant agency must be contacted to ensure there is no duplication of supply and also to confirm when subsequent supplies can be collected. This should only be done after discussion with the ward pharmacist and only applies to patients currently on an opioid substitute programme in community. Ensure patients are fully aware of the discharge arrangements regarding their methadone.

8 Referring patients

Refer the following patients to the Substance Misuse Liaison Team at the earliest opportunity
- Patients admitted using illicit opioids
- Patients without a community opioid substitute programme, both on admission and discharge.
- Any complex patients requiring specialist input.

9 Contact Details

Substance Misuse Liaison Team (Turning Point), 0300 123 1560 (Available 24/7)
10 Monitoring and Review

<table>
<thead>
<tr>
<th>What will be monitored</th>
<th>How/Method/ Frequency</th>
<th>Lead</th>
<th>Reporting to</th>
<th>Deficiencies/ gaps Recommendations and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy review</td>
<td>First review in one year and then every three years</td>
<td></td>
<td></td>
<td>Where gaps are recognised action plans will be put into place</td>
</tr>
</tbody>
</table>

11 Training and Implementation

No formal training has been identified for the use of this policy.

The policy will be made available on the intranet for all to view and implement.

12 Patient Information Leaflet

A patient information leaflet can be found on the intranet on webpage; 

http://www.medway.nhs.uk/resources/patient-information-leaflet-library/

If a patient information leaflet is given to the patient please record this in the patient notes.
13 Appendix 1 – Objective signs and symptoms of opioid withdrawal (OOWS)

OBJECTIVE SIGNS:

PULSE:

BLOOD PRESSURE:

BODY TEMPERATURE:

NAUSEA & VOMITING

Ask “Do you feel sick to your stomach?” AND “Have you vomited?”

Score:
0 No nausea, no vomiting
1 Mild nausea with no retching or vomiting
2 Intermittent nausea with dry heaves
3 Constant nausea, frequent dry heaves and/or vomiting

GOOSE FLESH

Score:
0 No goose flesh visible
1 Occasional goose flesh but not elicited by touch, not prominent
2 Prominent goose flesh, in waves and elicited by touch
3 Constant goose flesh over chest and arms

SWEATING

Score:
0 No sweat visible
1 Barely perceptible sweating, palms moist
2 Beads of sweat obvious on forehead
3 Drenching sweat over face and chest

TREMOR (Observe -arms extended and fingers spread apart)

Score:
0 No tremor
1 Not visible but can be felt finger tip to finger tip
2 Moderate, with patient's arms extended
3 Severe even if arms not extended

LACRIMATION

Score:
0 No lacrimation
1 Eyes watering, tears at corners of eyes
2 Profuse tearing from eyes over face

NASAL CONGESTION

Score:
0 No nasal congestion, sniffling
1 Frequent sniffling
2 Constant sniffling with watery discharge

YAWNING

Score:
0 No yawning
1 Frequent yawning
2 Constant, uncontrolled yawning

ABDOMINAL CHANGES

Ask “Do you have any pains in your lower abdomen?”

Score:
0 No abdominal complaint, normal bowel sounds
1 Reports waves of abdominal, crampy pain, active bowel sounds
2 Reports crampy abdominal pain, active bowel sounds, diarrhoeal movements

CHANGES IN TEMPERATURE

Ask “Do you feel hot or cold?”

Score:
0 No report of temperature change
1 Reports of feeling hot or cold, hands cold and clammy
2 Uncontrollable shivering

MUSCLE ACHES

Ask - “Do you have any muscle cramps

Score:
0 No muscle aching reported, e.g. arm and neck muscle soft at rest
1 Mild muscle pains
2 Reports severe muscle pains, muscles of legs, arms and neck in constant state of contraction

TOTAL
### 14 Equality Impact Assessment Statement & Tool – Appendix 1

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>▪ Age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Disability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Gender reassignment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Marriage and civil partnership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Pregnancy and maternity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Race</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Religion or belief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Sex</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Sexual orientation</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>If so can the impact be avoided?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Can we reduce the impact by taking different action?</td>
<td></td>
</tr>
</tbody>
</table>

All public bodies have a statutory duty under the Equality Act 2010. To have due regard to the elimination of discrimination, harassment, victimisation and any other conduct prohibited by the Act. The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none is placed at a disadvantage over others. This document was found to be compliant with this philosophy.

*Equality Impact Assessments will ensure discrimination does not occur also on the grounds of any of the protected characteristics covered by the Equality Act 2010.*

**END OF DOCUMENT**