



Clinical Guidelines

for Opioid Substitution
Treatment

Guidance Document for
OST in the Hospital
Setting

Introduction

Appropriate policies and standard operating procedures for the provision of in-patient Opioid Substitution Treatment (OST) is paramount to patient safety when treating a person with an opioid dependency (prescribed or unprescribed).

In December 2016 the HSE launched a Clinical Guidelines for Opioid Substitution Treatment (OST)¹ in conjunction with the College of Psychiatry of Ireland, the Irish College of General Practitioners and the Pharmaceutical Society of Ireland.

Following this publication, it became apparent there are specific in-patient aspects to the prescribing and dispensing of OST that would usefully be compiled for the hospital setting.²

This document provides links to relevant sections of the OST Guideline with ancillary information for the in-patient setting.

With thanks to: Aoife Davey, HSE National Social Inclusion Office; Ciara Gavin, Senior Pharmacist, St. James's Hospital, Dublin; Norma Harnedy, National Liaison Pharmacist, HSE Addiction Services; Dr Karen Harris, Consultant in Emergency Medicine, Sligo University Hospital; Dr Eamon Keenan, HSE National Clinical Lead-Addiction Services; and Hannah

- 1 Health Service Executive (2016) Clinical guidelines for opioid substitution treatment. Dublin: Health Service Executive.
- 2 Note the prescription of OST in hospital settings is covered under the Misuse of Drugs (Supervision of Prescription and Supply of Methadone and Medicinal Products containing buprenorphine authorised for Opioid Substitution Treatment) Regulations 2017. The regulations add certain buprenorphine medicinal products authorised for OST to the Schedule of products that fall within the scope of these regulations. These regulations replace the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998 (S.I. No 225 of 1998).

Rodrigues, UISCE, an advocacy service for people who use drugs in Ireland.

Opioid dependent patients in hospital

- » The objective of drug treatment in hospital is to stabilise drug misuse as quickly as possible and treat the Drug related or nondrug related condition.
- » On occasion, patients may wish to take the opportunity of a hospital admission to reduce their drug doses or even to detoxify fully. This may occasionally be useful, but, if unplanned, is likely to result in relapse on leaving hospital, which in turn exposes the patient to overdose risks.
- » Transfer of care on admission and discharge requires coordinated response by all professional staff.
- » Planned admissions to hospital are preferable.
- » All acute hospital settings and mental health inpatient units should have ready access to naloxone in case of opioid overdose.

Substitute opioids or other controlled drugs should only be prescribed following an adequate assessment. [See section 4.2 Phase 1: Assessing Dependence of the Clinical Guidelines for OST](#). The aims of this assessment are:

- » To enable treatment of emergency or acute problem or enable elective procedure to take place.
- » Confirm the patient is taking drugs; history, examination and urine analysis. [See section 5.4.1 Drug Screen of](#)

[the Clinical Guidelines for OST](#). Identify the degree of dependence; opioid withdrawal signs may be observed.

- » Identify complications of drug misuse and evaluate risk behaviour; blood borne virus tests, nutrition, alcohol intake.
- » Consider psychiatric comorbidity.

For patients currently being prescribed methadone or buprenorphine, good communication between hospital and community is essential for safe patient care. Prescribing in these cases should be a relatively straightforward matter of continuing the usual dose of OST while in hospital. Contact the Central Treatment List (CTL) to confirm that the patient is receiving OST. The CTL is available 9-5 Monday to Friday, telephone 01 648 8638.

Confirmation of the dose by the patient alone is not adequate. Confirmation of last dose received at clinic or pharmacy should be sought. [See contact list of Drug Treatment Clinics at appendix 1](#), or contact the dispensing pharmacy directly.

For patients not on OST, or where there is uncertainty about recent compliance, particular care must be exercised in initiating OST. Local services should be contacted at point of initiation to ensure continuity of care on discharge. [See contact list of Drug Treatment Clinics at appendix 1](#).



Initial dosing schedule for opiate dependent patients admitted to hospital:

- » Only prescribe following assessment [See section 4.2 Phase 1: Assessing Dependence of the Clinical Guidelines for OST.](#)
- » Polydrug and alcohol misusers may develop multiple withdrawal syndromes [See section 7.4.1 Other drugs of misuse of the Clinical Guidelines for OST](#), so these may need to be differentiated to prioritise treatment.
- » Methadone may initially mask alcohol or benzodiazepine withdrawal symptoms.
- » Exercise care when prescribing additional drugs such as sedatives to individuals who may also be using illicit substances. Interactions between 'Street Drugs' and psychotropic drugs should always be considered and clinicians should check a relevant text such as Maudsley Prescribing Guidelines (2018).³
- » Exercise care when prescribing additional drugs such as sedatives.
- » When it is appropriate to initiate opioid substitution in hospital to manage risk of withdrawal, methadone or buprenorphine can be utilised.

- » Induction should follow protocols. [See section 4.3 Phase 11: Induction phase of the Clinical Guidelines for OST.](#) However, close supervision in hospital may allow for a modified protocol. [See appendix 2 for an example modified protocol.](#)
- » Signs of intoxication, such as drowsiness, slurred speech, or constricted pupils indicate a need to discontinue the drug or reduce the dose.
- » Hospitals should contact the CTL. The CTL is available 9-5 Monday to Friday, telephone 01 648 8638. Contact before prescribing buprenorphine products to ensure continuity after discharge as approval from the HSE is required before buprenorphine products can be reimbursed in a community setting for the treatment of opioid dependence. [See Section 3.3.2 Buprenorphine/Naloxone of the Clinical Guidelines for OST.](#)

Other drugs of misuse

Opioid dependant patients in hospital may commonly be taking other drugs and misusing alcohol.

- » The misuse of benzodiazepines or alcohol may lead to associated withdrawal symptoms and seizures.
- » Benzodiazepine prescribing should only be initiated once dependence has been established by history taking and by noting symptoms of withdrawal. [See section 6.6 Health implications and interventions for continued alcohol and drug use when patients are on OST of the Clinical Guidelines for OST.](#)
- » In the inpatient setting, it is appropriate to provide a slow withdrawal regimen over one to four weeks, with a starting dose of diazepam of no more than 30mg daily, given in divided doses. For a range of useful tools and schedules, see the Community Detoxification Guidelines (ALDP, 2015).
- » Patients may also require concurrent detoxification from alcohol. [See Table 6: Responses to continued drug or alcohol misuse when patients are on OST of the Clinical Guidelines for OST](#) or local hospital Alcohol Management Policy.
- » Routine prescribing of benzodiazepines or 'z' drugs as hypnotics and benzodiazepines or gabapentoids, in particular pregabalin as anxiolytics, should be avoided while in hospital.

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³ Taylor, D., T. Barnes, A. Young, (2018) The Maudsley Prescribing Guidelines in Psychiatry, 13th Edition, Wiley Blackwell



Pain management for drug misusers

[See section 6.7 Pain management for drug misusers of the Clinical Guidelines for OST.](#)

Management of patients if Nil by Mouth (NPO)⁴

- » Seek specialist advice from the anaesthetist for peri-operative and NPO instructions.
- » Post-operatively the usual dose of methadone should be restarted, once the NPO restriction has been removed.
- » If a patient remains NPO post-op then both potential opioid withdrawal and pain should be managed with a conventional opioid such as morphine injection/infusion. IV methadone should not be used instead of the methadone maintenance dose due to differences in dose equivalence by different routes.
- » Referral to a specialist pain team referral may be required if careful monitoring shows that the patient may be in opioid withdrawal or in pain.

Discharge from hospital

For drug misusers not previously in treatment, attendance at the emergency department or hospital admission may present a window of opportunity to put them in touch with other services. It is essential to link with services well in advance of discharge to ensure continuity of care. This is in line with the HSE Code of Practice for Hospital Integrated Discharge Planning.

On discharge, the following information should be given:

- » General health promotion advice.
- » Contacts for further help, such as needle exchange, drug treatment services, or selfhelp groups. See the directory of services on www.drugs.ie for services in your area.
- » This is linked to <http://www.services.drugs.ie/>
- » Advice on preventing overdose. [See section 6.9.1 Overdose in the Clinical Guidelines for OST.](#)
- » Advice on reducing the risk of blood-borne viruses. [See section 6.4 Viral Infections in the Clinical Guidelines for OST,](#) and Hepatitis B vaccination. [See section 6.5 Hepatitis A and B vaccinations in the Clinical Guidelines for OST.](#)
- » Advise on loss of tolerance in hospital.

If the patient was admitted on an opioid prescription from the community, this should be continued on discharge and prescribing responsibility transferred back to the GP or HSE addiction clinic. Planned discharge is best done in collaboration with local drug treatment service, the GP, and the community pharmacy. [See section 3.10 Referral procedure for change of OST location in the Clinical Guidelines for OST.](#)

On the day of discharge confirm the following for the community services:

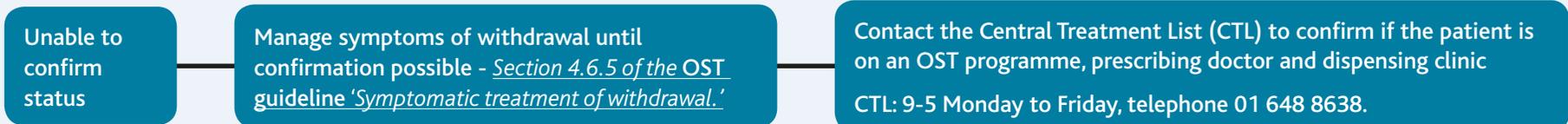
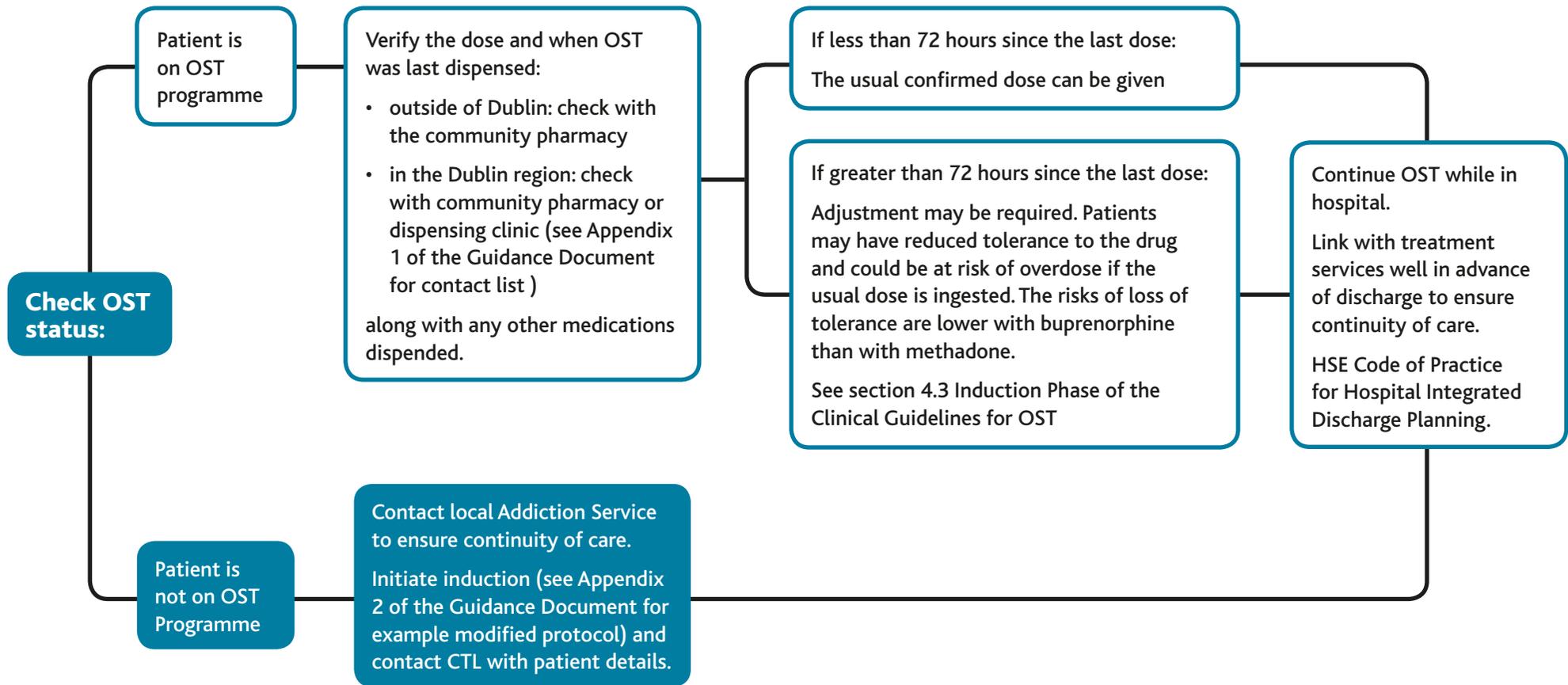
- » Whether that day's dose has been given and how much was given.
- » Any other drugs that the patient is being prescribed.
- » Patients should receive their dose on the day of discharge and contact should be made with their GP and community pharmacy to confirm that they have had that day's dose.
- » Arrangements should be made in advance of discharge to ensure the patient has a place in a community pharmacy to receive their methadone and a place with a methadone prescribing GP.

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4 The British Pain Society (2004) Pain and substance misuse: improving the patient experience. A Consensus statement prepared by the British Pain Society in collaboration with The Royal College of Psychiatrists, The Royal College of General Practitioners and The Advisory Council on the Misuse of Drugs.



Management of Opioid Substitution (OST) in the Hospital Setting

For individuals identified through assessment as being opioid dependent



Appendix 1: Contact details for Drug Treatment Clinics

Drug Treatment Clinics contact details:

Addiction Clinics	Location	Phone	Opening Hours
Greater Dublin area & Wicklow			
Aisling Clinic	Cherry Orchard Hospital	076 6956009	M-F:9-12, 2-4, 5-7 S-S: 10am-1pm
ARC Project	Cashel Rd, Crumlin	01 4563131	M 8.30-6, T 8.30-6.30 W:8.30-5, Th 8.30-8 F 9-5, S 11-3
Arklow Clinic	Arklow	086 8543733	M-F:6-7:30pm S-S:10-12am
Baggott St. Clinic	Haddington Rd Dublin 4	01 6699500	M-F:8:45-11:30 S-S: 10-11:30
Tolco Clinic -Cabra	Cabra Dublin 7	01 8307051	M,T,Th,F : 9-12 W 9-11.30 S-S: 9-11
Castle St. Clinic		01 476702 01 4785574 9	M-F:9-12:15, 2-4, 5-6.30 S-S: 10:30-12:30
City Clinic	Amiens St Dublin 2	01 8555310	M-W &F: 9-12, 2-4 Thursday 9 – 10.30, 2 -4 S-S: 9-12
Clondalkin/ Lucan Treatment Centre	Was Fortune House, Lucan	01 6433600 01 6433691	M-F: 9-12, 2-4 S-S: 10-1
Cork St. Addiction Centre	Cork St. Dublin 8	01 4544940 01 4544939	M-F: 10-12 S-S: 10-11
Darndale Dispensing	Beldale View Clinic, Darndale D9	01 8488951	M, W-F:9-12.00, 2-4, Tuesday, 9 – 11, 2 - 4 S-S: 9-11
Domville House	Ballymun Rd	01 8620111	M-T, T-F:9-12, 2-4, Wednesday 9 – 11.30, 2 - 4 S-S: 9:30-11:30



Dr. Steeven's Addiction Centre	Dr. Steeven's Hospital Dublin 8	01 6352078 01 6352058 01 6352530	M-F: 9-12, 2-4 S-S: 10-12
Drimnagh Clinic	Curlew Rd Dublin 12	076 6957483	M-F: 9.30-11:30 S-S: 11-12
Drug Treatment Centre	Trinity Court, Pearse St.	016488600	M-F:9-12:30, 2:15-4:30 S-S: 10-12:30
Dun Laoghaire Clinic	Patrick St.	01 2808472	M-F: 8:45-12:15, 2-2.30
Inchicore	St Michaels Estate Off The Bulfin Rd, Dublin 8	01 4531978	M-F: 12.30-1.30 S-S: 10:30-11:30
Irishtown	36/37 Castle StreetDublin 2	01 4767029	M-F: 5.30-7.30pm S-S: 10-11.30
Jobstown Clinics	Tallaght	01 4630656 01 4597756	M-F: 2:30-4:30 S-S: 10-11
Killarney Rd. Clinic	Bray	01 2762918	M-F:9.15-12, 2-3:45 S-S:9-12
Mountview Drug Clinic	Clonsilla	01 8248170	M-F:9-12 Tues: 2-3:30 5-6:30 Thurs/Fri: 2-3:30
The Lodge	Old County Rd, Crumlin	076 6957407	M-F:10-12, 2-4 S-S: 10-11
Tallaght Drug Services	Glen Abbey Centre Belgard Rd	01 4513894 01 4634124	M-F: 9.30-12, 2-4 S-S: 10-12
The Mews Clinic	North Circular Road	01 8383852	M-F: 9-12 2-4.00 W: 9.11, 2-4 S-S: 9.:30-11.30
The Thompson Centre	Grangegorman Primary Care Centre	01 8676370	M-W:9:30-1, 2-4 Th:9:30-1, 2-5,6-7:30 F:10-12 S-S: closed
Wellmount Clinic	Finglas	01 8501400	M-F:9-12, 5-6:30 Sat/Sun 9 – 10.30



Scripting clinics			
Bonnybrook Satellite Clinic	Brookhaven, Glin Road, Bonnybrook, Dublin 17	01 8770205	Tuesday 2 - 4, Wednesday 8 - 12, Friday 9 - 12
Donabate Satellite clinic	Donabate Health Centre, Donabate, Co Dublin	01 8436079	Wednesday 5-6.30
Donnycarney Satellite clinic	Le Chéile, Donnycarney Youth & Community Centre, Collins Ave East, Donnycarney, Dublin 5	01 8314895	Monday 2 - 3pm
Edenmore Health Centre	Edenmore Park, Edenmore, Dublin 5	01 8480666	Friday 8 - 10
Howth Satellite Clinic	Howth Health Centre, Main Street, Howth	01 8322984	Wednesday 5-6.30
Kilbarrack Health Centre	foxfield Crescent, Dublin 5	01 8391221	Friday 9 - 12, 2 - 4pm
Swords Health Centre	Bridge Street, Swords, Co Dublin	01 8902200	Tuesday/Thursday 5 - 6.30pm
Counties outside of Dublin/Wicklow/Kildare			
Athlone Drug Treatment Clinic	CADS Treatment Centre, Clonbrusk, Athlone, Co. Westmeath	090 6424820 087 1252237 (Liaison nurse)	9-5 (Mon-Thurs) 9-4.30 (Fri)
Cavan	Primary Care Centre, Connolly Street, Cavan	Contact GP clinic- 042 9665566	9-5 (Mon-Fri)
Carlow Drug Treatment Clinic	St. Dymphna's Hospital, Carlow	059 917 8050	9-5 (Mon – Fri) OST Clinics Tue: 9-12.30, 2- 2.30 Fri: 9-12.30
Cork Arbour House	St Finbarr's Hospital, Douglas Rd, Cork city	021 496 8933	9-5 (Mon-Fri)
Galway Drug Treatment Clinic (Mayo, Roscommon, Galway)	Mervue Health Centre, Michael Collins Road, Mervue, Galway	091 751971	9-2 (Mon-Friday)
Kerry Addiction Clinic	Edward Court, Edward Street, Tralee	066 7184968	9-5pm (Mon-Fri)
Kilkenny Ardú Drug Treatment Clinic	Kickham street, Kilkenny	056 7784638	9-5 (Mon-Fri) OST Clinics Mon 2-3.30 (ex BH) Thursday 2-3.30



North Louth Drug Treatment Service - Dundalk	Market St Health Centre, Market St, Dundalk, Louth	042 9394010 042 9396866 087 2820806 (Liaison nurse) 087 6310144 (HSE Doctor)	MONDAY 10am – 12pm and 2pm – 4pm
North Louth Drug Treatment Service - Navan	Railway Street Health Centre, Primary Care, Railway Street, Navan, County Meath	046 9076451 087 2820806 (Liaison nurse) 087 6310144 (HSE Doctor)	TUESDAY 10am – 12pm and 2pm – 4pm
North Louth Drug Treatment Service - Drogheda	HSE Social Inclusion Services , Drogheda Industrial Park, Donore Road, Drogheda, County Louth A92 DE03	041 9870160 087 2820806 (Liaison nurse) 087 6310144 (HSE Doctor)	WEDNESDAY 10am – 12pm and 2pm – 4pm (Please note this clinic is currently in the set up stage. However, at the moment, referrals come in through the Drogheda Service and clients are accessed through Market St, Dundalk on a temporary basis.
Limerick Drug Clinic (Clare, North Tipp, Limerick)	Corporate House, Mungret St. Limerick	061 318633	9-1pm, 2-5pm
Mullingar (& Longford) Drug Treatment Clinic	CADS Treatment Centre, St. Mary's Campus, Mullingar, Westmeath	044 9395200 087 1252237 (Liaison nurse)	9-5 (Mon-Thurs) 9-4.30 (Fri)
Portlaoise Drug Treatment Clinic	CADS Treatment Centre, St. Fintan's Healthcare Campus, Portlaoise, Co. Laois	057 869 2516 087 1252237 (Liaison nurse)	9-5 (Mon-Thurs) 9-4.30 (Fri)
South Tipperary Drug Treatment Clinic	St. Michael's Unit, South Tipperary General Hospital, Clonmel, Tipperary	0526177900/3	9-5 (Mon-Fri) OST Clinics Tues 2-4 Wed 1-3 Thurs 10-12
Tullamore Drug Treatment Clinic	CADS Treatment Centre, Midland Regional Hospital Tullamore, Arden Road, Tullamore, Offaly	057 9315801 087 1252237 (Liaison nurse)	9-5 (Mon-Thurs) 9-4.30 (Fri)



Waterford Substance Misuse Service	St Otteran's Hospital, John's Hill, Waterford city	051 848658 (reception) 051 848697 (clinic)	9-5 (Mon-Fri) OST Clinics Tues 9.30-4.30 Wed 9.00-4.30 Fri 2.00-4.30
Wexford Drug Treatment Clinic	St John's Hospital, Enniscorthy, Wexford	053 9259825	9-5 (Mon-Fri) OST Clinics Wexford: Tues 1.30 – 5.00 Thurs 9.00-5.00 Gorey: Wed 9.00-5.00



Appendix 1: Addiction Service GP Co-ordinators & Liaison Chief Pharmacists

Area		GP Co-ordinator Contact Number	Liaison Chief Pharmacist Contact Number
CHO 9	Drumcondra, Ballymun, Finglas, Skerries, Swords	GP Co-ordinator 087 2198094	Chief II Pharmacist, Addiction Service, CHO Dublin North City and County 087 3325540
	Fairview, Blanchardstown, North Strand, Thompson Centre, Dublin 1	GP Co-ordinator 087 9327972	
CHO 7	West Dublin and Southside: D2, D4 (Ringsend only), D6, D8,D12, D16, D24, Co. Kildare	GP Co-ordinator Addiction Services HSE DML 086 0222704	Chief II Pharmacist, HSE Addiction Services-Dublin South, Kildare & West Wicklow Community Healthcare 087 7068013
CHO 6	East Coast: Dún Laoghaire, South County Dublin and Wicklow		Chief II Pharmacist, Addiction Services, HSE (CHO 6) 086 8543733
All areas not included above	Co. Dublin, Co. Wicklow, Co. Kildare CHO 1, 2,3, 4, 5,and 8	National GP Co-ordinator for the HSE Addiction Service 086 8100803	National Liaison Pharmacist, HSE Addiction Services 086 8397159



Appendix 2: Modified induction for patients not already on OST who following a thorough assessment are considered opioid dependent and requiring OST

Methadone

Risk of overdose is increased by low opioid tolerance, too high an initial dose, too rapid increases and concurrent use of other drugs, particularly alcohol, benzodiazepines and antidepressants.

It normally takes four to five days for plasma levels of methadone to stabilise after dose commencement, but it may take up to ten days to reach steady state. This can increase the risk of overdose during the early stages of treatment.

ECG monitoring is recommended in patients with known risk factors for QT prolongation.

The person must be exhibiting objective opioid withdrawal symptoms, as assessed on an opioid withdrawal scale such as the Objective Opiate Withdrawal Scale, before any dose is prescribed.

See section [4.2 Phase 1: Assessing Dependence](#) of the Clinical Guideline for OST.

The following protocol is based on the Maudsley Prescribing Guidelines (2018)¹.

Day 1

- » Give a dose of 10 mg of methadone mixture 1 mg/1 mL based on the severity of withdrawal.
- » This should be given as a once only dose. Methadone will start to have an effect after 20–30 minutes with peak levels being reached at 4 hours.
- » Continue to monitor for signs of withdrawal 4 hourly and give a further dose of 5–10 mg as required – also observe for signs of intoxication.
- » The initial daily dose (over 24 hours) will not usually be more than 30 mg.
- » Prescribe naloxone as required in case of overdose.

Day 2

- » Prescribe the same dose as the patient required on day 1 as a single dose, or in divided doses.
- » Continue to monitor withdrawal symptoms and sedation.

Ongoing prescribing

- » Consider increasing the dose further in 5–10 mg increments every 3–4 days until full relief of withdrawal symptoms is achieved, in consultation with addiction specialists.
- » Once stability has been achieved, continue to prescribe the required dose.

In the acute in-patient setting it is usually advisable for the person to be maintained on a stable dose rather than commence detoxification.

Buprenorphine

Initiation of OST using buprenorphine containing products should not be commenced unless the patient is demonstrating clear signs of opioid withdrawal.

Initiation and dose titration of buprenorphine containing products should only be carried out by a doctor who has been trained in the prescribing of buprenorphine or in conjunction with an addiction specialist.

¹ Taylor, D., T. Barnes, A. Young, (2018) *The Maudsley Prescribing Guidelines in Psychiatry, 13th Edition*, Wiley Blackwell.





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3.10 Referral procedure for change of OST location (not applicable to prison transfer)

sample prescription form).⁹ Level 2 prescribers contact the HSE Chief Liaison Pharmacists and GP Coordinator when first prescribing opioid replacement therapy for a patient, in order for a suitable pharmacy to be organised. Pharmacists must also comply with the requirements of the Pharmacy Act 2007 (as amended) and the Regulation of Retail Pharmacy Businesses Regulations 2008 (S.I. No. 488 of 2008). The Pharmaceutical Society of Ireland has published guidance for pharmacists on the safe supply of Methadone from community pharmacies.¹⁰

All patients who are prescribed methadone need to be listed with the Central Treatment List (with the exception of patients prescribed methadone for palliative care or pain relief,

9 Statutory Instrument 323 of 2014 amended the Misuse of Drug Regulations 1988, as amended. Among other things, it removed the handwriting requirements in relation to certain details on prescriptions for controlled drugs specified in the Schedule to the Misuse of Drugs (Supervision and Prescription and Supply of Methadone) Regulations 1998 (S.I. No. 225 of 1998) i.e. Methadone. This amendment removed the handwriting requirement from Regulations 13(1)(f) and 13(1)(g) for Methadone Prescriptions only; including the name and address of the person for whom the treatment is issued; the dose; preparation; form; strength; and total quantity in words and figures. The SI took effect on 11 July 2014.

10 See www.thepsi.ie/gns/pharmacy-practice/practice-guidance/Guidance_on_the_Medicines_Safe_Supply.aspx

when notification is to the Controlled Drugs Department in the Department of Health).

3.3.2 Buprenorphine/Naloxone

The Department of Health Expert Group on the Regulatory Framework, for products containing buprenorphine/naloxone and buprenorphine-only for the treatment of opioid dependence (2012), sets out several recommendations for its use, including the appropriate cohort of patients for its use and when it may not be suitable for use.¹¹ (See Appendix 5 for the recommendations regarding appropriate patient cohort).

Staff of the Central Treatment List maintain, separately, a record of people receiving buprenorphine/naloxone, currently referred to as the 'Suboxone List' (this is an informal agreement in anticipation of the inclusion of buprenorphine/naloxone in the relevant legislation).

Approval from the Primary Care Reimbursement Service (PCRS) for each patient is currently required before buprenorphine products can be reimbursed in a community setting.

11 Increased phased access to buprenorphine/naloxone is currently being progressed by the HSE in the context of its service plan for 2016.

3.4 Provision of information to the patient

3.4.1 Prescribers

Once a decision has been made to prescribe OST, patients should be informed of the rationale for treatment, the expectations placed on them (such as daily attendance for supervised doses), and what they can expect, either verbally or by a written consensual agreement.

The patient should be informed of:

- » What will happen during treatment
- » The risks during induction
- » The dangers of using benzodiazepines and other Central Nervous System (CNS) depressant drugs
- » The planned rate of dose increase and rationale for this
- » Risks to children of ingesting prescribed medication and the importance of safe

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Chapter 3: Principles and key operational stages of pharmacological interventions for OST

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3.9 Ongoing assessment of OST

It is important to note that through the five stages of OST, as outlined in this guideline, ongoing assessment and care planning is central to the treatment process. At all phases, treatment is delivered through active key working and care planning; this is underpinned by psychosocial interventions.

In many cases, stabilisation on OST will be a key priority as an early step to recovery. For others, active support for detoxification, followed by relapse prevention, may be appropriate. However, assessment and recovery care-planning is an ongoing process and, once stabilised on OST, collaborative and active care planning (e.g. using mapping tools and motivational approaches), to consider options across a wide range of personal recovery goals, will be an important part of a recovery-orientated culture. For people to make informed choices through the assessment process, they need information and advice. As well as promoting clear pathways to recovery and abstinence, it is vital the nature of dependence is discussed and any risks of treatment and moving to abstinence are made clear. For collaborative recovery care-planning, people need balanced advice based on evidence, so they can weigh up their preferences and options in an informed way (Strang, 2012).

Treatment should seek to maximise outcomes across a range of domains, including drug and alcohol misuse, health, and psychosocial functioning. While drug treatment has been shown to be effective in reducing drug misuse, patients may not cease all illicit drug use. Clinicians will frequently be faced with decisions concerning what action to take if a patient is demonstrating limited progress on a treatment programme. In these circumstances, clinicians should consider optimising treatment by increasing the intensity of the programme rather than reducing it. Optimising treatment may include ensuring medication is provided within the optimal dose range; changing to another substitute medication if available; increasing key working or psychosocial interventions; and increasing supervised consumption.

Once the care plan is complete (see Appendix 3 for care plan templates) the actions should be addressed and reviewed in regular one-to-one sessions. When a new action is identified, this should be added, with interagency communications being undertaken, as required. A formal review should be undertaken every 3 months (or more frequently if required). The date for the next review should be explicitly stated in the care plan at the end of the session and at the end of each subsequent case review. Clinicians are encouraged to systematically document

progress in treatment under the five domains of care planning: Drug and alcohol misuse; Physical health; Mental health; Social functioning; and Criminal justice (see NDRIC National Protocols and Common Assessment Guidelines, 2011).

3.10 Referral procedure for change of OST location

The outcomes for a referral to change treatment location is that there is agreement and clarity among service providers and service user regarding referral to another service, including steps and timeframes involved and that the patient:

- » Accesses appropriate services in line with agreed assessment/care plan/shared care plan goals/needs.
- » Is supported throughout the process, as required, and appropriate follow-up takes place.
- » Will be tracked and supported to minimise disengagement from services

The transfer **from HSE addiction Clinic to HSE Addiction Clinic** is done through a request to and from the clinical teams, usually facilitated through the GP Coordinator.

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Chapter 3: Principles and key operational stages of pharmacological interventions for OST

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The transfer **from pharmacy to pharmacy** can be organised by the Chief Pharmacist using the Pharmacy Transfer Form (see Appendix 6).

Transfer **from GP to GP** can be organised by the GP Coordinator.

At all times, to ensure a continuum of care, contact should be made with the previous prescribing dispensing site to check the last date of OST received and also to confirm any other medication that may be prescribed.

The Central Treatment List should be informed of the change of treatment and dispensing location, as a new CTL card needs to be issued to the new community pharmacy.

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4.1 Key points

- » Methadone or buprenorphine, used at the optimal dose range, are both effective medicines for OST.
- » Dose induction with methadone should aim to achieve an effective dose, while also exercising caution about the inherent risks of too rapid an increase.
- » Dose induction, with buprenorphine, may be carried out more rapidly, with less risk of overdose.
- » Clinicians should aim to optimise treatment interventions for patients who are not benefiting from treatment, usually by providing additional and more intensive interventions (pharmacological and psychosocial) that may increase retention and improve outcomes.
- » Once stable on OST, at least one dose per week should be supervised.
- » Methadone and buprenorphine are both effective in detoxification regimens.
- » OST is a medical treatment, and should not be used punitively i.e. there should be no dose reduction as a sanction for ongoing illicit drug use.
- » Opioid detoxification should be offered as part of a care plan, including preparation and post-detoxification support in an appropriate setting to patients ready for and committed to abstinence.
- » Health professionals working in isolation must ensure they have an opportunity to discuss and review their work with colleagues working in the field, to maintain up-to-date good practice.

4.2 PHASE 1: ASSESSING DEPENDENCE

A prescription for substitute medication should normally only be considered if there is evidence of current dependence (ICD 10 and DSM-5; download at <http://www.who.int/classifications/icd/en/> also <http://www.dsm5.org>). ICD 10 has been developed by the World Health Organisation and are internationally accepted criteria for establishing dependence (see Table 2 below for quick reference guide).

In addition, opiate withdrawal symptoms can be assessed using the Objective Opiate Withdrawal Scale (OOWS) and the Clinical Opioid Withdrawal Scale (COWS).

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Table 2: Quick Reference to ICD10 Criteria for Dependence

Physical

- » Withdrawal manifested by the characteristic withdrawal syndrome or by the use of substance to relieve or avoid withdrawal symptoms.
- » Tolerance is defined by either increased amounts used to achieve intoxication or other desired effect or diminished effects with continued use of the same amount of substance.

Psychological

- » Difficulty in controlling substance use; unsuccessful attempts to cut down or taking the substance in larger amount over a longer period than intended.
- » Continued substance use, despite awareness of negative consequences of drug use.

Social

- » A great deal of time spent in obtaining the substance use, using the substance, or recovering from the effects of substance use.
- » Neglect of important social, occupational, or recreational activities.

Table 3: Objective and subjective signs of withdrawal from opioids

Objective signs of opioid withdrawal	Subjective signs of opioid withdrawal
<ul style="list-style-type: none"> » Yawning » Coughing » Sneezing » Runny nose » Lachrymation » Raised blood pressure » Increased pulse » Dilated pupils » Cool, clammy skin » Diarrhoea » Nausea » Fine muscle tremor 	<ul style="list-style-type: none"> » Restlessness » Irritability » Anxiety <p>The signs listed above may also be useful objective signs</p> <ul style="list-style-type: none"> » Sleep disorders » Depression » Drug craving » Abdominal cramps

4.2.1 General health assessment

All drug users should have a full health assessment completed prior to commencing OST. The aim of this is to identify unmet healthcare needs and improve the general health of the patient.

The history and assessment should include:

- » Current and past medical history
- » Current prescribed and non-prescribed medications, including cigarettes, cannabis, alcohol, and non-prescription medicines
- » Psychiatric history and current symptoms.
- » Drug-related complications such as abscesses, venous thrombosis, septicæmia,

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endocarditis, and constipation. Treatment and referral, as appropriate

- » Assessment of injecting practices and advice given
- » History of accidental and deliberate overdose
- » Presence of past infection with blood-borne viruses (including assessment of risks such as previous injecting or sharing or having tattoos), immunisations for hepatitis A and B, testing for hepatitis A, B, C, and HIV. Advice and information given prior to testing. Referral to specialist service, if required
- » Contraceptive history and cervical screening, menstrual and pregnancy history in women. Provision of contraception advice
- » Sexual health and history of sexually transmitted infections. Advice on safer sex and referral to the local sexual health service
- » Oral Health and referral to appropriate dental service
- » Assessment of diet and nutrition and advice given to improve same. Oral nutritional supplements may be prescribed if criteria for prescribing are evident. Note potential for diversion
- » All allergies and sensitivities

4.2.2 Physical Examinations, Assessments, Investigations and Vaccination

- » Assessment of the service user's physical and mental health
- » Assessment of injection sites in all limbs and inguinal areas if injecting - or has injected previously
- » Measurement of weight and height
- » Consider chest X-ray if appropriate and if considering tuberculosis
- » Urine for drug screening, also checking for glucose, infections, or pregnancy
- » Confirmatory drug testing to test for PH, specific gravity, creatinine levels to confirm integrity of the sample (see section on drug testing)
- » Blood pressure measurement
- » General impression of respiratory, cardiovascular, and other systems and if any symptoms in these areas
- » Examination of the cardiovascular, respiratory systems, including chest x-rays and pulmonary function tests i.e. peak flow. Examination of gastrointestinal system, including the liver
- » Pregnancy testing

- » Blood borne virus screen to include Hepatitis A, B, C, and HIV (all notifiable infections)
- » Vaccination for Hepatitis A and B, and Tetanus
- » Other blood tests, as appropriate – liver function tests, thyroid function, renal function and haematological indices
- » ECG, if cardiac risk factors or QT prolongation risk

Services should include access to:

- » Needle exchange services, harm reduction, advice and information
- » Adequate doses of OST
- » Provision of structured psychosocial interventions

Also, general measures:

- » Availability of injecting equipment and education to reduce sharing
- » Advice on accessing harm reduction services
- » Regular sexual health screening, particularly if involved in sex-work
- » Testing and vaccination for blood borne viruses offered to all drug users and their sexual partners
- » Testing should be repeated if exposure persists

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Table 4: Infections for which people who inject drugs may be at increased risk

- » HIV infection
- » Hepatitis A
- » Hepatitis B (HBV)
- » Hepatitis C (HCV)
- » Tuberculosis (TB)
- » Skin and soft tissue infections caused by *Staphylococcus aureus* (including methicillin-resistant staphylococcus aureus, MRSA) and streptococcal infections (e.g. endocarditis, necrotising fasciitis)
- » Severe systemic sepsis (e.g. infections with *Clostridium novyi*, *Bacillus anthracis*)
- » STIs other than infection or hepatitis (e.g. chlamydia infection, syphilis, and gonorrhoea)

Table 5: Health promotion for safer injecting behaviour

- » Use a sterile needle and syringe and clean equipment for each injection: 'one needle – one syringe – one time'. Never share or borrow needles, syringes, or other equipment.
- » Be aware of, and prepared for, situations where it may be difficult to prevent infections. For example, if there is a social pressure to share utensils or if the situation is somewhat chaotic when preparing an injection. Enact strategies to reduce the likelihood of unintentional sharing of injecting equipment (such as using colour-coded or labelled syringes).
- » Encourage peers who do not inject not to start injecting. Encourage peers who do inject to use safe injection practices.
- » Wash hands before and after injecting; clean the skin with alcohol or another disinfectant before injecting; use a filter; avoid the use of dangerous injection sites, such as the neck and groin; avoid injecting under the skin or directly into a muscle; and clean all materials, including the table surface, with a disinfectant, following injection.
- » Rather than injecting, use non-injecting routes such as smoking or orally ingesting the drug. Foil or gelatine capsules can be used for these purposes.
- » Prevent overdose by using smaller amounts of drugs (especially after periods of abstinence or less intense drug use), by not using drugs while alone, and by recognising signs of overdose in injecting partners and calling for help immediately upon their recognition. Take care when using drugs from new or unknown sources, and avoid mixing drugs, such as alcohol, benzodiazepines, and opioids. Utilise supervised health facilities for hygienic injecting, if such services are available.

Ref EMCDDA Prevention & control of ID amongst PWID

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4.2.3 Drug testing at assessment phase

» There must be a diagnosis of opioid dependence before a patient is started on OST. This may be assessed through a range of different parameters and criteria, for example, written assessment, collateral history, physical evidence, past knowledge of the patient, and past history of OST treatment

» The recommendation is that at least one random drug test is taken prior to commencement of OST. If the clinician is concerned about the validity of any of the above parameters, additional tests should be carried out. The frequency and type of test required is assessed on an individual basis

» If the clinician is still uncertain of the diagnosis of dependence, additional drug screens may assist in the confirmation of the diagnosis, for example, 6-AM

» If concerns remain, it is prudent to discuss the case with a specialist colleague

4.2.4 Referral to Level 2 GP/HSE Addiction Clinic

For a clinician to make a referral upon assessing dependence to a level 2 GP or to a HSE Addiction Clinic:

» If clinically indicated, a referral is made to either the HSE Addiction service or the GP Coordinator

» If and when the patient is initiated onto OST, it is the responsibility of the Addiction Clinic/Level 2 GP to keep in contact with the referrer

» This should be an ongoing communication within the care planning process

4.2.5 Linkage with the Central Treatment List (CTL) and National Waiting List (NWL) and the National Drug Treatment Reporting System (NDTRS)

On assessment, once the clinician is satisfied that:

» The patient has the capacity to consent to the course of treatment

» The patient's needs can be appropriately addressed by the competencies of the staff at the treatment location

» The patient is not already in receipt of OST. This can be confirmed by contacting the Central Treatment List (CTL)

Either the patient:

» Commences OST, if there is a position available. Priority is given to pregnant women, under-18s, patients with HIV

and serious illnesses, and those who have detoxed and recently relapsed

» Or, if there is not a position available, the patient is placed on the Waiting List for the service (this is overseen by the National Waiting List Coordinator in the CTL)

The National Waiting List (NWL)

» The person will remain on the NWL until the service is in a position to commence their OST. A NWL information sheet (see Appendix 7) should be explained and signed by the patient

» The waiting time is determined by numbers and existing caps in clinics and Level 2 GPs, and on the number of community pharmacy places available

» Once a treatment place becomes available, the person exits the NWL and is registered on the CTL

The Central Treatment List

» Once the decision is made to initiate OST:

- The clinician must send a signed 'CTL Entry Form' (see Appendix 8) to the CTL (with the patient's first and surname) and two signed recent passport sized photographs. The CTL is available 9-5 Monday to Friday

- Further details include patient's recent address, the treatment provider details,

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and pharmacy details (pharmacy details can be provided at a later date)

- » The CTL issues a patient treatment card (for patients receiving OST in a community pharmacy), with a unique patient number, which is sent to the designated pharmacy and a letter is issued to the GP stating the activation date of the card.
- » The CTL records the patient details on the confidential CTL list.

The National Drug Treatment Reporting System (NDTRS)

- » Treatment demand data are collected from practitioners and agencies in Ireland that report to the National Drug Treatment Reporting System (NDTRS).
- » Providers of addiction services must ensure compliance with the NDTRS; they must provide details on the NDTRS form for each new person coming for first treatment, and each previously treated client returning to treatment in a calendar year.
- » The NDTRS reporting form can be downloaded at <http://www.hrb.ie/health-information-in-house-research/alcohol-drugs/ndtrs/information-collected/>.

4.3 PHASE II INDUCTION PHASE

Methadone is the drug of first choice in the treatment of opioid dependence and therefore should be available to everyone who requires it. If methadone and buprenorphine/buprenorphine-naloxone are equally suitable, methadone should be prescribed as the first choice. See Appendix 9 for list of drug to drug interactions with methadone.

4.3.1 Methadone Induction

Methadone:

- » Should be commenced by suitably trained level 2 GPs and HSE addiction Clinic prescribers.
- » Initial dose between 10-40 mg depending on patient assessment.
- » The initial dose should be maintained for at least 3 days to ensure that the effects of the methadone dose can be fully assessed.
- » Requires frequent monitoring and daily supervision of consumption.
- » Patients and their carers should be alerted to signs of an overdose.
- » Watch for drug interactions.
- » Dose increase should be done at a daily max of 5-10 mg and a weekly max of 20 mg.

Starting patients on too high a dose of methadone may result in toxicity and death. Conversely, too low a dosage may cause withdrawal, which may prompt patients to seek relief from other sources, such as illicit opiates and benzodiazepines.

The critical factor in response to methadone is the degree of tolerance to opioids. In individuals with low tolerance, a starting dose, deemed safe for the majority of patients, may prove toxic. In addition, the prolonged half-life (as long as 55 hours in methadone-naïve individuals) and the slow bioaccumulation of methadone accounts for its insidious onset of overdose. During dose increases, serum levels accumulate over several days, even if the dose is kept the same. Therefore, a dose that is barely adequate on day 1 can be toxic by days 3 to 5.

Concurrent use of benzodiazepines, alcohol, and other sedating drugs substantially increases the risk of death from methadone toxicity. The risk of fatal methadone overdose during the first 2 weeks of OST is estimated to be 6 to 7 times higher than that of heroin users who are not in treatment, and 98 times higher than that of patients on maintenance doses of methadone in treatment for longer periods (Caplehorn and Drummer, 1999). See section on drug related deaths.

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» Maintain effective collaboration with other care providers

» Discuss access to naloxone. See section on Dealing with overdose emergency; naloxone

For a range of useful tools and schedules to support community detoxification, see the Community Detoxification Protocols (ALDP, 2011).

Methadone or buprenorphine should be offered as the first-line treatment in opioid detoxification. Neither opioid medicine is more effective than the other in achieving good outcomes from detoxification. Detoxification should be carried out with the medicine on which the patient had stabilised.

4.6.1 Methadone detoxification

If the patient has been stabilised on methadone, the dose can be reduced at a comfortable and acceptable rate to that individual. This should be based on client assessment and on client direction; for example, this could be around 5 mg every one or two weeks. Patients often prefer a faster reduction at the beginning, although there is no evidence to indicate the superiority of a linear or exponential dose reduction.

4.6.2 Buprenorphine/buprenorphine-naloxone detoxification

Buprenorphine doses can be reduced initially by 2 mg every two weeks or so, with final reductions being around 400 micrograms. Patients report being able to reduce buprenorphine doses more quickly than methadone.

4.6.3 Drug testing at detoxification phase

» Drug testing is one of a range of parameters used by clinicians within the detoxification phase. Other parameters include clinical review, patient self-report and collateral drug history.

» The recommendation is that at least one random drug test be taken per month, used in conjunction with other parameters.¹⁸

4.6.4 Frequency of supervision

» A reduction from daily supervised consumption can be considered,¹⁹ depending on clinical assessment and patient need.

» No more than 6 days should be prescribed to take home, except for holidays.

¹⁸ Note some residential services may require additional screening.

¹⁹ With the exception that OST administration in prison should be dispensed for supervised consumption only.

4.6.5 Symptomatic treatment of withdrawal

Prescribing symptomatically can reduce some of the physical effects of withdrawal (See Appendix 10 for drugs that may help symptoms in the end stages of detoxification). There is no systematic evidence that any of these medicines work to improve outcome but they may be useful for the clinician in situations where it is not possible to prescribe effective opioid substitution. Particular care is needed concerning the risks of polypharmacy and appropriate supervision and support should be paramount in such cases.

Lofexidine is a non-opioid alpha-adrenergic agonist and is not a controlled drug. It is an unlicensed medicine for use in opioid detoxification and is used predominantly within prisons and specialist treatment centres.

4.6.6 Relapse prevention

Addiction is a chronic relapsing condition and therefore relapse is common during treatment. For some patients, the period of relapse is short and they quickly regain stability again. This always requires careful re-evaluation and care planning. For some patients, this may require re-induction and stabilising.

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Chapter 5: Drug Testing

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5.3 Why and when drug testing can be useful

5.4 Choosing an appropriate drug test

5.5 Procedures for drug testing

5.6 Urine sample adulteration

5.7 Supervision of the provision of urine samples

5.8 Testing for Alcohol

5.9 Testing for Z-drugs

- » To monitor illicit drug use
 - » As a motivational tool to support recovery
- » To document periods of abstinence and evidence to support progress in treatment
- » To assist in contingency management interventions, e.g. deciding on takeaway doses
- » To re-evaluate treatment plans
- » To identify substance use disorders in pregnant women
- » To facilitate other agencies in assessing progress in treatment e.g. criminal justice and child welfare agencies. This is on the understanding that drug test results should not be considered in isolation in determining progress.
- » It may assist in detecting and monitoring emerging trends in substance use

The rationale for drug testing and the results of those tests should be clearly delineated to those responsible for service user care to ensure cost-effectiveness and maximise usefulness. The service user should be informed of the reasons for this measure.

Drug testing should be viewed as an informative measure, and not as a reason for punitive action towards the service user.

Repeated positive urine drug test results imply a treatment plan may not be working effectively and that another approach should be considered. Efforts to reduce a client's substance use by monitoring drug test results are most effective where open communication is practised between the person and the care team.

Drug testing to confirm drug use when a patient has already self-reported use is generally not cost-effective or regarded as necessary practice. A combination of self-reporting and drug testing is more useful than either alone.

5.4 Choosing an appropriate drug test

Most drug testing processes consist of two separate types of analysis: a drug screening and a confirmation test. In most clinical situations, the most practical and cost-effective option for screening purposes is the use of a randomised drug testing regime.

Many licit and illicit drugs can be misused, but not all can be targeted by routine screening. Testing regimens generally target commonly misused drugs or drug groups. Where more specific testing is required, confirmatory analysis should be used.

See Appendix 11 for different matrices for drug testing, and Appendix 12 for the

approximate durations of detectability of selected drugs in urine/oral fluid.

5.4.1 Drug Screen:

The screening test is less time consuming and is designed to easily identify negative results. An immunoassay system is used, either in the laboratory or using point of care tests (POCT). With these tests, a negative result can be reliably accepted as negative. However, although a positive result is reliable, the chance of a false positive cannot be ruled out due to possible cross reactions.

The most convenient drug screening test used in general practice is a urine POCT. This dipstick test provides immediate results. The advantages of this type of testing are that it is less time consuming than other tests and it is designed to easily identify negative results.

Cross reactivity: Care should be taken when interpreting immunoassay screening results, as some over-the-counter codeine-containing products, or prescribed opioid based medication, will give an opioid positive result.

If a patient has used ecstasy or New Psychoactive Substances (NPS), they may test positive for amphetamines.

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Chapter 6: OST and associated health considerations

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6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

Table 6: Responses to continued drug or alcohol misuse when patients are on OST (adapted from Drug misuse and dependence, UK guidelines on clinical management, 2007)

Scenario	Risks	Possible Reason	Responses to consider
Opiate misuse on top of OST	<ul style="list-style-type: none"> • Overdose • Blood-borne viruses and other infections if injecting • Continued offending and involvement in drug-misusing lifestyle • Impairing engagement 	<ul style="list-style-type: none"> • Inadequate dose • Medication unsuitable • Patient on reducing regimen • Patient using heroin and/or other opiates on effective dose of OST 	<ul style="list-style-type: none"> • Dose assessment, increase dose • Change medication regimen • Transfer patient to maintenance regimen • Review psychosocial interventions • Review contingency management, plus urine tests and supervised consumption • Provide harm reduction interventions • Address social functioning domains (including housing, employment and relationships) within a shared care approach
Crack cocaine and cocaine and/or other stimulants on top of OST	<ul style="list-style-type: none"> • Blood-borne viruses and infections if injecting • More chaotic drug misuse • Increased crime • Psychological problems • Overdose 	<ul style="list-style-type: none"> • Recreational use • Patient dependent on cocaine or crack cocaine 	<ul style="list-style-type: none"> • Review psychosocial interventions. • Review contingency management, plus urine tests and supervised consumption • Provide harm reduction interventions • Address social functioning domains (including housing, employment and relationships) within a shared care approach • For stimulant users, the strongest evidence for effective psychological treatment is for CBT approaches, including motivational interviewing, relapse prevention, community reinforcement approach, and contingency management; suggests a combination of approaches as being the most helpful

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» It is important to distinguish between substance-induced and substance-related psychosis.

» It is advisable to allow three to four weeks of abstinence before making a diagnosis of a psychiatric disorder.

» Stimulants such as cocaine, ecstasy, and amphetamines are significant causes of psychosis and paranoia, however any psychoactive drug used to excess can cause these symptoms.

» Use of NPS has also been implicated in the development of psychosis in individuals.

» The main forms of psychosis that are not substance-induced are schizophrenia and bipolar disorder.

» Substance use, particularly with NPS, with these disorders is common and can precipitate an acute episode.

» The occurrence of substance induced psychosis in some individuals may indicate an 'at-risk' mental state, and they are at risk of developing schizophrenia.

If it is clinically indicated that psychosis is substance-related, and not substance-induced, consider referral for specialist psychiatric assessment.

Personality Disorders

» Personality Disorders are long-standing and maladaptive patterns of perceiving and responding to other people and stressful circumstances.

» The two subtypes most researched are Emotionally Unstable Personality Disorder and Dissocial Personality Disorder.

» High-risk behaviour can persist, despite successful opiate treatment.

» Patients with Personality Disorders can be offered the same range of treatment to those without Personality Disorders.

» Management includes the use of limit setting and therapeutic contracts. Scheduling of brief, structured, and frequent visits may be helpful.

» There is no specific pharmacological treatment for Personality Disorders.

» Collaborative care planning with other service providers can be indicated.

6.4 Viral Infections

6.4.1 Hepatitis A

» Commonly transmitted by fecal-oral contamination.

» Usually self-limiting and requires no treatment, unless occurring with another disease e.g. Hepatitis B or C.

» Based on current evidence, it is recommended that injecting drug users are vaccinated against Hepatitis A.

» The combined Hepatitis A and B vaccines may improve uptake.

» Hepatitis A (acute) infection is a notifiable disease.
See www.hpsc.ie/hpsc/NotifiableDiseases

6.4.2 Hepatitis B

» May present with flu-like illness or may be asymptomatic in early stages.

» May be discovered by abnormal liver function test results and subsequent positive Hepatitis B blood test.

» Initial assessment of any drug user should include history of Hepatitis B vaccination and results of screening for Hepatitis B.

» Vaccination for Hepatitis B should be carried out for all those at risk and records of these vaccinations should be kept.

» Hepatitis B (acute and chronic) infection is a notifiable disease.
See www.hpsc.ie/hpsc/NotifiableDiseases

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6.4.3 Hepatitis C

- » Most patients are asymptomatic during early stages of infection, but others can suffer from nausea, fever, vomiting, or jaundice.
- » 20-30% of those infected will spontaneously clear the virus, 70-80% may become chronically infected.
- » Recent developments in non interferin based treatments has dramatically improved treatment outcomes. All chronically infected Hepatitis C patients should be referred for consideration for these new treatments.
- » Chronic infection can lead to cirrhosis, liver failure, and/or hepatocellular carcinoma.
- » When a patient tests positive for Hepatitis C antibody, further blood tests should be carried out. It is recommended that Hep C antigen and liver function tests should be done in primary care and community drug services. Patients who are antigen positive should be referred to specialist services for PCR blood testing, Fibro scanning, and consideration for treatment.
- » Counselling prior to screening for Hepatitis C is no longer routine.
- » All patients who are at risk of contracting Hepatitis C should be given information and advice on the disease and how it is transmitted.

- » It is recommended that all drug users are screened for Hepatitis C, even if they are not intravenous drug users.
- » Early detection and early referral of all active Hepatitis C cases to secondary care is now recommended.
- » Patients who continue to inject drugs or misuse alcohol should not be excluded from treatment because of these behaviours.

- » Risks of concurrent alcohol use should be explained to all Hepatitis C positive patients. Alcohol has been shown to be a significant risk factor in the development of cirrhosis in patients who are chronically infected with Hepatitis C.
- » Hepatitis C infection is a notifiable disease. See www.hpsc.ie/hpsc/NotifiableDiseases

Disease progression in Hepatitis C infection

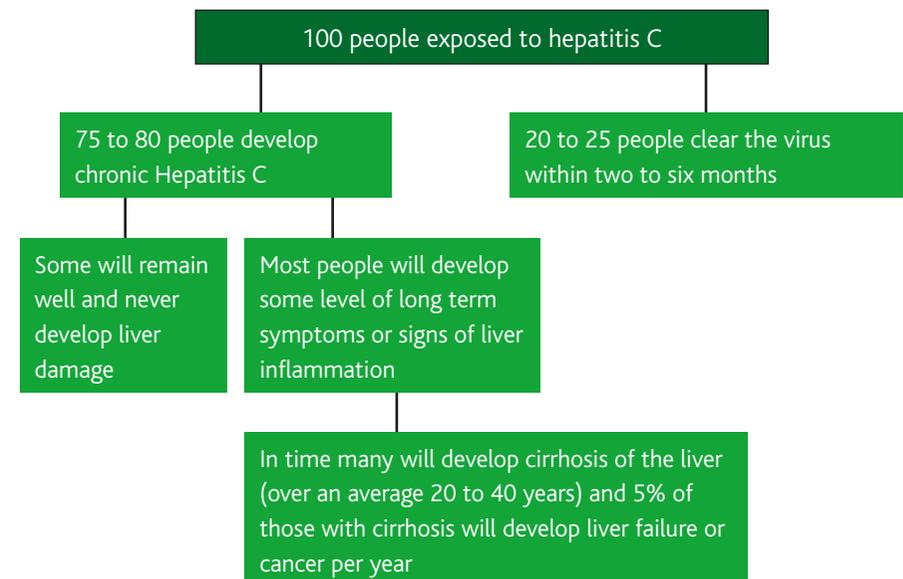


Figure 2: Disease progression in Hepatitis C infection (Source: RCGP Hep C guidance)

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6.4.4 HIV

- » All service users should be offered education and prevention advice on HIV transmission, safe injecting, and safe sexual practises.
- » Among people who inject drugs, HIV is passed by sharing equipment used for intravenous drug use, as well as through unsafe sexual practices.
- » Increased risk of HIV transmission in injecting drug users has been associated with injecting synthetic cathinones and homelessness.
- » Some newly infected people experience flu-like symptoms, develop a rash, and/or lymphadenopathy; others may have no symptoms.
- » All drug users entering OST should be offered a HIV anti-body blood test. Patients should be regularly reviewed for HIV risk behaviour and repeat tests offered, as clinically appropriate.
- » On site point of care and salivary antibody testing may be considered for screening at risk or hard to reach populations. All reactive test results must be confirmed using a laboratory-based confirmatory test, as a small number of people who are not HIV infected will produce a positive (reactive) result. The importance for confirmatory testing at an approved HIV testing laboratory needs to be emphasized to rule

out the possibility of a false-positive result in the rapid HIV test and to confirm a true positive result.

- » PCR testing may be considered if a clinician has concerns about more recent infection
- » All service users who are HIV infected should be referred to specialist hospital based services for ongoing monitoring of CD4/ viral load and antiretroviral therapy.
- » For chaotic /non-adherent service users, directly observed therapy may be considered.
- » Changes in drug use patterns may increase HIV transmission risks in certain categories of drug users. The Health Protection Surveillance Centre (www.hpsc.ie) identifies high risk populations and targets areas for intervention.
- » HIV infection is a notifiable disease. See www.hpsc.ie/hpsc/NotifiableDiseases

6.5 Hepatitis A and B vaccinations (Department of Health Immunisation Guidelines for Ireland 2012) see summary tables Appendix 15

- » Hepatitis A and B can be given as combined or separate vaccines.
- » Hepatitis A, if given on its own, is a single dose, with a booster at 6-12 months. This results in immunity beyond 10 years.

» Immunity against Hepatitis A is the same whether gained by combined Hepatitis A and B vaccine or Hepatitis A vaccine alone.

- » Immunity against Hepatitis A is the same whether gained by routine or accelerated schedule.
- » The Hepatitis B vaccine requires a series of doses following the routine schedule (0, 1, 6 months), or an accelerated schedule (0, 7, 21 days, 12 months).
- » If offering Hepatitis B vaccination on its own, it is recommended that individuals at risk of infection are offered a single booster once at 5 yrs. Measuring Hepatitis B immunity is not required before or after this booster.
- » The combined Hepatitis A and B vaccine requires a series of doses following the routine schedule (0, 1, 6 months), or an accelerated schedule (0, 7, 21 days, 12 months).
- » Testing for immunity after vaccination is recommended only for persons whose subsequent clinical management or occupational risk depends on knowledge of their immune status.
- » Such persons include immunocompromised people and sex or needle-sharing partners of HBsAg-positive persons.

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» Testing should be performed 2 months after the last dose of vaccine.

» About 10% of patients fail to respond adequately to three doses of the Hepatitis B vaccine. This is more common in those over 40 years of age, obese people, and in smokers. Poor response is also reported in alcoholics and in advanced liver disease.

» Ideally, after the vaccination course, Anti-HBs levels of >100mIU/ml would be achieved, levels >10mIU/ml are generally accepted as enough to protect against infection.

» Both the Hepatitis B and Hepatitis A and B combined vaccines are inactivated and so are considered safe in pregnancy and for patients with HIV. These groups may not mount the same immune response, and may need further boosters.

» It is recommended that vaccination should be offered to the children and sexual partners of those at high risk.

» It is important that vaccination does not encourage relaxation of other measures designed to prevent exposure to blood borne viruses, for example, condom use and needle exchange.

» All health workers should be vaccinated for Hepatitis A and B.

6.6 Health implications and interventions for continued alcohol and drug use when patients are on OST

6.6.1 Alcohol

Problematic alcohol use is a significant risk factor for drug users on OST due to:

» It being a significant cause of death due to alcohol overdose, inhalation of vomit, hypoglycaemia, and accidents or violence

» It increases the dropout rates from treatment

» It increases risk of hepatic cancer in people with Hepatitis C

» One third of patients receiving methadone have been identified as having a current drink problem.

The National Treatment Outcomes Research Study (Comiskey *et al.*, 2009) found 24% of the cohort at the start of the study were drinking above Department of Health recommended limits, and 25% were doing so at the five-year follow-up. Some, 8%, were drinking at harmful levels.

About one-third of patients receiving methadone have been identified as having a current drink problem, and a further one-sixth

have a history of a drinking problem. It follows that clinicians working with drug users require:

» An awareness that alcohol misuse is not separate from misuse of other drugs

» Competence at detecting problem drinking

» The ability to give harm reduction and educational messages regarding misuse of alcohol

» The ability to manage alcohol misuse emerging alongside pharmacotherapies, such as substitute prescribing

It may be clinically helpful to think of different patterns of drinking associated with drug misuse:

» Drinking that is substantially independent of other drug misuse

» Drinking that is interchangeable with the use of other psychoactive drugs.

» Drinking and other other drug misuse, as a supplement to a substitute prescription

Assessment of the cumulative effects of high-risk behaviours and polydrug use requires repeat assessment by an experienced clinician. Opiate users who are chronically intoxicated with alcohol are difficult to manage. Some strategies to deal with the problems are outlined in the section on responding to failure to benefit from treatment (section

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5.5). As the risks of prescribing opioids, in conjunction with high levels of alcohol use, need to be balanced against the benefits of retaining the patient in treatment, specialist competencies are required.

Interventions:

- » An alcohol screen and appropriate intervention in line with the HSE National Screening and Brief Intervention (SAOR) Programme; the level of brief intervention is dependent on the score someone receives. See <http://www.hse.ie/eng/services/Publications/topics/alcohol/alcoholscreening.html> for the SAOR Guideline Framework, alcohol screening tools, and support materials.
- » The standard interventions for problem alcohol use and dependence apply for patients on OST (see Table 6).
- » Consider a care plan towards alcohol detoxification, either in-patient or out-patient, psychological interventions, pharmacology to prevent relapse, and supplements to prevent vitamin deficiencies problems.
- » Minimise polypharmacy, particularly with benzodiazepines.
- » Provide posters with information on supports, such as Narcotics Anonymous, Alcoholics Anonymous, SMART Recovery etc.

6.6.2 Benzodiazepines and Z-compounds

Doctors should familiarize themselves with the recommendations of the Benzodiazepine Best Practice Guidelines, published by the Department of Health and Children in 2002.²⁵ These commonly prescribed drugs do cause tolerance and dependence. Initiation should be avoided in substance misusers. For a range of useful tools and schedules to support community detoxification, see the Community Detoxification Guidelines (ALDP, 2015).

They are often taken in large quantities:

- » To enhance other drug effects
- » To help manage withdrawals from other drugs
- » As a form of self-medication for anxiety & mood problems

Actions:

- » Identify those who qualify as having a dependence on benzodiazepines.
- » Assess if they also may have anxiety or mood symptoms.
- » Avoid double prescribing, by liaising with their community GP.

²⁵ www.drugs.ie/resourcesfiles/reports/DOHC_Benzo_committee.pdf

- » Prescribing to attenuate benzodiazepine withdrawal symptoms should only occur when there is evidence of dependence.
- » Clear treatment goals should be agreed and documented.
- » Regular patient review, and dispensing and supervision should follow a schedule similar to that for other drugs of dependence, including daily dispensing and supervised consumption.
- » Aim to convert other BDZ and sedative hypnotics into an appropriate dose of diazepam.
- » Aim for the lowest dose of diazepam that will prevent withdrawal symptoms.
- » To minimize diversion, prescribe in 2mg doses.
- » Only very rarely should doses of more than 30mg diazepam per day be prescribed.
- » Patients that are likely to need in excess of this dose should be considered for referral for inpatient medically assisted detoxification, in either St. Michaels, Beaumont or Cuan Dara, IPU Cherry Orchard Hospital.
- » Aim to prescribe a reducing regimen for a limited period of time, reducing slowly, at a rate of 2-2.5mg every fortnight.

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» OST dose should be kept stable throughout the benzodiazepine reduction period.

» Consider adjunctive therapies where available.

Patients should be advised to:

» Reduce their use of benzodiazepines to an equivalent dose of diazepam 10mg TDS/ QDS daily i.e. between 30 and 40mg of diazepam daily as an outpatient.

» Not to take extra benzodiazepines while prescribed a benzodiazepine detoxification programme.

» Benzodiazepine withdrawal symptoms include anxiety, agitation, insomnia, tension, sweating, and sensory and perceptual distortions.

» That concurrent use of benzodiazepines and other opioids, including methadone and heroin, may increase the risk of sedation, respiratory depression, risk of overdose, and death.

» That benzodiazepine use is associated with decreased reaction time and impaired motor co-ordination that may lead to accidents and injuries.

» That any prescription above 30 mg diazepam daily, or consumption above the doses recommended in the SmPC and BNF for the individual medications, constitutes misuse for driver licensing purposes.

Benzodiazepine agonist drug	Half Life of Parent Drug (hours)*	Speed of onset	Equivalence to diazepam 5mg**	Use
Chlordiazepoxide	5-30	Slow	15mg	Anxiety
Diazepam	20-100	Rapid	5mg	Anxiety/Insomnia
Loprazolam	4-15	Slow	0.5mg (to 1mg)	Insomnia
Lorazepam	10-20	Intermediate	0.5mg ***	Anxiety/Insomnia
Lormetazepam	11	Intermediate	0.5 (to 1mg)	Insomnia
Nitrazepam	18-25	Rapid	5mg	Insomnia
Oxazepam	4-15	Slow	15mg	Anxiety
Temazepam	8-22	Intermediate	10mg	Insomnia
Zaleplon	1	Rapid	10mg	Insomnia
Zolpidem	2	Rapid	10mg	Insomnia
Zopiclone	5-6	Rapid	3.75mg	Insomnia

*Some variation between individuals

**Equivalence as BNF and Clinical guidelines

***Approximately equivalent oral dosage from other sources

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Anxiety symptoms <small>(can mimic symptoms the drug was first taken for and also appear on rebound as drug stopped)</small>		Distorted perceptions <small>(usually a sign of drug withdrawal, rather than anxiety)</small>	Major incidents <small>(occurs especially when high doses are stopped abruptly)</small>
Psychological	Physical		
<ul style="list-style-type: none"> » Anxiety » Panic attacks » Insomnia » Poor memory » Depression » Paranoia » Intrusive memories » Cravings » Nightmares » Excitability » Agoraphobia » Social phobia » Obsessions » Rage, aggression » Irritability 	<ul style="list-style-type: none"> » Agitation » Tremor » Headache » Weakness » Dizziness » Nausea » Vomiting » Diarrhoea » Constipation » Palpitations » Rashes » Tingling, numbness, altered sensation » Fatigue » Flu-like symptoms 	<ul style="list-style-type: none"> » Hypersensitivity to sound, light, touch, taste, etc. » Abnormal body sensation, e.g. itching, widespread pain & stiffness, blurred vision, paraesthesia, muscle twitching, tinnitus, burning sensations, etc. » Feeling self or world to be abnormal » Depersonalisation 	<ul style="list-style-type: none"> » Fits (1-2% of patients, esp. if stopping high dose abruptly) » Delirium (rare) » Transient hallucinations (visual, tactile, auditory) or illusions (rare) » Psychosis (very rare)

(Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice, 2014)

6.6.3 Stimulants (cocaine & amphetamines)

- » The mainstay of treatment is psychological. There are no substitute pharmacological interventions recommended.
- » Give safe injecting advice where appropriate.
- » Consider careful management in patients who use cocaine while on OST, such as no take home doses.
- » Observe for significant psychiatric symptoms, as withdrawal may be associated with significant depression, and suicidal risk.
- » Be cautious when prescribing SSRIs, as toxic reactions have been described while cocaine or amphetamines continue to be taken.
- » Treatment of young people may require: full mental health assessment, treatment and careful monitoring, with close liaison with CAMHS or other mental health team.

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6.6.4 Cannabis

- » Withdrawal may precipitate sleep disturbance, irritability, cravings, weight loss, vivid dreams etc. and these may require brief symptomatic management
- » Prescribing benzodiazepines should be avoided.
- » Cannabis can exacerbate existing mental health problems and if there is any evidence of psychosis, a full mental health assessment is required.
- » Psychosocial interventions are recommended for young cannabis misusers.

6.6.5 Tobacco

Most patients in drug treatment smoke and this is often the only drug dependence that is not addressed. This is despite smoking-related diseases being highly prevalent in drug misusers, with a likelihood of causing premature death. Smoking may act as a cue for the misuse of other drugs that are consumed in the same way. Therefore, smoking may increase the risk of relapse into drug misuse.

Smoking cessation in drug treatment

Evidence suggests smoking cessation may be associated with improved drug treatment outcomes. Similar processes apply to smoking cessation treatment as to treatment for other types of drugs, such as coping with cravings and preventing relapse. Despite this, most drug treatment services do not offer smoking cessation. This may be because staff have not been appropriately trained, or believe it may interfere with drug treatment or are tobacco smokers themselves, or it may result from a lack of evidence and clinical experience of using smoking cessation treatments in this patient group. However, societal attitudes are changing and the smoking bans introduced across Ireland in 2004, and in the UK three years later, may increase the demand for treatment for tobacco dependence among drug misusers.

Treatment options

There is a large evidence base for the effectiveness of smoking cessation treatment in the general population and in prisons, with the best outcomes from a combination of behavioural support and pharmacological interventions, such as nicotine replacement therapies, bupropion, and varenicline. In the absence of evidence to the contrary, it seems likely that drug misusers will respond to the same treatments as the general population,

although they may need more intensive options to achieve the same results.

Given the high rates of smoking and the low quit rates in drug misusers, it may be reasonable to consider harm reduction approaches to smoking, such as replacing cigarettes with clean nicotine in the form of patches for some of the day. This may be particularly useful in alleviating the symptoms of tobacco withdrawal while a patient is in a residential or inpatient drug treatment facility.

Clinicians should encourage patients to stop or reduce their smoking and refer them to smoking cessation services. See www.quit.ie.

6.7 Pain management for drug misusers

The most common causes of pain are back pain, arthritis, and headache; all increasing in prevalence with age. Acute pain commonly occurs in drug users, as they have a higher risk of physical illness and injury.

Pharmacological intervention is only one aspect of pain management and non-pharmacological interventions such as CBT should be considered for drug users.

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6.9.1 Overdose

- » The induction period for OST and the early part of treatment are both associated with a high risk of overdose, as tolerance can be difficult to assess.
- » Similarly, the period after leaving treatment, either after detoxification or with the sudden cessation of treatment, are associated with an increased risk of death.
- » The risk of overdose is especially high following release from prison if tolerance has been reduced, they have a history of intravenous drug use, and/or a long history of opioid dependence or polydrug use.
- » Those who are out of treatment are approximately three times more likely to die than those who are stable in treatment (Farrell and Barry, 2010).

6.9.2 Reducing drug-related deaths

- » Be aware of those most at risk.
- » Provide easy and timely access to treatment.
- » Retain people in treatment.
- » Provide education and training to drug misusers and their families, on the risks of overdose and how to respond effectively.
- » Advise on the dangers of combining drugs, especially alcohol and benzodiazepines.
- » Educate new patients on the risks of loss of tolerance.
- » Use appropriate supervised consumption in the early stages of OST.
- » Confirm satisfactory home storage arrangement and document this, especially when children are in the home.
- » Conduct or arrange a mental health assessment for anyone with a suicidal risk.
- » Liaise effectively with the prison regarding transfer of care.
- » Have an emergency protocol in place that covers the management of drug overdoses.

6.9.3 Dealing with overdose emergency; naloxone

- » Treat opiate overdose with standard resuscitation techniques and naloxone.
- » Naloxone is given 0.4-2.0 mg IV/IM/SC, and this can be repeated every 3-4 minutes up to a maximum of 10 mg.
- » The half-life of naloxone is much shorter than methadone or buprenorphine.
- » Patients should be helped to understand that they are at risk of life-threatening sedation when naloxone wears off.
- » This should be made clear to patients, especially in emergency departments and other situations where the patient may leave suddenly.

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» Transfer of care on admission and discharge requires coordinated response by all professional staff.

» Planned admissions to hospital are preferable.

Substitute opioids or other controlled drugs should only be prescribed following an adequate assessment. The aims of this assessment are:

» To enable treatment of emergency or acute problem or enable elective procedure to take place.

» Confirm the patient is taking drugs; history, examination and urine analysis.

» Identify the degree of dependence; opioid withdrawal signs may be observed.

» Identify complications of drug misuse and evaluate risk behaviour; blood borne virus tests, nutrition, alcohol intake.

» Consider psychiatric comorbidity.

For patients currently being prescribed methadone or buprenorphine, good communication between hospital and community is essential for safe patient care. Prescribing in these cases should be a relatively straightforward matter of continuing the usual dose of OST while in hospital. The OST dose needs to be independently verified

through the CTL, the community pharmacist, and the patient's methadone prescriber.

For patients not on OST, or where there is uncertainty about recent compliance, particular care must be exercised in initiating OST.

Initial dosing schedule for opiate dependent patients admitted to hospital:

» Only prescribe following assessment, as described above.

» Polydrug and alcohol misusers may develop multiple withdrawal syndromes, so these may need to be differentiated to prioritise treatment.

» Methadone may initially mask alcohol or benzodiazepine withdrawal symptoms.

» Exercise particular care in cases of respiratory disease, head injury, and liver diseases.

» Exercise care when prescribing additional drugs such as sedatives.

» When it is appropriate to initiate opioid substitution in hospital to manage risk of withdrawal, methadone is usually preferred over buprenorphine.

» Induction should follow the protocols previously described for induction (see section 3.10). However, close supervision in hospital may allow for a modified protocol.

» Signs of intoxication, such as drowsiness, slurred speech, or constricted pupils indicate a need to discontinue the drug or reduce the dose.

» Hospitals should contact community drug treatment services before prescribing buprenorphine products to ensure continuity after discharge as approval from PCRS is required before buprenorphine products can be reimbursed in a community setting for the treatment of opioid dependence (see section 3.3.2).

7.4.1 Other drugs of misuse

Opioid dependant patients in hospital may commonly be taking other drugs and misusing alcohol.

» The misuse of benzodiazepines or alcohol may lead to associated withdrawal symptoms and seizures.

» Benzodiazepine prescribing should only be initiated once dependence has been established by history taking, by noting symptoms of withdrawal and by urine analysis.

» In the inpatient setting, it is appropriate to provide a slow withdrawal regimen over one to four weeks, with a starting dose of diazepam of no more than 30mg daily, given in divided doses.

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- » Patients may also require concurrent detoxification from alcohol.
- » Routine prescribing of benzodiazepines as hypnotics and as anxiolytics should be avoided while in hospital.

7.4.2 Discharge from hospital

For drug misusers not previously in treatment, attendance at the emergency department or hospital admission may present a window of opportunity to put them in touch with other services.

On discharge, the following information should be given:

- » General health promotion advice.
- » Contacts for further help, such as needle exchange, drug treatment services, or self-help groups.
- » Advice on preventing overdose.
- » Advice on reducing the risk of blood-borne viruses and Hepatitis B vaccination.
- » Advice of loss of tolerance in hospital

If the patient was admitted on an opioid prescription from the community, this should be continued on discharge and prescribing responsibility transferred back to the GP or HSE addiction clinic. Planned discharge is

best done in collaboration with local drug treatment service, the GP, and the community pharmacy. See section 3.8, Referral procedure, for change of treatment location.

On the day of discharge confirm the following for the community services:

- » Whether that day's dose has been given and how much was given.
- » Any other drugs that the patient is being prescribed.
- » Patients should receive their dose on the day of discharge and contact should be made with their GP and community pharmacy to confirm that they have had that day's dose.
- » Arrangements should be made in advance of discharge to ensure the patient has a place in a community pharmacy to receive their methadone and a place with a methadone prescribing GP.

7.5 Pregnancy and neonatal care

Women who are pregnant or who may become pregnant are high priority for interventions to reduce drug use. Women may be more prepared to change drug using behaviour if they are pregnant. Substitute prescribing can occur at any time in pregnancy and carries a lower risk than continuing

illicit drug use. It allows engagement and identification of health and social needs, and also offers opportunity for interventions and advice to improve outcomes.

All women with problematic substance use should be made aware of the benefits of antenatal care and advised to attend early in pregnancy. Research suggests that women who misuse substances have better outcomes, as do their infants, if they take up antenatal care early and they use services consistently throughout pregnancy. However, pregnant women, with substance misuse problems, can be subjected to social disapproval and judgemental attitudes. Discriminatory professional practice deters women from seeking help.

Drug using women of child bearing age should be offered pregnancy test, as amenorrhoea is common in female opiate users, and symptoms of opiate withdrawal may mimic early pregnancy.

If a pregnancy test is positive, a referral to a crisis pregnancy agency may be appropriate. Referral also may be appropriate to the Drug Liaison Midwife service connected to the three Dublin Maternity hospitals.

Drug misusing women are often at risk of domestic violence and at high risk of antenatal and postnatal mental health

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