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

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Version Control

Version	Date	Comments/Change
1.0	19 March 2020	
2.0	23 March 2020	Added caution about using > 1 sedative agent – (i.e. methadone for opioid dependence and chlordiazepoxide for alcohol withdrawal)
3.0	25 March 2020	Added recommendations to consider buprenorphine as first line choice given respiratory comorbidity and reduced risk of overdose
4.0	2 April 2020	Added in comments from Steve Taylor. Advised caution with regards UDS and updated national picture of relaxed supervised dispensing and pick up frequency

Table of Contents

1. Introduction

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

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

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

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

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

2. Aims and Objectives

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

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

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

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

   If the answer is NO then:

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

   If the answer is NO then:

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

Question One:

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

You need to confirm that the person is both:

A) Prescribed OST
B) Taking their prescribed OST
C) Cannot continue their prescription with their existing local service and need prescribing to be taken over

In order to do this, you must confirm:

1. The person reports receiving OST, and has not missed any doses in the last three days
2. The pharmacist responsible for dispensing the OST or the prescriber responsible for prescribing OST confirms that the patient has a valid OST prescription
3. The pharmacist responsible for dispensing OST confirms that the person has collected their prescription as directed
4. There are no clinical signs of opiate toxicity: intoxication, sedation or constricted pupils

NB This guidance is in light and in response to a national relaxation of supervised consumption and pick-up frequency rules regarding OST.

Urine Drug Screening (UDS) should be kept to a minimum, as many people with opioid dependence have comorbid renal pathology which could lead to an increased risk of COVID19 transmission, where people are infected with the virus. If UDS are used they should be conducted using adequate Personal Protective Equipment (PPE)

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

DOSES SHOULD BE WITHHELD IF THERE IS ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

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

Question Two:

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

You need to confirm the person is both:

A) Dependent on opioids
B) Suitable for OST treatment

In order to do this, you must confirm:

1. The person reports using opioids (heroin, methadone, buprenorphine etc.)
2. The person meets ICD criteria for opioid dependence (see appendix 10.2)
3. There is objective evidence of opioid withdrawal (e.g. using Clinical Opioid Withdrawal Scale (COWS) (See appendix 10.3)

Urine Drug Screening (UDS) should be kept to a minimum, as many people with opioid dependence have comorbid renal pathology which could lead to an increased risk of COVID19 transmission, where people are infected with the virus. If UDS are used they should be conducted using adequate Personal Protective Equipment (PPE)

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

DOSES SHOULD BE WITHHELD IF THERE IS ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

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

Question Three:

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

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

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

4. Initiation of Opioid Substitution Treatment (OST):

If you have determined that a person is suitable for initiation of OST your choices are to initiate methadone oral solution 1mg/1ml or buprenorphine sub-lingual tablet or oral lyophilisate, 2mg or 8mg.

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

In this setting buprenorphine should be considered the first line choice given the risk of COVID-19 respiratory co-morbidity, and the reduced risk of overdose

Caution is advised if prescribing > 1 sedative agent i.e. OST for opioid dependence and chlordiazepoxide for alcohol withdrawal

4.1 Methadone Induction Regimen:

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

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

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

Doses above 20mg should be discussed with an experienced prescriber, there have been reports of iatrogenic deaths in opioid naïve people at doses of 20mg once daily

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

Increment should be no more than 10mg per day

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

The target methadone OST maintenance dose in subsequent weeks is 60-120mg orally once a day.

DOSES SHOULD BE WITHHELD IF THERE IS ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

4.2 Buprenorphine Induction Regimen:

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

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

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

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

Aim to titrate in 4mg increments every 3 days

WEEK 1: No more than 16mg total daily dose

The target buprenorphine OST maintenance dose in subsequent weeks is 12-16mg s/l od and up to 32mg

DOSES SHOULD BE WITHHELD IF THERE IS ANY SIGN OF INTOXICATION/SEDATION/CONSTRICTED PUPILS

5. Naloxone

All people who are using opiates must have naloxone supplied.

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

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

Call an ambulance
Check breathing and put in recovery position
Give 400 micrograms naloxone IM and repeat after 2-3 mins if not breathing

6. Medication Storage

All OST are controlled drugs and a person's supply should be stored in an individual's secure locked box on the premises, preferably in the persons room

7. Needle and Syringe Availability

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

All people should be provided with sharps bins and advice on how to dispose of needles, syringes and equipment safely. These can be collected and disposed of by hotel healthcare staff.

8. Overall Prescribing Flow Chart

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

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

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

You need to confirm that the person is both:

A) Prescribed OST

B) Taking their prescribed OST

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

Are all four conditions described above met?

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

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

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

You need to confirm that the person is:

A) Dependent on opioids

B) Suitable for OST treatment

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

Are all four conditions described above met?

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

Induction OST Regimen

Buprenorphine should be considered first line given the risk of COVID-19 respiratory co-morbidity, and the reduced risk of overdose

Buprenorphine (Subutex™)

People should be heroin free for 12 hours and methadone free for at least 24 hours before starting

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

DAY 1: First Dose: Prescribe up to a maximum of 8mg

If tolerance unclear or amount of use unclear = 2-4mg

If regular heroin or OST user = consider starting at 4mg

If recent intravenous user = consider starting at 4-8mg

Aim to titrate in 4mg increments every 3 days

WEEK 1: No more than 16mg total daily dose;

Target buprenorphine maintenance dose 12-16mg s/l od

Methadone

If in withdrawal prescribe 1mg/1ml sugar free methadone mixture PO as a STAT dose;

Never prescribe as a PRN medication

DAY 1: First Dose: Prescribe up to a maximum of 30mg

If tolerance unclear or amount of use unclear = 10mg

If regular heroin or OST user = consider starting at 20mg

If recent intravenous user = consider starting at 30mg

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

Increment should be no more than 10mg per day

WEEK 1: No more than a 60mg total daily dose;

No more than three dose increases per week

Target methadone maintenance dose 60-120mg PO od

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

CAUTION IF PRESCRIBING > 1 SEDATIVE AGENT (E.G. CHLORDIAZEPOXIDE + OST)

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

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

9. Appendices

Appendix 9.1 **Length of drug detection times in urine**

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

Appendix 9.2: **ICD-10 criteria for opioid dependence**

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

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

Appendix 9.3 **Clinical Opioid Withdrawal Scale 'COWS'**

Clinician rated scale; 11 items; Maximum Score 48

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

Clinical Opiate Withdrawal Scale

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

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

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

This version may be copied and used clinically.

Appendix 9.4 **Contraindications and Interactions with OST**

- OST in combination with any CNS depressant (e.g. alcohol, benzodiazepines, TCAs); ↑ risk respiratory depression/potential overdose
- Doses of > 100mg methadone PO od are a risk factor for prolonged QTc; Patients may require ECG monitoring

Medications which affect OST:

Medicines which ↓ OST levels

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

INCREASE RISK OF WITHDRAWAL AND OVERDOSE

All OST: Barbiturates, Carbamazepine, Phenytoin, Rifampicin, St John's Wort
Only Methadone: Smoking, Antiretrovirals: abacavir, amprenavir, lopinavir, efavirenz, nevirapine, nelfinavir, ritanovir

Medicines which ↑ OST levels

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

INCREASE RISK OF INTOXICATION AND OVERDOSE

All OST: Ciprofloxacin; Macrolide Abx; Fluconazole; Fluvoxamine (+/- Sertraline, Fluoxetine, Paroxetine); Amiodarone
Only Methadone: Disulfiram, Verapamil, Grapefruit Juice
Only Buprenorphine: Protease inhibitors (e.g. indinavir, saquinavir)

Appendix 9.5 **Signs and Symptoms of Opioid Intoxication**

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