A Protocol for the Management of Opioid Dependence in Temporary Homeless Hotels during the COVID-19 Outbreak

Authors	Dr Emmert Roberts, Dr Michael Kelleher

Version Control

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1. Introduction

It is vital to remember throughout any decision pertaining to opioid dependence treatment:

OPIOID WITHDRAWAL IS NOT LIFE THREATENING –
OPIOID TOXICITY IS LIFE THREATENING

This document reflects the Drug Misuse and Dependence – UK Guidelines on Clinical Management 2017 'The Orange Guideline'

The average pattern of drug misuse is likely to alter when an individual becomes unwell or enters a temporary homeless hotel. Although, clinicians should regard drug misuse management in temporary homeless hotels as equivalent to any other setting, there are some particular differences they will need to take into account:

- Reduced availability of drugs and alcohol during the outbreak, leading to a risk of intermittent intoxication and unanticipated withdrawal
- A potential change in injecting behaviour, and potentially much higher risk behaviours due to the scarcity of injecting equipment
- The high volume and frequency of movement of people. At times with limited clinical information available
- The risk of overdose on leaving the temporary homeless hotel due to diminished opioid tolerance
- Limited continuous access for clinicians and therefore difficulty monitoring treatment
- Significant levels of co-morbidity

2. Aims and Objectives

- To reduce drug related harm
- To maintain tolerance to opioids, which reduces the risk of fatal drug overdose
- To reduce or prevent withdrawal symptoms
- To continue community prescribed methadone or buprenorphine treatment
- To support wider recovery

3. Prescribing for opioid dependence on admission to temporary homeless hotel

When someone reports use of opiates upon admission to the temporary homeless hotel there are only three questions which need to be posed that relate to prescribing:

1. Do I need to/can I safely prescribe continuation of opioid substitution therapy (OST)?

   If the answer is NO then:

2. Do I need to/can I safely prescribe initiation of opioid substitution therapy (OST)?

   If the answer is NO then:

3. Do I need to prescribe for symptomatic relief of opioid withdrawal?

Question One:

Do I need to/can I safely prescribe continuation of opioid substitution therapy (OST)?

You need to confirm that the person is both:

A) Prescribed OST
B) Taking their prescribed OST

In order to do this, you must confirm:

1. The person reports receiving OST
2. The person has a Urine Drug Screen (UDS) that is positive for OST (methadone or buprenorphine) (see appendix 10.1 for opiate detection times in urine)
3. The pharmacist responsible for dispensing the OST confirms that the patient has a valid OST prescription
4. The pharmacist responsible for dispensing OST confirms that there have been no missed OST doses in the last three days (i.e. the doses were supervised, and the pharmacist saw them taking their dose)

Only when all four of these conditions are met can you prescribe OST at the person's regular maintenance dose. You must also always prescribe naloxone PRN

WITHOLD DOSE IF ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

If the answer to question one is NO then proceed to question two

Question Two:

Do I need to/can I safely prescribe initiation of OST?

You need to confirm the person is both:

A) Dependent on opioids
B) Suitable for OST treatment

In order to do this, you must confirm:

1. The person reports using opioids (heroin, methadone, buprenorphine etc.)
2. The person meets ICD criteria for opioid dependence (see appendix 10.2)
3. The person has a Urine Drug Screen which is positive for opioids (e.g. heroin (which will show as positive to morphine), methadone, buprenorphine) (see appendix 10.1 for opiate detection times in urine)
4. There are signs of opioid withdrawal (e.g. using Clinical Opioid Withdrawal Scale (COWS) (See appendix 10.3)

Only when all four of these conditions are met can you initiate a new prescription of OST. For initiation regimens please see section 4. You must also always prescribe naloxone PRN

WITHOLD DOSE IF ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

If the answer to questions one and two is NO then proceed to question 3

Question Three:

Do I need to prescribe for symptomatic relief of opioid withdrawal?

If you are unable to safely prescribe OST the following medications can be used to symptomatically manage opioid withdrawal:

Diarrhoea	Loperamide 4mg PO STAT and 2mg PO after each loose stool; Normal dose 6-8mg PO od; Maximum 16mg PO/24°
Nausea	Metoclopramide 10mg PO tds PRN or Prochlorperazine 5mg PO tds PRN
Stomach Cramps	Mebeverine 135mg PO tds
Agitation and Insomnia	Diazepam 5-10mg PO tds PRN or Zopiclone 7.5mg PO on PRN
Headache/Pain	Paracetamol 1g PO qds PRN

4. Initiation of Opioid Substitution Treatment (OST):

If you have determined that a person is suitable for initiation of OST your choices are to initiate methadone or buprenorphine.

Discuss with the person if they have previously had either of these medications, and if so which they would prefer.

If there is significant respiratory comorbidity buprenorphine is the medication of choice

4.1 Methadone Initiation Regimen:

If in withdrawal prescribe 1mg/1ml sugar free methadone mixture PO as a STAT dose; Never prescribe as a PRN medication

DAY 1: First Dose: You can prescribe up to a maximum of 30mg on day one

If tolerance is unclear or the amount of use is unclear start at 10mg
If a regular user of heroin, methadone or buprenorphine consider starting at 20mg
If an intravenous opiate user with fresh/recent track-marks consider starting at 30mg

Aim to titrate in 5-10mg increments every 3 days

Increment should be no more than 10mg per day

WEEK 1: No more than a 60ml total daily dose, and no more than three dose increases per week

The target methadone OST maintenance dose is 60-120mg PO od

WITHOLD DOSE IF ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

4.2 Buprenorphine Induction Regimen:

People should normally have been heroin-free for around 12 hours and methadone free for at least 24 hours before starting buprenorphine

If in withdrawal prescribe buprenorphine s/l as a STAT dose; Never prescribe as a PRN medication

DAY 1: First Dose: You can prescribe up to a maximum of 8mg on day one

If tolerance is unclear or the amount of use is unclear start at 2-4mg
If a regular user of heroin, methadone or buprenorphine consider starting at 4mg
If an intravenous opiate user with fresh/recent track-marks consider starting at 4-8mg

Aim to titrate in 4mg increments every 3 days

WEEK 1: No more than 16mg total daily dose

The target buprenorphine OST maintenance dose is 12-16mg s/l od

WITHOLD DOSE IF ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

5. Naloxone

All people who are using opiates must have naloxone prescribed.

When they are due to leave the temporary homeless hotel they should be provided with naloxone to take away (TTA)

In the event of a suspected overdose anyone can administer naloxone for the purpose of saving a life without a prescription.

Give 400 micrograms naloxone IM every 2-3 mins
The maximum dose is 10mg (25 x 400 microgram doses)

6. Medication Storage

All OST are controlled drugs and should be stored in a secure locked box on the premises

7. Dispensing

All OST should be dispensed on site and consumption supervised in the temporary homeless hotel

8. Needle and Syringe Availability

All people should be provided with sterile needles, syringes, foil and other injecting equipment (without the need to return used equipment)

All people should be offered sharps bins and advice on how to dispose of needles, syringes and equipment safely

9. Overall Prescribing Flow Chart

OPIOID WITHDRAWAL IS NOT LIFE THREATENING – OPIOID TOXICITY IS LIFE THREATENING

Person at admission says they use opiates (Heroin, Methadone, Buprenorphine etc.)

Question One: Do I need to/can I safely prescribe continuation of OST?

You need to confirm that the person is both:

A) Prescribed OST

B) Taking their prescribed OST

1. The person reports receiving OST
2. Urine Drug Screen is positive for OST (methadone or buprenorphine)
3. Dispensing pharmacist confirms that the patient has a valid OST prescription
4. Dispensing pharmacist confirms no missed OST doses in the last three days (i.e. doses were supervised)

Are all four conditions described above met?

YES: PRESCRIBE REGULAR DAILY OST DOSE + PRN NALOXONE **NO: MOVE ON TO QUESTION TWO**

WITHOLD DOSE IF ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

Question Two: Do I need to/can I safely prescribe initiation of OST?

You need to confirm that the person is:

A) Dependent on opioids

B) Suitable for OST treatment

1. The person reports opioid use
2. The person meets ICD criteria for opioid dependence
3. Urine Drug Screen is positive for opioids (e.g. heroin)
4. There are signs of opioid withdrawal (e.g. using Clinical Opioid Withdrawal Scale (COWS))

Are all four conditions described above met?

YES: PRESCRIBE INITIATION OST DOSE + PRN NALOXONE **NO: MOVE ON TO QUESTION THREE**

Induction OST Regimen

Significant Respiratory Comorbidity = Buprenorphine

Methadone

If in withdrawal prescribe 1mg/1ml sugar free methadone mixture PO as a STAT dose;
Never prescribe as a PRN medication

DAY 1: First Dose: Prescribe up to a maximum of 30mg
If tolerance unclear or amount of use unclear = 10mg
If regular heroin or OST user = consider starting at 20mg
If recent intravenous user = consider starting at 30mg

Aim to titrate in 5-10mg increments every 3 days
Increment should be no more than 10mg per day

WEEK 1: No more than a 60mg total daily dose;
No more than three dose increases per week
Target methadone maintenance dose 60-120mg PO od

Buprenorphine

People should be heroin free for 12 hours and methadone free for at least 24 hours before starting
If in withdrawal prescribe buprenorphine s/l as a STAT dose; Never prescribe as a PRN medication

DAY 1: First Dose: Prescribe up to a maximum of 8mg
If tolerance unclear or amount of use unclear = 2-4mg
If regular heroin or OST user = consider starting at 4mg
If recent intravenous user = consider starting at 4-8mg

Aim to titrate in 4mg increments every 3 days

WEEK 1: No more than 16mg total daily dose;
Target buprenorphine maintenance dose 12-16mg s/l od

WITHOLD DOSE IF ANY SIGN OF INTOXICATION/ SEDATION/CONSTRICTED PUPILS

Question three: Do I need to prescribe for symptomatic relief of opioid withdrawal?

Diarrhoea	Loperamide 4mg PO STAT and 2mg PO after each loose stool; Normal dose 6-8mg PO od; Maximum 16mg PO/24^{o}
Nausea	Metoclopramide 10mg PO tds PRN or Prochlorperazine 5mg PO tds PRN
Stomach Cramps	Mebeverine 135mg PO tds
Agitation and Insomnia	Diazepam 5-10mg PO tds PRN or Zopiclone 7.5mg PO on PRN
Headache/Pain	Paracetamol 1g PO qds PRN

10. Appendices

Appendix 10.1 **Length of drug detection times in urine**

Approximate durations of detectability of selected drugs in urine	
Drug or its metabolite(s)	**Duration of detectability**
Amphetamines, including methylamphetamine and MDMA	2 days
Benzodiazepines: • Ultra-short acting (half-life 2h) (e.g. midazolam) • Short-acting (half-life 2-6h) (e.g.triazolam) • Intermediate-acting (half-life 6-24h) (e.g.temazepam, chlordiazepoxide) • Long-acting (half-lie 24h) (e.g. diazepam, nitrazepam)	12 hours 24 hours 2-5 days 7 days or more
Buprenorphine and metabolites	2-4 days
Cocaine metabolite	2-3 days
Methadone (maintenance dosing)	2-4 days
Codeine, dihydrocodeine, morphine, propoxyphene (Heroin is detected in urine as the metabolite morphine)	48 hours
Cannabinoids: • Single use • Moderate use (three times a week) • Heavy use (daily) • Chronic heavy use (more than three times a day)	3-4 days 5-6 days 20 days Up to 45 days

Appendix 10.2: **ICD-10 criteria for opioid dependence**

≥ 3 of the following 6 criteria in the past 12 months

a) Desire or compulsion to take opioids
b) Difficulties to control opioid taking behaviour
c) Physiological withdrawal
d) Development of tolerance
e) Neglect of other things in favour of opioids
f) Persistent use despite evidence of harm

Appendix 10.3 **Clinical Opioid Withdrawal Scale 'COWS'**

Clinician rated scale; 11 items; Maximum Score 48

0-4 No evidence of withdrawal
5-12 Mild
13-24 Moderate
25-36 Moderately severe
> 36 Severe

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

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 1/2 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 1/2 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 assessment* 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 or 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: _____

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

This version may be copied and used clinically.

Appendix 10.4 **Contraindications and Interactions with OST**

- OST in combination with any CNS depressant (e.g. alcohol, benzodiazepines, TCAs); ↑ risk respiratory depression/potential overdose

- Doses of > 100mg methadone PO od are a risk factor for prolonged QTc; Patients may require ECG monitoring

Medications which affect OST:

Medicines which ↓ OST levels

Cytochrome P450 inducers; ↑ OST metabolism; ↓ bioavailable OST; Potential need to ↑ OST dose

INCREASE RISK OF WITHDRAWAL AND OVERDOSE

All OST: Barbiturates, Carbamazepine, Phenytoin, Rifampicin, St John's Wort

Only Methadone: Smoking, Antiretrovirals: abacavir, amprenavir, lopinavir, efavirenz, nevirapine, nelfinavir, ritanovir

Medicines which ↑ OST levels

Cytochrome P450 inhibitors; ↓ OST metabolism; ↑ bioavailable OST; Potential need to ↓ OST dose

INCREASE RISK OF INTOXICATION AND OVERDOSE

All OST: Ciprofloxacin; Macrolide Abx; Fluconazole; Fluvoxamine (+/- Sertraline, Fluoxetine, Paroxetine); Amiodarone

Only Methadone: Disulfiram, Verapamil, Grapefruit Juice

Only Buprenorphine: Protease inhibitors (e.g. indinavir, saquinavir)

Appendix 10.5 **Signs and Symptoms of Opioid Intoxication**

SIGNS OF OPIATE INTOXICATION
Constricted pupils (miosis) Drowsy Intermittent dozing Eyes closing Orthostatic hypotension Shallow Breathing Blue lips (cyanosis) Loud snoring