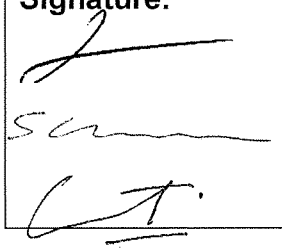
NHS Grampian

Guidance For The Management Of Patients With Problematic Drug Use In Inpatient Settings In Grampian

Author:	Consultation Group	Approver:
Drug And Alcohol Pharmacist Clinical Lead Drug And Alcohol Services Consultant Anaesthetist	See Page 1	Medicines Guidelines and Polices Group

Signature:		Signature:
		

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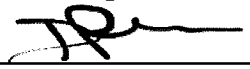
Policy Statement:

It is the responsibility of all staff to ensure that they are working to the most up to date and relevant guideline, policies, protocols and procedures.

Version 1

Executive Sign-Off

This document has been endorsed by Director of Pharmacy and Medicines Management

Signature: 

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Consultative Group

Christina Anderson	Clinical Nurse Specialist Acute Pain Service ARI
Steve Beason	Clinical Lead Drug And Alcohol Services Aberdeen
Jill Carnegie	Pharmacist Drug And Alcohol Service Aberdeen
Raymond Collie	Nurse Specialist Acute Pain Dr Grays
Douglas Coventry	Consultant Anaesthesia And Critical Care
Mairi Cruickshanks	Consultant Emergency Medicine
Patrice Forget	Clinical Chair In Anaesthesia University Of Aberdeen
Anne Montgomery	Acting Lead Alcohol Liaison Nurse
Emma Mitton	Pharmacist Drug And Alcohol Service Aberdeenshire
Kenneth O'Brien	Associate Director For Public Protection
Despoina Papamichail	Consultant Respiratory And Acute Medicine
Simon Rayner	Service Manager Drug and alcohol services
Victoria Russell	Pharmacist Unscheduled Care
Lucy Skea	Lead Pharmacist Drug And Alcohol Service
Dave Taylor	Nurse Manager Drug And Alcohol Services Aberdeenshire
Malaika Thom	Acute Pharmacist
Michael Turner	Consultant Drug And Alcohol Services Aberdeenshire
Andrew Wilson	Principal Pharmacist, Quality and Governance
Group review	Mental Health Operational Medicines Management Group

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1. Introduction

Drug Misuse and Dependence: UK guidance on clinical management provides in-depth guidance and recommendations when caring for people who use drugs. Section 7.5 provides specific advice on care provision during hospitalisation. It states that:

"People who use drugs have the same entitlement as other patients to the services provided by the NHS, including access to adequate symptomatic and pain relief, and to proper discharge planning. It is the responsibility of all doctors and other clinicians to provide the appropriate care for both general health needs and for relevant drug related health problems, whether or not the patient is ready to stop using drugs. Wherever possible, all hospitals should maintain contacts with local drug and alcohol services, as well as with emergency homeless shelters and support organisations, preferably through hospital-focused staff trained in substance misuse issues".

Admission to hospital provides opportunities to engage with people experiencing problems with drug use. Effective management of substance use during admission has potential to improve outcomes. Patients whose substance use is acknowledged, well managed, and who are therefore comfortable may be less likely to discharge against medical advice.

This document is a reference to support clinical decision making but is not all encompassing. Local and national guidance, specialty teams, e.g. liver team, acute and chronic pain teams and alcohol and drug services are other sources of support. Contact details for key services are available in Appendix 1.

Some treatments recommended in this guidance are off label. Please refer to NHS Grampian's policy on the prescribing of off label medicines for further information on this.

2. History, Examination And Investigation

2.1. History

Management of opioid and benzodiazepine/z-drug dependence are the main focus of this guidance. The International Classification of diseases (ICD-11)[ii] uses the same essential (required) features to classify dependence in both drug classes. That is "a pattern of recurrent episodic or continuous use of [the substance] with evidence of impaired regulation of use of [the substance] that is manifested by two or more of the following":

- Impaired control over [substance] use (i.e. onset, frequency, intensity, duration, termination, context);

- Increasing precedence of [substance] use over other aspects of life, including maintenance of health, and daily activities and responsibilities, such that use of [the substance] continues or escalates despite the occurrence of harm or negative consequences (e.g. repeated relationship disruption, occupational or scholastic consequences, negative impact on health);
- Physiological features indicative of neuroadaptation to the substance, including:
  1) Tolerance to the effects of [the substance] or a need to use increasing amounts of [the substance] to achieve the same effect;
  2) Withdrawal symptoms following cessation or reduction in use of [the substance],
     or
  3) Repeated use of [the substance] or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.
- The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if use is continuous (daily or almost daily) for at least 3 months.

In addition to the usual medical history the following should be documented:

- Drugs currently used
- Date and time of last drug use
- Usual frequency and amount of each substance used
- Route of use, e.g. injected, smoked, swallowed
- Current or previous treatment for substance use
- BBV (Blood Borne Virus) and tetanus status – including vaccination history
- Pregnancy status in women of childbearing age. Consider testing.

2.2. Examination and Investigations

Routine investigations should be undertaken as directed by clinical presentation. In addition:

- Observe for signs of recent drug use or symptoms of withdrawal - the Clinical Opioid Withdrawal Scale (COWS) can support assessment (Appendix 2).
- Assess health of any injection sites if any concerns refer to tissue viability pages for guidance.
- **Undertake drug urinalysis (if available)**: This does not replace full clinical assessment. Positive results indicate that a drug has been taken but does not indicate when or how frequently. Be mindful that some substances may not be detected for using standard urine tests.
- **Consider need for ECG**: Consider for all patients prescribed methadone at 100mg or greater **or** at any dose if other risk factors are present to assess for prolonged QT interval. The QT interval is corrected for heart rate by the QTc, concern should be raised if the QTc exceeds 440ms in men and 460ms in women[ii].

Prolongation of the QT interval is associated with ventricular arrhythmias and death. Causes other than methadone should be considered and excluded, e.g. genetic, adverse drug effects (e.g. anti-psychotics), endocrine and metabolic disturbances. QTc can be modified by the correction of electrolytes and then reassessed.

- If QTc is consistently prolonged on repeat ECGs and reversible causes are excluded, a risk assessment of altering methadone dose or switching to buprenorphine should be discussed with drug and alcohol service staff.
- For more information, please refer to Drug Misuse and Dependence: UK Guidelines on Clinical Management[i]
- If prescribing, consider cautions, contraindications and interactions. These can be viewed in the BNF.

Cautions

Exercise extra caution when considering prescribing opioids or benzodiazepines in:

- Respiratory disease
- Head injury - in head injury the Glasgow Coma Scale is not sensitive enough to assess opioid intoxication
- Liver disease/Hepatitis
- Co-existent alcohol dependence
- Uncertain tolerance
- Co-prescribed opioid analgesia or other sedating medications
- Interactions with other prescribed drugs
- Pregnancy
- Renal impairment – check with Renal Drug Database or renal service for guidance as required.

- **Test for Blood Borne Viruses** - Hepatitis B, Hepatitis C and HIV.

Opportunistic screening for blood borne viruses should be offered. It is recommended that the clinician undertaking the test informs the patient of the result wherever possible.

In NHS Grampian, hepatology and/or sexual health are notified of any positive BBV results by the lab and will contact the patient to advise them of the result and arrange follow up. This process allows opportunistic testing even in high turnaround areas where the patient is likely to be discharged before the result is returned. Please ensure there are up to date contact details recorded in Trakcare and advise the patient they will only be contacted if the result is positive.

- **Suspicious Substances**

Guidance on patients or visitors found in possession of suspicious substances can be accessed here: https://www.nhsgrampian.org/globalassets/services/medicines-management/policies/procedure_cd_unauthsubs.pdf

2.3. Public Protection Considerations

Adults experiencing problematic substance use may also be 'adults at risk' under the Adult Support and Protection (Scotland) Act 2007. Staff should raise any concerns about their safety using the current, agreed interagency procedures.

Some adults with vulnerability due to illness, disability, frailty and unborn babies, children and young people may also be at risk if they live in a household where there is an adult experiencing issues with problematic substance use.

Further information on adult protection is available on the public protection pages of the intranet. Staff should discuss any concerns with their line manager and seek advice and support from gram.publicprotection@nhs.scot .

If there are any concerns for a child's safety, staff should discuss this with their line manager and seek advice and support from gram.cpinfo@nhs.scot or direct dial 51706.

3. Treatment Options

Opioid Dependence

Opioid Substitution Treatment (OST) is the treatment of choice for opioid dependence. In community settings this is supported by psychological and social interventions tailored to the individual. On admission to inpatient settings patients may or may not be prescribed OST which will determine the course of action.

Note: For patients admitted due to overdose or who display signs of toxicity, opioids should be withheld, and the patient monitored. Review when symptoms subside. Similarly, for patients who have been administered naloxone, a period of monitoring is recommended. Toxbase should be used to decide on the duration of monitoring.

3.1. Patients already prescribed OST (methadone or buprenorphine)

An Opioid Substitution Treatment (OST) checklist is now included on HEPMA as a task which should be added during admission. The checklist and an accompanying flow chart is included in Appendix 3.

For patients already prescribed methadone oral solution and buprenorphine (sublingual, supralingual and long-acting injections are available), the recommended course of action is to continue OST at its current dose where clinically appropriate.

OST may be prescribed when assessment, examination, medicines reconciliation and relevant investigations have been completed and safe prescribing can be assured. If there is any uncertainty contact the patient's alcohol and drug service. Contact with speciality teams may also provide advice where there is uncertainty due to co-morbidities.

Check with the patient if they have any dispensed doses with them and consider suitability for use as patient own medication. If there is uncertainty about the contents then ward stock should be used instead (see also NHSG acute controlled drug guidance).

Trakcare is a source of prescribing information, but limitations exist, and other sources will be required to complete medicines reconciliation. Medication prescribed by drug and alcohol services may not be listed and information on dispensing arrangements is not available.

The patient's Community Pharmacy is well-placed to confirm many of these details and should be contacted as soon as possible. Advise them to suspend any current instalment prescriptions and contact them early on during discharge planning to highlight changes and ensure access to prescribed medication continues on discharge without overlaps or breaks in doses to be supplied.

If not completed during medicines reconciliation, the relevant specialist service or primary care prescriber(s) should also be contacted at the earliest opportunity to advise of admission, discuss the current treatment plan and obtain any relevant information.

3.2. Missed Doses of OST on Admission

3.2.1. Patients Who Have Missed Doses of Methadone on Admission

- Tolerance to the current dose of methadone falls after approximately 3 days of consecutive missed doses. There is potential for toxicity if the previous dose is continued. Information on substances used in the interim period and assessment for symptoms of withdrawal (or toxicity) will aid decision making.
- Less than 3 consecutive days (up to 72 hours) of methadone missed. Loss of opioid tolerance is less likely. A reduction in prescribed OST dose is not usually needed. Monitor for over-sedation following administration.
- 3 to 4 consecutive days of methadone missed and abstinent from other opioids. Recommend decreasing the daily dose by 50% or prescribe 30mg daily, whichever is higher on day 1. From day 2 the dose can be re-titrated upwards by up to 10mg of methadone daily, monitoring for signs of withdrawal or over-sedation before each dose increase.
- 5 days or more consecutive days of methadone missed. Re-titrate from a starting dose of methadone as below.
- If a patient has been physically unwell, is relatively new to treatment or completely abstinent a more cautious approach to prescribing may be required.

3.2.2. Patients Who Have Missed Doses of Buprenorphine on Admission

- Toxicity is less of an issue for buprenorphine products following missed doses.
- For patients prescribed supra or sub-lingual buprenorphine at daily doses over 8mg who have missed 5 days, it is recommended that the patient is restarted as if they were new to treatment. This is also recommended if there are concerns on admission following 3 or 4 days of missed doses.

- Patients receiving daily doses of 8mg or less can generally be continued on the current dose being mindful of the risk of precipitating withdrawal - see Section 3.3.2 for more information.
- Buprenorphine 7-day long-acting injections (LAI) can be administered two days before or after the due administration date.
- Buprenorphine 28-day LAI can be administered up to 7 days before or after the due administration date.

Out with these timescales a pragmatic approach to prescribing buprenorphine or methadone should be adopted, following assessment of the patient's presentation. Where there is uncertainty, contact the prescribing service for advice.

3.3. Management of Opioid Dependence in Patients Not Prescribed OST

For patients who are not prescribed OST and are:

- Awaiting further assessment
- Awaiting confirmation of patients methadone/buprenorphine dose or
- Short term admissions for whom no through care is possible.

Dihydrocodeine can be prescribed in doses of up to 60mgs four times daily. This dose can be reduced or maintained during short admissions depending on the clinical condition of the patient. Contact senior medical staff for patient review if symptoms of withdrawal persist on this dosing scale. The Clinical Opioid Withdrawal Scale (COWS) can be used to assess severity of symptoms (Appendix 2).

Dihydrocodeine should not be continued on discharge, a referral to the local substance use service is recommended.

Dihydrocodeine is off label for this indication and evidence to support its use is limited. It should only be used in the limited scenarios described above and the patient offered the opportunity to transfer to standard opioid replacement therapy as soon as possible.

Inpatient settings provide opportunity to engage patients in treatment and initiate OST where time and clinical presentation allow. Contact the local drug and alcohol service at the earliest opportunity. A plan for continuation of treatment on discharge must be agreed prior to discharge.

Medication choice will depend on each person's circumstances including consideration of their personal preference. Appendix 4 provides a comparison between methadone and buprenorphine.

3.3.1. Initiation of Methadone

If initiating methadone referral to specialist drug services should take place as early as possible. Methadone should only be initiated by prescribers who feel confident and competent to do so. If there are any concerns specialist drug services can be contacted for advice and support prior to initiation.

Methadone is available in both sugar free and sugar containing solution. It is standard to offer a sugar containing preparation as the sugar free preparations can cause unacceptable side effects due to sorbitol content.

An association between sugar containing methadone and dental problems has not been established. Sugar free methadone may be beneficial for patients with diabetes.

Methadone requires some caution during induction due to its variable pharmacokinetics and accumulation during repeated dosing[iii] which can lead to toxicity.

→ Peak plasma concentrations occur between 1 and 5 hours after administration.
→ Half-life following single doses averages 18 hours.
→ Half-life following repeated doses shows individual variation between 15 to 60 hours.

Consider expected duration of stay and opportunity to observe following dose increases when deciding the prescribing plan. A more conservative approach to titration may be appropriate for short stays. Risks associated with discharge immediately prior to, or during, the weekend should be considered. Community services may not be available for support or assessment.

Induction dosing used in community settings along with other information can be found in the MAT (medication assisted treatment) guidance.

Whilst induction should broadly follow the protocols used in community settings, the close supervision available in hospital settings allows for a modified protocol as follows.[i] **Naloxone should be prescribed** and be available for administration "as required" to safeguard in the event of toxicity occurring.

- First 24 hours. Prescribe and administer methadone in divided doses of 5 to 10mg to a maximum of four 10mg doses in 24 hours. Dose and frequency should be determined by extent of symptoms of withdrawal in combination with history taking and assessment. Prescribe doses on day 1 as, once off "STAT" doses to ensure review before each increase.[i]
- The total dose prescribed in the first 24 hours can then be converted to a single daily dose and titrated upwards by 5 to 10mg daily in response to ongoing symptoms of withdrawal on assessment. The maximum increase in daily dose in week one should not exceed 30mg more than the starting dose.[i,iv]
- Assess the patient for symptoms of withdrawal or toxicity before each dose is administered. Withhold subsequent doses if there are signs of over-sedation/toxicity and contact the prescriber to review.
- Monitoring symptoms of withdrawal or toxicity around 4 hours after dosing will coincide with peak effects.
- From week 2 onwards it is recommended to leave 3 days or more between any subsequent dose increase due to risk of accumulation and toxicity.
- For most patients the daily dose will fall between 60 and 120mg although some may settle on lower doses and some may require higher.

3.3.2. Initiation of Buprenorphine

If initiating buprenorphine referral to specialist drug services should take place as early as possible. Buprenorphine should only be initiated by prescribers who feel confident and competent to do so. If there are any concerns specialist drug services can be contacted for advice and support prior to initiation.

Buprenorphine has higher affinity for opioid receptors than many other opioids. It can remove and replace full opioid agonists from receptors but produces less opioid effect which can precipitate symptoms of withdrawal on initiation of treatment. At high doses, it can impact the effect of other opioids. Consider prescribing requirements where opioid analgesia may be indicated (see Section 8).

Initiating buprenorphine when patients start to experience mild symptoms of withdrawal helps avoid precipitating significant symptoms of withdrawal. As a rule of thumb withdrawal should be evident 6 to 12 hours following the last dose of heroin but at least 24 hours following the last dose of long-acting opioid such as methadone. Day 1 dose can be split to minimise the strength and duration of precipitated withdrawal should it occur. Patients should be reassured that symptoms will be short lived if experienced. Buprenorphine comes in sublingual, oral lypophilisate and long-acting injectable formulations for management of dependence.

Product Choice

The first line buprenorphine product is generic sublingual buprenorphine.

Buprenorphine oral lyophilisate (Espranor®) can also be considered and is useful for patients who would benefit from faster dissolution time.

Sublingual and oral lyophilisate formulations are not bioequivalent and cannot be used interchangeably. If there is a need to switch from one to the other please refer to the Guidance for the Use of Oral Buprenorphine Products for the Treatment of Opioid Dependence in Grampian.

Guidance for initiation is as follows:

Buprenorphine tablets	Buprenorphine Oral Lyophilisate (Espranor®)
DAY 1	
4mg of buprenorphine. A further 4mg can be administered after 2 hours based on individual need. Maximum dose on Day 1 = 8mg	2mg of buprenorphine followed by a further 2mg to 4mg later in the day based on individual need. Maximum dose on Day 1 = 6mg
DAY 2 ONWARD	
Titrate dose in steps of 2 to 8mg according to response to a maximum of 16mg buprenorphine daily on day 2. From day two doses can be prescribed as a single daily dose.	Titrate dose in steps of 2 to 6mg according to response to a maximum of 12mg buprenorphine daily on day 2. From day 2 doses can be prescribed as a single daily dose.
MAXIMUM DAILY DOSE	
Maximum daily doses: Buprenorphine sublingual tablets = 32mg Doses above 16mg are less commonly needed due to ceiling effect.	Maximum dose = 18mg daily. Doses above 16mg are less commonly needed due to ceiling effect of buprenorphine.
DIFFERENCES IN BIOAVAILABILITY	
The oral lyophilisate and sublingual preparations are not bioequivalent. If a change in formulation is needed it may be necessary to increase or decrease the dose if adverse effects or symptoms of withdrawal occur. This is more common in daily doses above 8mg. Buprenorphine oral lyophilisate (Espranor®) 12mg is considered equivalent to 16mg of sublingual tablets.	

Buprenorphine long-acting injection (Buvidal®) is available as weekly and 4 weekly formulations. The date of last administration should be established. Weekly doses can be given up to 2 days before or after the next administration date and 4-weekly doses can be given up to 7 days before or after the due date. The local alcohol and drug service should be contacted to ensure continuation of OST initiated in hospital on discharge. If buprenorphine long-acting injection is the preferred treatment option, it is recommended the local drug and alcohol service is contacted prior to initiation. NHSG guidance for its use can be accessed here.

3.3.3. Symptomatic Relief of Opioid Withdrawal

Patients may continue to experience symptoms of withdrawal during titration, particularly with methadone due to restrictions on rate of titration. Symptomatic treatment is an option where clinically appropriate to the patient and symptoms are troublesome. **Note**: Suggested treatment is specific to opioid withdrawal. Consideration should be given to the potential for other underlying causes which should be managed accordingly.

Symptom	Treatment
Diarrhoea	Loperamide 4mg followed by 2mg after each loose stool; Maximum 16mg daily for up to 5 days.
Nausea or vomiting	Metoclopramide 10mg up to three times daily for 5 days **or** Prochlorperazine 5mg up to three times daily for 5 days **or** Prochlorperazine 12.5mg twice a day by intramuscular injection.
Abdominal cramps	Mebeverine 135mg up to three times a day
Agitation, anxiety and insomnia	Diazepam 5 to 10mg up to three times a day as required **or** Zopiclone 7.5mg at night as required (insomnia only). Max 7 to 14 days duration.
Muscular aches and pains	In community settings paracetamol and NSAIDs are recommended. In hospital settings other pain requirements may influence choice of analgesic.
Clonidine **Note:** OST is the preferred option for management of opioid dependence and detoxification.	This is a second line drug, reserved for circumstances in which treatment with opioids is not an option or not sufficient. It can reduce autonomic symptoms of withdrawal such as; sweating, tremors, nausea, vomiting, diarrhoea, abdominal cramps, goose bumps, yawning, sneezing, pupil dilatation, runny eyes and nose. Use of clonidine is off label. Hypotension and sedation are adverse effects. Blood pressure requires monitoring. Start at 0.1mg 2 to 3 times daily orally. Increase as tolerated in divided doses to manage withdrawal symptoms, to a maximum of 1mg daily.

3.4. Patients on Pass from Inpatient Settings

If a patient prescribed OST is to leave hospital for a short period such as a weekend pass, it is the responsibility of the hospital to ensure continuity of prescribing.

The community prescriber (alcohol and drug service or GP) and dispensing pharmacy should be contacted to agree and/or ensure awareness of the plan and avoid risk of duplicate prescribing.

Options to consider include:

- Patient returning to the ward for administration of doses.
- Patient dispensed dose(s) away and responsible for managing “take home” supply.

- Hospital ward prescribes using HBP prescription pad for dispensing by community pharmacy for the period of the pass. A suitable community pharmacy must be contacted in advance, the pharmacy details specified on the prescription and controlled drug requirements met. The current dispensing pharmacy should also be contacted to avoid duplication of dosing if applicable.
- Contact current community prescriber to prescribe for dispensing by community pharmacy for the period of the pass.

4. Management Of Benzodiazepine Or Z Drug Dependence

Recent years have seen the emergence of benzodiazepine type substances which are not prescribable on the NHS in the UK. They can be significantly more potent than diazepam, unpredictable in content and effect experienced but are widely available. Diversion of prescriptions is no longer the main route of supply. Access through online and existing drug supply networks is common. Nationally discussion is ongoing to develop best practice guidance. Public Health Scotland and the Scottish Drug Death Taskforce have published an informed for benzodiazepine harm reduction which encourages a pragmatic approach to managing benzodiazepine type dependence. They recommend a collaborative risk assessment to consider risk of prescribing versus not.

- Acute signs of benzodiazepine use include slurred speech, disinhibited behaviour and unsteady gait.
- Occurrence, onset and severity of symptoms of withdrawal will depend on frequency, amount and type of use (binge, regular, prn), type of benzodiazepine (short or long acting, effect).
- Benzodiazepine withdrawal can cause potentially life-threatening seizures. Other symptoms of acute benzodiazepine withdrawal include; anxiety, tremor, shaking, insomnia, nausea and vomiting, agitation, confusion, hallucinations, increased heart rate and blood pressure.
- Management of seizures should follow the standard emergency response.
- The duration of action of benzodiazepines varies widely and will determine time to onset of symptoms of withdrawal. Benzo.org.uk compares equivalence of common benzodiazepines. Wedinos.org is a resource which can provide information on those which are not licensed for use in the UK/found in illicit supplies.
- Where clinically appropriate to do so, benzodiazepine prescribing confirmed during medicines reconciliation should be continued on admission. Considering any cautions to prescribing of benzodiazepines (refer to section 2.2 for further information).

Where benzodiazepine or z-drug dependence is suspected but benzodiazepines are not prescribed:

- Urine screening to confirm presence of benzodiazepines can support assessment.
- Consider pattern of use. Irregular access or consumption of benzodiazepines, e.g. binge use, is less likely to result in dependence.

- Monitor for symptoms of withdrawal. CIWA-B[xiii] (Clinical Institute Withdrawal Assessment - Benzodiazepine) tool can support assessment.
- Polydrug use including opioids may mask initial symptoms of benzodiazepine withdrawal.
- Regular use, particularly at high doses influences pharmacokinetics of diazepam. Half-life ranges from 20 to 100 hours. Active metabolites have a half-life range from 36 to 200 hours. Symptoms of withdrawal can take some days to present following sudden cessation in patients with dependence.
- Where symptoms of withdrawal are present:
    - Prescribe diazepam 5 to 10mg on an as required basis. Max 30mg daily.
    - In severe hepatic impairment, a short acting agent such as lorazepam at a dose of 0.5 to 1mg is indicated. Max 4mg daily.
    - Peak effects occur between 30 to 90 minutes after oral administration for diazepam and after 2 hours for lorazepam. Monitor at 2 hourly intervals. Administer further doses in response to continuing symptoms of withdrawal. Hold or reduce further doses if signs of toxicity present. For example over sedation or confusion.
- The local alcohol and drug team (Appendix 1) should be contacted at the earliest opportunity to discuss presentation and agree a management plan.

5. Discharge Planning

Discharge from hospital is one of the times highlighted as being higher risk for overdose. Effective planning is required to ensure a smooth transition and minimise risks.

Arrangements must be made to ensure community dispensing of OST and other instalment medications is in place before the patient is discharged. Contact with the community prescriber (alcohol and drug service or GP) should be made as soon as the discharge date is known to allow time for prescriptions to be generated and in place at the agreed community pharmacy.

Information to be discussed with the community prescriber:

- Form, strength and current daily dose of medication at discharge.
- Date and time of last hospital administration/timing of first community dose.
- Who is contacting the community pharmacy to discuss the plan.

Unplanned discharges at weekends or on public holidays may increase risk to patients as most alcohol and drug services and GP surgeries are closed. Ensure a robust plan is in place to ensure it is safe to discharge. If discharge is agreed to be the best option or is unavoidable, and the community prescriber cannot be contacted before this, ensure that a safe and robust plan for continuing treatment is in place. Consider options outlined for weekend pass (section 3.4).

5.1. Assertive Outreach

In line with MAT standard 3, there are teams across Grampian that can provide assertive outreach for people at high risk of severe drug related harm. The aim of assertive outreach is to actively connect people with support.

Ideally referral to relevant services should be discussed with people at risk of drug related harm who are admitted to hospitals before discharge. Where this has not been possible, for example due to discharge against medical advice or leaving the ward without notice, then referral to assertive outreach would be appropriate where risk determines this an appropriate action (as per GDPR instructions). See Appendix 5 for contact details. Refer to the team based in the same area as the patient's current address.

6. Harm Reduction

Admission may provide opportunity to offer basic harm reduction advice relevant to the person. This may include:

- Highlighting drug treatment and support services in their area.
- Overdose awareness and carrying naloxone.
- Risks associated with injecting drugs. This includes transmission of BBVs and skin and soft tissue infection. Encourage single use of injecting equipment, avoidance of sharing any injecting equipment and wider paraphernalia such as water, filters and spoons. If confident it can provide an opportunity to discuss injecting technique and advise on ways to improve this.
- Sexual health and contraception.

Details of Injecting Equipment Providers (also known as needle exchanges) can be accessed here.

6.1. Take Home Naloxone

Opioids are the most commonly implicated substances in drug related deaths in Scotland. Polydrug use with other central nervous system depressants such as alcohol and benzodiazepines is common. Grampian's "Take Home Naloxone" programme equips people at risk of, or likely to witness, opioid overdose with the knowledge on how to respond to overdose, how to use naloxone and provides them with a personal supply.

Staff are encouraged to use every opportunity to discuss and supply naloxone with eligible patients.

The three products licensed for community administration are Nyxoid® intranasal spray, naloxone 1.26mg nasal spray and Prenoxad® intramuscular injection. Over labelled supplies are available from ARI pharmacy and can be added to ward medication lists. It can be prescribed on discharge or supplied using the NHSG PGD. Staff should complete the eLearning module, watch the product videos and be signed up to the PGD as per ward protocols before making supplies.

ELearning and product videos for staff can be accessed here:

- www.sdftraining.org.uk/e-learning/156-overdose-prevention-intervention-and-naloxone-3
- Nyxoid video: www.nyxoid.com/uk
- Naloxone 1.26mg nasal spray video: https://naloxone.uk/
- Prenoxad video: www.prenoxadinjection.com/video/admin.mp4

NHSG PGD for supply of naloxone:

- https://www.nhsgrampian.org/globalassets/services/medicines-management/pgds/pgd_naloxone_supply.pdf

7. Management Of Pregnant Patients

Substance use presents an increased risk for both maternal and foetal wellbeing. Hospital stays provide opportunity to engage pregnant women and link them with the necessary support. Management of pregnant patients who use drugs should be multidisciplinary, with particular importance placed on communication between all professionals involved.

Aberdeen Maternity Hospital hosts the Unity Pregnancy Support Team which includes Specialist Midwife support. They can be contacted on 01224 (5)54516 or by email at gram.unityteam@nhs.scot. Specialist obstetric addictions advice is not available 24/7. In the absence of specialist advice pregnant women using alcohol or other drugs should be managed according to this general guideline and specialist advice sought at the earliest opportunity.

There is evidence to suggest that maternal withdrawal can be associated with foetal stress, foetal distress and stillbirth, particularly in the third trimester. Abrupt withdrawal of opioids is best avoided as it carries a risk of miscarriage, foetal distress and premature labour.

It is recommended that pregnant women who are experiencing problematic drug use, including those already receiving treatment, are referred to the Unity Team. This ensures they receive the appropriate care and support both during and following their pregnancy.

Opioid Substitution Therapy in Pregnancy

- The Unity Team or alcohol and drug service should be contacted prior to initiating OST in pregnant patients or for advice in managing pregnant patients.
- Substitute prescribing can occur at any time in pregnancy and carries a lower risk than continuing illicit use.
- For patients already prescribed OST when they become pregnant both methadone and buprenorphine can be continued. There is little evidence to suggest a difference in outcomes for mum or baby.
- Methadone doses in particular may need increased in the final trimester and can be titrated in response to symptoms of withdrawal and will require review and potential reduction after birth.

- Most reference sources advise against initiation of, or a switch to, buprenorphine in pregnant women due to the risk of precipitated withdrawal to the foetus. In these circumstances methadone is the preferred option.
- Best Use of Medicine in Pregnancy and Choice and Medication contain leaflets which may support discussion with patients.

Benzodiazepine Dependence in Pregnancy

Careful assessment of benzodiazepine use should be undertaken by the Unity Team or alcohol and drug service to diagnose dependence. Sudden cessation in dependent patients may result in harm to mum and the foetus.

UK Guidance [orange book] recommends "Women who are dependent on benzodiazepines should be stabilised on diazepam and, where this can be tolerated without restarting illicit use, the dose reduced. A woman being maintained on methadone or buprenorphine should have her dose maintained during benzodiazepine reduction".

For patients already prescribed a benzodiazepine for this reason, contact the prescribing community service to discuss the plan. If unavailable at time of admission, continue the current dose until this occurs.

Cocaine, other Stimulants and Cannabis in Pregnancy

There are no substitutes for these substances, the best course is to recommend cessation. Patients who report problems with use of these should be linked with the Unity Team or alcohol and drug service.

8. Management Of Pain In Patients Prescribed OST

This section refers to patients on prescribed opiate replacement therapy only. For patients not currently on opiates lower doses may be required.

The acute pain service intranet page should be accessed for current recommendations NHS Grampian Protocol For The Prescribing And Administration Of Oral Opioids Following Trauma Or Surgery In Adults. They provide the following guidance for patients prescribed OST to support decision making and encourage effective management.

Do Not Withhold Analgesia If Patients Are In Pain

- Patients prescribed methadone or buprenorphine may feel that their pain will be difficult to manage and are frequently anxious about the possibility of symptoms of withdrawal.
- This information is to be used where non-opioid analgesics (primarily paracetamol and ibuprofen) have failed or are inappropriate.
- There is no direct conversion between methadone and morphine.
- Methadone prescribed for opioid dependence does not provide sufficient levels of analgesia and should not be relied upon in this patient group.

- Buprenorphine should not be used as analgesia in patients taking full agonists, such as codeine or morphine-based drugs.
- Consider adjuncts, e.g. paracetamol, ibuprofen (or other NSAIDs if appropriate), nerve blocks or splints.

8.1. Anticipated Pain (Elective)

This guidance has considered multiple scenarios, however each case should be considered on an individual basis with the responsible anaesthetic team.

According to the NHS Grampian Protocol For The Prescribing And Administration Of Oral Opioids Following Trauma Or Surgery In Adults, consider:

1) Prescribing oral morphine solution (10mg/5mL) 15mg prescribed for regular administration, e.g. at 0800, 1200, 1800 and 2200 hours (maximum dose 80mg/24 hours) **and**
2) Oral morphine sulfate solution (10mg/5mL) 15mg hourly as required for breakthrough pain (maximum dose 200 mg/24 hours).
3) These doses may have to be increased further in opioid tolerant patients, or in those requiring more than 4 breakthrough doses in 24 hours.

Patients Prescribed Methadone as OST

- Where a patient on methadone is to undergo a procedure resulting in moderate to severe pain, they should continue on their normal dose until the day of surgery.
- Patients should take their normal dose of methadone on day of the procedure.
- Patients should recommence methadone on their current dose, provided oral medication can be restarted within 48 hours. Refer to Section 3.2.1 if methadone is omitted for 3 or more days (e.g. due to a prolonged nil by mouth period).

Patients Prescribed Buprenorphine as OST

- Where the patient is on buprenorphine, the recommendation is to maintain it during the perioperative period and to refer the patient to the Acute Pain Services in advance.
- Response to opioids may be unpredictable because buprenorphine is a partial agonist, and as such, can act as an antagonist and induce a partial opioid blockade.
- Restart buprenorphine as per Section 3 if administration has been interrupted.

8.2. Unanticipated Pain (Emergency)

In any case, consider regular non-opioids (paracetamol and ibuprofen) and advice from the Acute Pain Services (or Anaesthesia out-of-hours). For some pain conditions, a nerve block with local anaesthetic may be considered by the Acute Pain Service or Anaesthetist.

According to the NHS Grampian Protocol For The Prescribing And Administration Of Oral Opioids Following Trauma Or Surgery In Adults, consider:

1) Oral morphine solution (10mg/5mL) 15mg prescribed for regular administration, e.g. at 0800, 1200, 1800 and 2200 hours (maximum dose 80mg/24 hours) **and**
2) Oral morphine sulfate solution (10mg/5mL) 15mg hourly as required for breakthrough pain (maximum dose 200mg/ 24 hours).
3) These doses may have to be increased further in opioid tolerant patients, or in those requiring more than 4 breakthrough doses in 24 hours.

Patients Prescribed Methadone as OST

- There is no direct conversion from methadone to morphine. Ideally methadone should be maintained and pain should be treated with appropriate non opioids (regular paracetamol and ibuprofen) as appropriate.
- If in ITU and ventilated, propofol and morphine should be adequate without the immediate reintroduction of methadone.
- If a patient is on patient controlled analgesia (PCA) or regular IV morphine seek advice from the Alcohol and Drug Service's medical staff as to dose of methadone to be prescribed.
- To restart methadone, if interrupted
  - Start at 20mg and increase dose of methadone as dose of morphine decreases.
  - On day 1, patient can have a further 10mg methadone if required to stop withdrawal.
  - Dose would then be titrated in the usual way, outlined in Section 3.

Patients Prescribed Buprenorphine as OST

- If prescribed buprenorphine, it should be ideally maintained with doses remaining unchanged.
- Monitor for signs of Acute Withdrawal using COWS rating scale (Appendix 2).
- Over next 72 hours, reduce the dose of pain relief to 10 to 20mg morphine.
- Continue to observe for signs of withdrawal but do not confuse with signs of inadequate pain relief.
- To restart if interrupted, no opioids for 12 to 16 hours and re-titrate as per Section 3.

8.3. Experience of Pain in Opioid Dependent Patients

- Patients who continue to show objective signs of acute pain, such as sweating, dilated pupils and rapid respiratory rate, may require higher doses of opioid analgesia than those mentioned above.
- However, this should not be confused with 'Opioid-Induced Hyperalgesia Syndrome', where pain is increased following opioid administration. A patient, who has increased pain as a result of tolerance, would be expected to improve with further opioid administration.
- Patients with problematic drug use have frequent episodes of intoxication/withdrawal which may alter the intensity of their pain experience.

- When suitable and safe, non opioid analgesics should be used (regular paracetamol and ibuprofen).

8.4. Discharge Arrangements for Opioid Analgesia

If patient requires to be discharged on opioid analgesia, the dose should be the lowest effective dosage as per local pain guidelines. GPs can facilitate daily pick up of their analgesia with their methadone/buprenorphine prescription. Communication with the GP and community pharmacy should begin as soon as possible when discharge planning.

9. References

i. Department of Health (England) and the devolved administrations (2017). Drug Misuse and Dependence: UK Guidelines on Clinical Management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive. Available at: www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management/

ii. Pharmaceutical press. Martindale: The Complete Drug Reference. QT interval prolongation. Available at: https://www.medicinescomplete.com/#/content/martindale/qt-interval-prolongation

iii. Pharmaceutical press. Martindale: The Complete Drug Reference. Methadone hydrochloride. Available at: Medicines Complete - CONTENT > Martindale: The Complete Drug Reference > Drug: Methadone Hydrochloride

iv. Pharmaceutical press. BNF. Methadone. Available at: Medicines Complete - CONTENT > BNF > Drug: Methadone hydrochloride

v. World Health Organization. (2022). ICD-11: International classification of diseases (11th revision). Available at: https://icd.who.int/

vi. Scottish Government (2021). Medication Assisted Treatment (MAT) Standards for Scotland Access, Choice, Support. Available at: www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/documents/

vii. Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253-9. Available at: https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

viii. Scottish drug deaths task force (2021). Interim guidance on benzodiazepine prescribing. Available at: Drug Deaths Taskforce

ix. Ashton, C. H. (2013). Benzo.org.uk table 1 benzodiazepines and related drugs. Available at: benzo.org.uk : Benzodiazepines: How They Work & How to Withdraw, Prof C H Ashton DM, FRCP, 2002

x. Public Health Wales (2025). Wedinos. Available at: WEDINOS - Welsh Emerging Drugs & Identification of Novel Substances Project

xi. World Health Organization (2019). mhGAP Intervention Guide Mental Health Gap Action Programme for mental, neurological and substance use disorders in non-specialized health setting Version 2.0 [online]. Available at: https://www.who.int/publications/i/item/9789241549790

xii. NHG Grampian (2024). Acute Pain Services Documents [online]. Available at https://nhsgintranet.grampian.scot.nhs.uk/depts/AcutePainService/Pages/Acute%20Pain%20Service%20Documents.aspx
xiii. CIWA-B Insight - Resources - Clinical Institute Withdrawal Assessment Scale - Benzodiazepines (CIWA-B)(2019)

Appendix 1 - Useful Contacts

Service	Area Covered	Contact
Timmermarket Clinic	Aberdeen City – new patients	gram.timmermarket@nhs.scot Tel: 01224 651130. Ext 61130
Fulton Clinic and Clusters	Aberdeen City – existing patients	gram.fultonenquiries@nhs.scot Tel: 01224 557212. Ext 57212
Aberdeen Integrated Alcohol Service	All Aberdeen City alcohol patients	gram.macrappointment@nhs.scot Tel: 01224 557845. Ext 57845
Aberdeenshire North Drug and Alcohol Services	Banff, Fraserburgh, Peterhead hubs and surrounding areas	gram.kessockclinic@nhs.scot Tel: 01346 585160. Ext 85160
Aberdeenshire Central and South Drug and Alcohol Services	Stonehaven and Inverurie hubs and surrounding areas	gram.southcentralsms@nhs.scot Tel: 01467 532833
Moray Integrated Drug and Alcohol Service	Moray	gram.midasadministration@nhs.scot Tel: 01343 552211
Alcohol and Drugs Action (3rd Sector)	Aberdeen City and Aberdeenshire	www.alcoholanddrugsaction.org.uk Tel: 01224 594700
Arrows (3rd Sector)	Moray	https://www.quarriers.org.uk/blog/service/drug-and-alcohol-recovery/arrows-service/ Tel: 01343 610 500 / 07812 228547
Grampian Drug and Alcohol Pharmacy Team	Grampian	gram.smspharmacists@nhs.scot
Unity Pregnancy Support Team	Grampian	gram.unityteam@nhs.scot Tel: 01224 554516 (answering service available - not 24/7)

Appendix 2 - Clinical Opioid Withdrawal Scale (COWS)

APPENDIX 1
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:_____

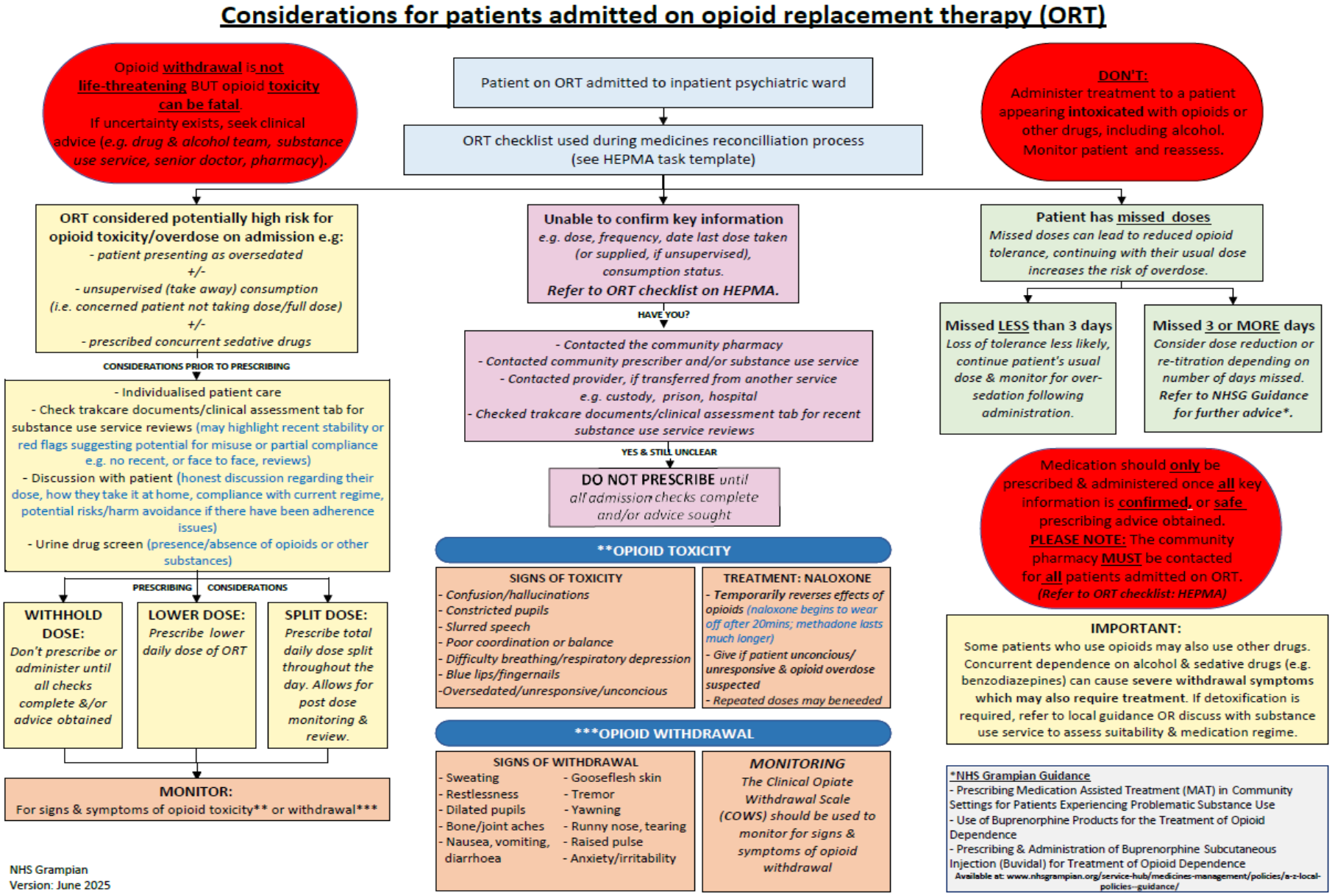
Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or 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.

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

Appendix 3 - Consideration For Patients Admitted On Opioid Replacement Therapy (ORT)



Opioid Replacement Therapy checklist – Available as a template task on HEPMA

DO NOT PRESCRIBE until dose/administration details have been confirmed with Substance Misuse Service/community pharmacy and **deemed clinically appropriate**.
Opioid withdrawal is not a life-threatening condition, but opioid toxicity can be fatal.

Record the product name, dose and frequency in the medicines reconciliation form.

Community dispensing arrangements

- Details of dispensing interval;
- Supervised; Y/N
- When was last dose taken/administered;
- Community pharmacy details (including phone number);
- Community pharmacy contacted; (date and initial)

Community prescriber details

- Name;
- Service (e.g. GP, clinic name);
- Prescriber informed of admission; (date and initial)

Appendix 4 - Comparison Of Methadone And Buprenorphine

	Methadone	Buprenorphine/buprenorphine plus naloxone
Can it precipitate withdrawal when you start it?	No risk of causing (precipitating) sudden symptoms of withdrawal when you start it although some people will experience withdrawal until titrated to the correct dose.	Risk of precipitating withdrawals if full opioid agonists such as heroin, morphine or methadone are still in the body. Leave enough time after taking these to avoid it. Reassure patients it will pass if it does occur – stick with it.
Overdose risk	Full opioid agonist. Greater risk of overdose (intentional or accidental) if higher than normal dose is taken or when used with other opioids or in polydrug use. Caution needed with starting dose, speed of titration and rate of dose increase. Start low, go slow.	Partial agonist. Lower risk of overdose (intentional or accidental) with other opioids or in polydrug use. May be better option if risk of overdose is particularly high (e.g. previous overdoses, significant polydrug use, high risk injecting activity).
Rate of titration	May take a few weeks to reach the appropriate dose.	Can be quickly titrated to the appropriate dose.
Comorbid alcohol use disorder	Higher risk (more sedative).	Lower risk (less sedative).
QTc prolongation	More likely to prolong QTc.	Less likely to prolong QTc.
Respiratory conditions	Generally considered to cause more respiratory depression than buprenorphine.	Generally considered to cause less respiratory depression than methadone.
Interaction with other medication	More affected by interactions. Plasma levels may be altered by inducers/ inhibitors of CYP3A4, e.g. some anti-epileptic drugs, some SSRIs, erythromycin/clarithromycin. Check BNF for full list.	Less affected by interactions. Risk of precipitating withdrawal if taking prescribed opioids when starting buprenorphine. May reduce efficacy of opioid analgesia. Check BNF for details.
Retention in treatment	Some evidence suggests better retention in treatment than with low dose buprenorphine (<8mg).	Retention in treatment may be worse than with methadone at daily doses <8mg. No difference for doses >8mg daily.
Clear headed feeling/level of sedation from treatment	Not associated with clear headedness. Patients with mental health symptoms (e.g. anxiety or trauma symptoms) may benefit from the greater sedative effects.	Gives clear headed feeling and less sedation.
Patients desire for a period of stability	Suitable for patients a seeking longer period of stability.	Suitable for patients a seeking longer period of stability. Patients aiming for more rapid detoxification (within 12 months) likely to find this better tolerated.
Withdrawal symptoms when stopped	More marked and prolonged compared to buprenorphine.	Less marked and prolonged compared to methadone. May be easier for patients to tolerate detoxification.
Long acting preparations/ dosing	No long acting preparation available. Daily oral dosing required.	Long acting options available. Less than daily oral doses possible.
Pregnancy: Check BUMPS – Best Use of Medicine in Pregnancy	If pregnant and already on methadone this should be maintained. If not already on OST should be offered methadone.	If pregnant and already on buprenorphine this they should be maintained. Weigh up risks of initiation during pregnancy. (Risk of precipitating withdrawal in mother and baby).

Appendix 5 - Assertive Outreach Contact Details

Service name	Area	Contact details
Assertive outreach	Aberdeen City	gram.assertiveoutreach@nhs.scot Ext 57780 (voicemail only)
ARIES	Aberdeenshire	aries@aberdeenshire.gov.uk
MIDAS/Arrows	Moray	01343 552211/01343 610500