Title of Guideline	**Guidelines for the Management of Illicit Drug Users in General Hospitals**
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Explicit definition of patient group to which it applies	For patients who are identified to use illicit drugs or prescribed opiate substitute medication form the Community Drugs Service
Abstract	The guidelines have been designed to aid the management of illicit drug misuse in general hospitals. Good management of the patient's drug problem is essential if there is not to be disruption of ward management and if the patient is to stay so that any medical problems they have can be fully treated.
Statement of evidence base of the guideline Evidence Base (1-5)	

1a	Meta analysis of RCT
1b	At least 1 RCT
2a	At least 1 well designed controlled study without randomisation
2b	At least 1 other well designed quasi experimental study
3	Well –designed non-experimental descriptive studies (i.e. comparative / correlation and case studies)
4	Expert committee reports or opinions and / or clinical experiences of respected authorities
5	Recommended best practise based on the clinical experience of the guideline developer

Consultation Process	
Target Audience	
Date of Submission:	
Date of Review:	

This guideline has been registered with the trust. However, clinical guidelines are

guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.	

Guidelines for the Management of Illicit Drug Users in General Hospitals

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Introduction

Illicit drug use is common and persons with illicit drug use are frequently seen in accident and emergency and admitted to general hospital wards. Their drug use may or may not be easy to recognise. The link between illicit drug use and the reason for admission may be simple or complex.

The long-term management of those who are dependent on heroin is usually a prescription of methadone or buprenorphine. Methadone is the long acting oral substitute for heroin. Buprenorphine is a sublingual opiate preparation which is also long acting and prescribed on a daily basis. Buprenorphine is a substitute for heroin that also acts as an antagonist at endogenous opioid receptors and which at higher doses can block the effect of heroin and other opiate medications. When it is initiated in someone who has other opiates in their system, it may cause withdrawal symptoms.

They are prescribed in order to reduce the harm that heroin addicts accrue from the use of illicit drugs, (abscesses, endocarditis, overdose, HIV, Hepatitis, etc). Methadone and buprenorphine are usually prescribed on fortnightly prescriptions, which are dispensed by community pharmacists at intervals ranging from daily (most usual) to fortnightly. Local patients will be prescribed methadone or buprenorphine by Wigan and Leigh Recovery Partnership or their GP.

1.0 Purpose and scope of the guidelines

The guidelines have been designed to aid the management of illicit drug misuse in general hospitals. Good management of the patient's drug problem is essential if there is not to be disruption of ward management and if the patient is to stay so that any medical problems they have can be fully treated.

2.0 Policy statement

These guidelines are applicable to all medical, nursing and pharmacy

staff, caring for patients with problems of illicit drug use. It has been designed to provide Trust staff with sufficient information to ensure that patients receive appropriate management with regards to their illicit drug use.

3.0 Monitoring and review

The guidelines will be reviewed on a yearly basis or in the intervening period if new research is published that means an update is required before one year has passed.

4.0 Opiate withdrawal and intoxication

4.1 Opiate withdrawal

This is characterised by the following features:

Dilated pupils	Nausea	Dysphoria
Sweating	Diarrhoea	Restlessness
Gooseflesh	Muscle cramps	Anxiety
Rhinorrhoea	Insomnia	Sneezing
Craving	Yawning	Irritability
Tachycardia		

Though extremely uncomfortable it is NOT life threatening. It is likely to occur from six to twelve hours after a dose of heroin and from eighteen to forty eight hours after a dose of methadone or buprenorphine.

4.2 Opiate intoxication

This is characterised by the following features:

Pinned pupils	Drowsiness	Slurred speech
Relaxation	Euphoria	Poor concentration

Appearing asleep, but rousable

If a patient appears intoxicated there should be careful assessment prior to administering any further opiate or benzodiazepine medication.

5.0 Identification of drug misusers

All persons seen at hospital will normally be asked about their smoking behaviour and their use of alcohol. **It is important that all patients are asked about the use of illicit drugs and a full medical history is taken.** Some patients would admit to such use, but others would deny it for a time, particularly if they think that admitting to illicit drug use is likely to lead to lack of treatment and possible prejudicial attitudes. If a person does not admit to illicit drug use, the reason for presentation at hospital may sometimes prompt further questioning. Persons admitted with overdose or intoxication, changes in mental state and physical problems such as abscesses, deep vein thrombosis, hepatitis B or C, or HIV, thrombophlebitis, tachycardia, septicaemia or endocarditis may have problems related to illicit drug use, others may show physical evidence of injecting such as track marks.

Changes in mental state a few days after admission, periods of apparent intoxication during admission or other behaviour suggestive of drug use, such as frequent absences from the ward or strange behaviour with visitors, may also lead to suspicion that drugs are being used illicitly.

Illicit drug use can be detected by urine testing, whilst covert urine testing may be of value in the assessment of the seriously mentally ill or persons who are intoxicated, patients should in most circumstances be informed in advance of suspicions and should give consent to testing.

6.0 Possession of illegal substances

On occasion ward staff will encounter patients possessing illegal substances, which may include schedule one controlled drugs, for example cannabis. Health care

professional cannot take possession of the product other than in two cases where exemptions are granted. The first exemption is where a person takes possession of controlled drugs for the purpose of destruction and the second for the purpose of handing over to a police officer. The patient's confidentiality should normally be maintained and the police should be called in only on the understanding that there will be no identification of the source. If however, the quantity is so large that the drug cannot be purely for personal use, it may be that the greater interest of the public requires identification of the source. Such a decision would not be taken without first discussing with other health professionals involved in the patients' care, including the ward pharmacist and the hospital's legal advisor and if possible the Department of Health. In theory the patient should give authority for the removal and destruction of the drug. If a patient refuses then the hospital may feel that it has no other alternative to call the police. Under no circumstances can a schedule one controlled drug be handed back to the patient on discharge, as the person doing so could be guilty of an offence of the unlawful supply of a controlled drug. The penalty for this type of offence is high enough to result in a custodial sentence.

7.0 **Patient seen for treatment at the accident and emergency department**

A patient who attends the accident and emergency department is unlikely to need any replacement methadone or be bupenorphine, if they are given treatment which does not involve admission to hospital. Patients who attend with painful conditions in which the doctor suspects malingering or factitious disorder should be examined for evidence of drug taking and after that their drug taking history. Opiate withdrawal is not a medical emergency. It is good practice to inform drug treatment services when a patient under their care has attended A&E departments (see phone numbers below).ICIS records can be accessed by the hospital specialist nursing team.

8.0 **Management of the problem drug user on the ward.**

Drug treatment services can be called for advice on the management of individual patients (see phone numbers below). The following general guidelines are suggested for the management of drug users.

9.1 Assessment

All persons should be asked about the range of drugs that they use (including alcohol and benzodiazepines) amounts taken, whether the drugs taken are prescribed or used illicitly, the route of administration and the withdrawal symptoms that they get. Particular note should be taken of the drugs already consumed on the day of admission and if prescribed drugs are taken, of the name of the prescriber and chemist at which the drugs are collected. On examination, do they appear intoxicated or experiencing withdrawal symptoms. Is there any other objective evidence, such as injection sites. A urine drug screen will confirm recent illicit substance use.

9.2 Treatment

Treatment is usually only necessary for a person who takes opiates and more rarely tranquilisers (usually benzodiazepines) on a regular basis. Persons who use stimulants (amphetamines or cocaine) will not usually show a withdrawal syndrome, although they may exhibit intense drug craving behaviour and can become quite depressed. Specialist advice should be sought if either of these behaviours poses a problem for management. Patients may be difficult or demanding, but giving in to entreaties against the doctor's better judgement usually leads to more demands rather than a resolution of the situation. Ask advice from a senior member of your team and/or a specialist.

9.2.1 Opiates

(a) A person using opiates on a daily basis will start to have opiate withdrawal symptoms when their opiate intake ceases. The following treatment regime is suggested for those with problems with opiate withdrawal. If a person was receiving treatment outside of hospital this treatment should be continued during their admission. It is important, however, that independent checks are

made to ascertain whether the patient has been truthful about their treatment regime.

It is dangerous to prescribe methadone without confirming the dose or seeking expert advice, because the dose of methadone prescribed to many illicit drug users would be lethal to a non-tolerant individual. The person who they say prescribes to them should therefore be contacted. During 9.00 to 5.00 Monday to Friday, it should be straightforward.

As well as the Substance misuse service, GPs may have access to patient information and the pharmacy where the patient collects the methadone or buprenorphine from can be contacted. When prescribing starts particular note should be taken of any drugs the patient admits to have having used already that day. Methadone should usually be prescribed on a daily or twice daily basis. Buprenorphine should be prescribed once daily. Caution should be used if the patient has recently used heroin or other opiates as buprenorphine may precipitate withdrawal from opiates. Some patients are on injectable rather than oral methadone and rarely still, some patients are prescribed heroin (diamorphine) itself.

When prescribed for the treatment of addiction as opposed to the treatment of other medical conditions (such as pain, LVF and MI) diamorphine must only be prescribed by a doctor with a Home Office licence to do so. It may therefore be necessary to replace with methadone while the patient is in hospital. Injectable drugs should not be administered in hospital unless the patient is unable to consume the drugs by mouth for specified medical reasons. The drug should instead be given in oral form during the period of admission. (1 mg of injectable methadone is equivalent to 1 mg of oral methadone).

(b) **For patients not already in treatment or where it is not possible to confirm that they are in treatment the following regime should be prescribed for opiate withdrawal. The patient should show signs of**

physical withdrawal and have a urine test positive for opiates. Methadone mixture (1 mg in 1 ml) should be administered 10 mgs 4 hourly prn. The dose can be given every 4 hours providing that (a) the patient requests it and (b) they are not at all drowsy or intoxicated. After 24 hours the dose required can be given henceforth on a twice-daily basis. The person requiring 10 mgs every 4 hours will then be stabilised on 60 mgs a day or 30 mgs twice a day. Persons apparently requiring larger doses than this will need expert advice.

(c) Apart from confirming details, the prescriber and community pharmacist should also be contacted in order to prevent the patient or anyone else collecting their methadone whilst they are in hospital.

(d) Methadone, like any other drug has a potential for drug interactions. Watch especially for potentiation with other sedatives and interaction with enzyme inducers such as rifampicin and phenytoin. Consult your ward pharmacist.

9.2.2 Benzodiazepines

Patients who are definitely in receipt of prescribed benzodiazepines outside hospital should have their prescription continued. Persons who give a history of benzodiazepines misuse but are not in receipt of such drugs should not be prescribed them at all during admission unless under specialist advice.

9.3 Liaison with Drug Services

Close liaison with Drug Services and all acute hospital wards is very helpful to patient management. Persons receiving prescriptions for methadone or similar drugs outside hospital who are admitted to hospital will have outpatient prescriptions that are continuing to run. Other persons may continue to collect these drugs whilst the patient receives the supplies in hospital. The patient's prescriber should therefore be contacted as soon as possible after admission so that outpatient

supplies can be stopped. Please do not allow patients to use their own medication whilst in hospital.

Liaison will also need to take place at an early stage so that patient's medication can be put on hold at the pharmacy and be re-instated again on discharge. It should usually be possible for the Drug Service (or the GP if one is prescribing) to take up treatment immediately upon discharge so that no take home methadone has to be supplied by the hospital. Again however, close liaison is necessary to avoid an interruption in treatment or alternatively to make sure that a patient does not simultaneously receive take home supplies from the hospital and their normal out patient prescription.

In the case of new patients, early referral to the Drug Service is vital if they are to be taken into ongoing treatment after they leave hospital (should they wish to avail themselves of this).

10.0 **Drug Service Phone numbers**

Wigan Recovery Partnership Coops Building Dorning Street Wigan 01942 827979
Leigh Recovery Partnership Kennedy House Brunswick St Leigh 01942 404299

The Duty Psychiatrist is available out of hours for advice about patient management via switch on 0161 773 9121. Dr Jonathan Dewhurst, consultant addiction psychiatrist for Wigan and Leigh, is available for advice and further information via his secretary on 01942 487545.

11.0 Points to consider

Patients who are identified to be opiate dependent so therefore opiate tolerant may require higher doses of analgesia to manage their pain

The use of Cyclizine is not recommended for use in patients who are prescribed Methadone

12.0 **Summary**

1. Ask all patients if they use illicit drugs.
2. Continue to suspect illicit drug use in patients who's medical condition or behaviour suggests this.
3. Check all claims of prescribing before commencing treatment on the ward.
4. If checks cannot be made, methadone mixture 10 mgs 4 hourly pm can be prescribed for opiate withdrawal.
5. Liaise with Drug Services in all cases and with any other prescriber and copy the Drug Team into correspondence with the GP.

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