Managing opioid dependence in psychiatric settings

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General principles

- people dependent on opioids need reassurance, assessment and suitable prescribing as soon as safely possible after admission
- opioid withdrawal symptoms are not generally life threatening but associated anxiety and distress can be significant and affect engagement with treatment of co-morbid mental and physical health problems
- early liaison with drug treatment service for advice and support on admission and discharge
- there should be access to naloxone on mental health wards
- opioid substitution treatment (OST) is usually oral methadone or buprenorphine

Methadone – some important facts

- methadone oral solution 1mg/1ml
- half-life with repeated dosing around 24 hours
- peak plasma concentration around 4 hours after oral dose
- hepatic metabolism
- steady state 5 half-lives (about 5 days) after last dose increase - cumulative toxicity
- optimal community dose 60 -120mg daily after titration
- associated with QTc prolongation

Buprenorphine – some important facts

- sub-lingual tablet or oral lyophilisate ('wafer' - Espranor)

- partial agonist with high affinity at μ opioid receptor
  - milder opioid effects than methadone
  - safer in overdose
  - displaces heroin/methadone producing opioid withdrawal
  - don't start until around 12 hrs after heroin, at least 24 hrs after methadone

- effective dose range in community 12 – 16mg daily

Assessment of opioid dependence

- history including use, frequency of use (usually daily), amount, route of use, other drugs/alcohol
- withdrawal symptoms
- physical examination
  - injection sites, abscesses etc
- drug screening
- 3rd party information about OST
  - Drug service
  - Community pharmacist

Opioid Withdrawal Syndrome 1

craving, anxiety

↓

yawning, sweating, runny nose, lacrimation

↓

dilated pupils, gooseflesh, hot & cold flushes, abdominal cramps, aches & pains, sleep disturbance, nausea

↓

increased BP, pulse & temperature

↓

vomiting and diarrhoea

↑ time since last used opioids

Opioid Withdrawal Syndrome 2

From heroin

- onset around 6 hours after last dose
- peak 36 - 72 hours

From methadone

- onset around 24-36 hours after last dose
- peak 4 - 6 days

Patient's Name:_____ Date and Time ____/_____/____:_____
Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute
Measured after patient is sitting or lying for one minute
0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

GI Upset: *over last ½ hour*
0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting

Sweating: *over past ½ hour not accounted for by room temperature or patient activity.*
0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor *observation of outstretched hands*
0 No tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness *Observation during assessmen*t
0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 Unable to sit still for more than a few seconds

Yawning *Observation during assessment*
0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil size
0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability
0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*
0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/ muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin
0 skin is smooth
3 piloerrection of skin can be felt or hairs standing up on arms
5 prominent piloerrection

Runny nose or tearing *Not accounted for by cold symptoms or allergies*
0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Total Score _____
The total score is the sum of all 11 items
Initials of person completing Assessment: _____

Clinical Opiate Withdrawal Scale

Score:
5-12 = mild;
13-24 = moderate;
25-36 = moderately severe;
more than 36 = severe withdrawal

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

Drug screening

- urine drug screen
- heroin will show as opiate positive
- morphine, codeine, dihydrocodeine - opiate positive
- methadone and buprenorphine – specific tests

Interpret in context of history and presentation

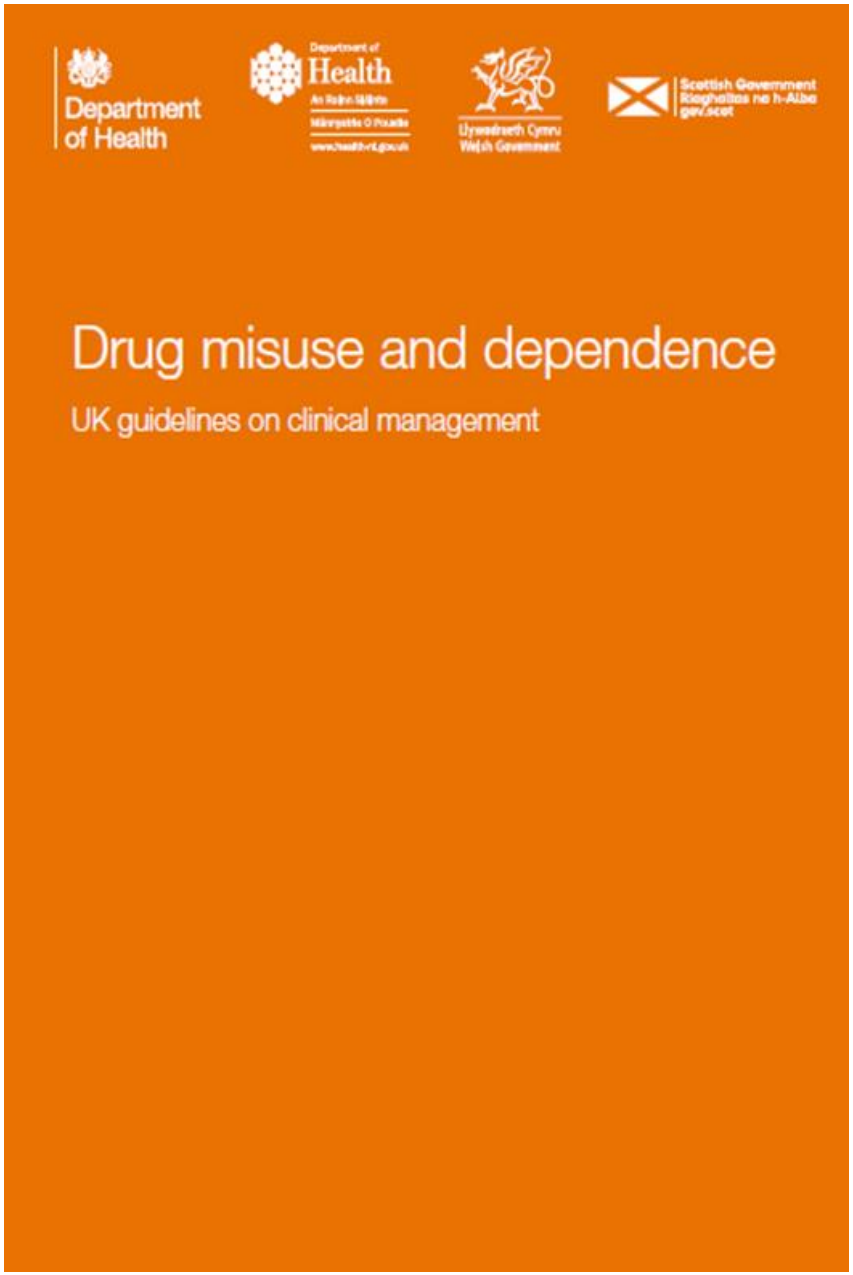
For those prescribed OST in the community

- liaison with community drug service and pharmacist to confirm current prescription and to cancel community prescription
  - the daily dose of methadone or buprenorphine prescribed
  - dispensing arrangements and if supervised
  - recent compliance
- unless compliant with supervision tolerance to that dose cannot be assumed
- if confirmed to have collected daily by supervised consumption this dose can usually be prescribed (subject to any changes to health/presentation)
- for methadone, this could be divided into a twice daily dose for additional safety assurance

Managing opioid withdrawal

- for those not in community OST, or not supervised or where OST cannot be confirmed
- if starting or re-starting methadone, titrate dose carefully against withdrawal symptoms and monitor for intoxication (e.g.10mls 4-6 hourly)
- if starting or re-starting buprenorphine, manage starting dose with sufficient interval after heroin use or other opioid use to avoid precipitating withdrawal
- do not give if drowsy or otherwise intoxicated
- be very careful when prescribing additional sedating drugs such as benzodiazepines
- early liaison with community treatment services

CAUTION: Those on community OST may have doses in possession



https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

Thank you

South London and Maudsley NHS
NHS Foundation Trust

METHAMPHETAMINE INTOXICATION AND PSYCHOSIS
Emergency Management

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