Form 6.2 Response

SHERIFFDOM OF CENTRAL, TAYSIDE AND FIFE AT PERTH

Court ref: PER B17-20

RESPONSE

to the

DETERMINATION OF SHERIFF W M WOOD

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC. (SCOTLAND) ACT 2016

IN THE

INQUIRY INTO THE DEATH OF SCOTT ANDREW ROSS (born 17 October 1980)

To: the Scottish Courts and Tribunals Service

1. Tayside Health Board, being a participant in the inquiry and being an organisation to whom a recommendation under section 26(1)(b) was addressed, do respond to the Court's six recommendations as follows.

Recommendation		Response
1.	**There should be a co-ordinated approach between the hospital and the prison systems in the management of a prisoner's drug withdrawal.**	
	Prison Healthcare	Prior to any patient being admitted to hospital, the prison clinician speaks to Consultant Connect in the hospital to discuss treatment plans.
	Emergency Department	Prison Healthcare staff have direct access to a Senior Emergency Medicine Clinician 24hrs a day / 7 days per week for emergency clinical advice through NHS Tayside Flow Navigation Centre via Consultant Connect. All calls are recorded for governance purposes.
	Acute Medicine	There is an agreement in place that prisoners transferred to hospital for acute care should be accompanied by a photocopy of their drug prescription Kardex on admission. If this is not available at the point of admission, the ward clinical pharmacist will contact the prison to request a copy.

2.	**Those managing benzodiazapine withdrawal should consider carefully the proper dosage required for safe discontinuation. Under-prescription in respect of benzodiazapine discontinuation may cause seizures, which can cause brain damage and death; the expert evidence was that overprescription was less harmful than underprescription.**	
	Prison Healthcare	Within prison, a standard detox is given to all. This is a standard detox prescribed across prisons in Scotland and is safe and effective in the majority of patients when treated in the prison setting. Should the patient require the detoxification to be optimised based on inadequate clinical response this will be done with advice from addiction specialists and/or medical consultants. Transfer to a medical ward will be facilitated if this is necessary for safe treatment to be delivered.
	Emergency Department	Within the Emergency Department, a patient with seizures due to withdrawal would be treated acutely based on their individual clinical emergency needs. Acute benzodiazepine withdrawal symptoms (without seizure) would be dealt with based on their individual clinical needs and admitted for inpatient management. Outlined in Royal College of Emergency Medicine Best Practice Guideline, Drug Misuse and the Emergency Department: *7. Drug detoxification should not be undertaken by the ED, but clinicians should know how to treat acute intoxication or withdrawal.*
	Acute Medicine	A protocol for benzodiazapine withdrawal standardises treatment and reduces the risk of under prescription, however individual patients' clinical condition requires to be a reviewed with regard to withdrawal symptoms and dose adjusted accordingly. Currently, a comprehensive history is sought at the point of admission to an acute hospital. This can be difficult if patients are still intoxicated and the history of drug doses may not be reliable. This allows an individualised risk/benefit assessment in the context of the patient's clinical presentation.
3.	**NHS Tayside staff both in prison and in hospitals should consider the existing protocols relating to drug withdrawal. The protocols should be fit for purpose and, where appropriate, tailored to fit the needs of individual prisoners. The requirements for safe opiate withdrawal and safe benzodiazapine withdrawal are unlikely to be the same.**	
	Prison Healthcare	Within Prison Healthcare, there are standard withdrawal protocols as per Recommendation 2. There are different detox regimes for opiate and benzodiazepine withdrawal.
	Emergency Department	Within the Emergency Department a patient with seizures due to acute withdrawal (benzodiazepine or opiate) would be treated acutely based on their individual clinical emergency needs. Acute benzodiazepine or opiate withdrawal symptoms (without seizure) would be dealt with based on their individual clinical needs and admitted for inpatient management. Outlined in Royal College of Emergency Medicine Best Practice Guideline, Drug Misuse and the Emergency Department:

		7. Drug detoxification should not be undertaken by the ED, but clinicians should know how to treat acute intoxication or withdrawal.
	Acute Medicine	NHS Tayside has an agreed protocol for the planned withdrawal of benzodiazepine. This is contained within the *Guidelines on Medical Treatments for Substance Use*, developed by NHS Tayside Substance Use Services and is available to clinicians on NHS Tayside intranet (copy of June 2023 guidelines attached to response for reference). Clinicians assess and prescribe appropriate withdrawal medication based on clinical judgement taking into account reported drug use, Prison Kardex, clinical assessment and consideration of concurrent diagnoses and medication. The prescribed dose can be increased beyond the protocol as required to minimise the risk of under-prescribing.
4.	**All NHS staff should be supported in their care of prisoners withdrawing from illicit substances by being able to seek expert support and advice.**	
	Prison Healthcare	Prison Healthcare staff have access to a Substance Use Specialist GP and Psychiatrist, when on site. They have access to support and advice out with these times through Consultant Connect.
	Emergency Department	NHS Tayside Emergency Medicine has senior medical cover available 24hrs a day / 7 days per week for emergency clinical advice.
	Acute Medicine	NHS Tayside Acute Medicine has senior clinical decision makers on acute medical receiving 24hrs a day / 7 days per week. In working hours there is close contact with clinical pharmacists for complex cases when drug interaction is considered, or further information required from the Prison. The in hours period would be considered as 9am to 5pm. Out of hours, prescribing would be based on the clinician's judgement and the assessment of the patient's condition at the time. Senior medical input is available during the out of hours period.
5.	**A patient's reported use of illicit drugs ought to be taken into account and not ignored or disbelieved - particularly where there is evidence of such abuse (such as urine samples) and observed withdrawal seizures.**	
	Prison Healthcare	The patient reported use will be taken into account when confirmed by evidence such as urine samples and observed withdrawal seizures.
	Emergency Department	Patients attending the Emergency Department with presentations that might possibly be related to drug use, or may be a marker for drug use, are asked about this as part of their clinical assessment.
	Acute Medicine	Currently, a comprehensive history is sought at the point of admission to an acute hospital. This can be difficult if patients are still intoxicated and the history of drug doses may not be reliable. The information conveyed by the patient regarding their drug use is taken into consideration to avoid under prescription of withdrawal treatment. This allows an individualised risk/benefit assessment in the context of

		the patient's clinical presentation and reported drug use.
6.	**More generally, there must be a co-ordinated approach between NHS staff in prison and those working in hospitals in relation to the timely and expeditious passage of clinical information in respect of a patient moving from one facility to another.**	
	Prison Healthcare	All patients are transferred following a conversation with a hospital doctor. The patient kardex will accompany them to hospital or if this is not available at the point of admission, the ward clinical pharmacist will contact the prison to request a copy. Details of any medication prescribed and administered to the patient will be discussed and a copy of the kardex may be sent to the hospital if appropriate
	Emergency Department	Prison Healthcare staff have direct access to a Senior Emergency Medicine Clinician 24hrs a day / 7 days per week for emergency clinical advice through NHS Tayside Flow Navigation Centre via Consultant Connect. All calls are recorded for governance purposes. In wider collaborative interface, Emergency Department staff have been supported in visiting HMP Perth to gain a better understanding of the Prison Healthcare interface and wider prison structure.
	Acute Medicine	NHS Tayside now has fully electronic notes and discharge systems. All inpatient notes are immediately available to health care professionals in NHS Tayside (including primary care and prison service) via 'clinical portal' and electronic discharge scripts are available same day on the electronic system. Electronic documentation will contain information about any plans for current drug regimes eg. the duration of treatment and any titration regime should be clearly documented. There may be recommendations or suggestions about future treatments but these will not necessarily be prescribed. Digital advances since this event have improved communication between the healthcare services, including Prison Healthcare.

18th April 2024

Contributors to Response:

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Guidelines on Medical Treatments for Substance Use

June 2023

NHS Tayside

Tayside Substance Use Services

Document: Guidelines on Medical Treatments for Substance Use
Version Date: June 2023
Review Date: June 2025

Introduction

Tayside Substance Use Services (TSUS)
TSUS comprises the specialist NHS elements of the comprehensive programmes of care, treatment and recovery delivered across the Tayside region to support those experiencing problems associated with the use of drugs and alcohol. Care, treatment and recovery are delivered in partnership with many agencies from the local authorities and 3rd sector as well as local communities and volunteers. TSUS holds responsibility for specific specialist elements of this holistic treatment approach.

Purpose
The aim of the guideline is to clearly describe the use of all prescribed treatments for problem drug and alcohol use in Tayside. It will form the basis of prescribing within TSUS and its use will reduce variation in practice, ameliorate clinical risk and improve patient safety. The protocol takes into account existing national guidance documents and good practice statements, and is the basis for the clinical governance of substance use treatment in Tayside.

Secondary care should refer to specific hospital polices for alcohol withdrawal protocol and management of opiate withdrawal for people not on OST available on staffnet.

How this document should be used
Prescribing treatments are a small part of any individual's package of care to enable recovery. When prescribing treatments are required, the agreed process is contained within this document. Other guidance documents describe the psychosocial elements of care.

The document covers the management of all substance use problems for which evidence-based prescribing treatments exist or which result in presentation to TSUS including;

- Primary alcohol dependence
- Primary opioid dependence
- Co-morbid Benzodiazepine use
- Inpatient Interventions

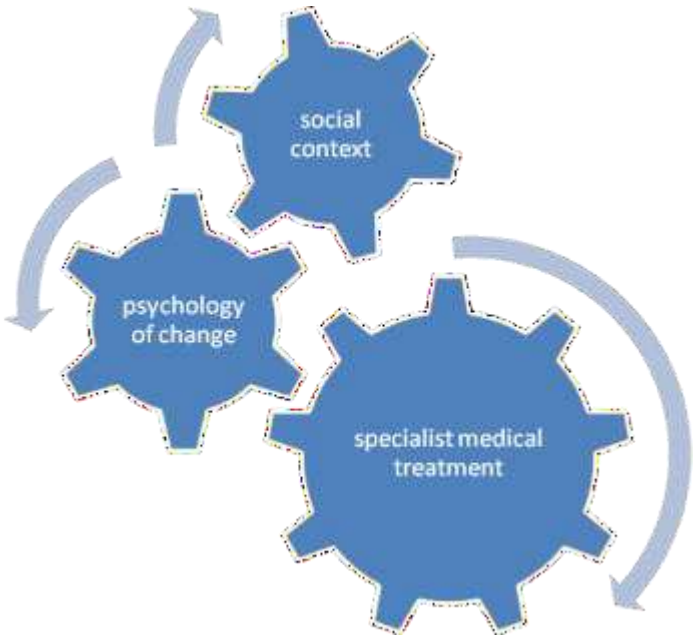
The document is arranged in self-contained sections, addressing these clinical groups:

- Pathways of care, addressing the assessment, the appropriate treatment to be delivered and flowcharts outlining the clinical processes which underpin treatment delivery
- Standardised assessment tools
- Key references and guidance documents

Clinical Governance
The clinical governance of substance use treatments will be overseen by the Health and Social Care Partnerships and NHS Tayside

Section Index

Principles of Treatment to address problematic substance use



Generic TSUS specialist prescribing treatment pathway

The treatment of problem substance use (involving alcohol, illicit and prescribed drugs) involves medical, nursing, psychological and social aspects of care. These are delivered by a range of professionals and organisations, commissioned as part of local and regional services holding responsibility for specific aspects of the care pathway. In NHS Tayside region, Tayside Substance Use Services (TSUS) are tasked with delivering evidence-based clinical (prescribing and psychological) treatments for Tayside residents experiencing problem substance use underpinned by the following aims, values, and principles.

Aims

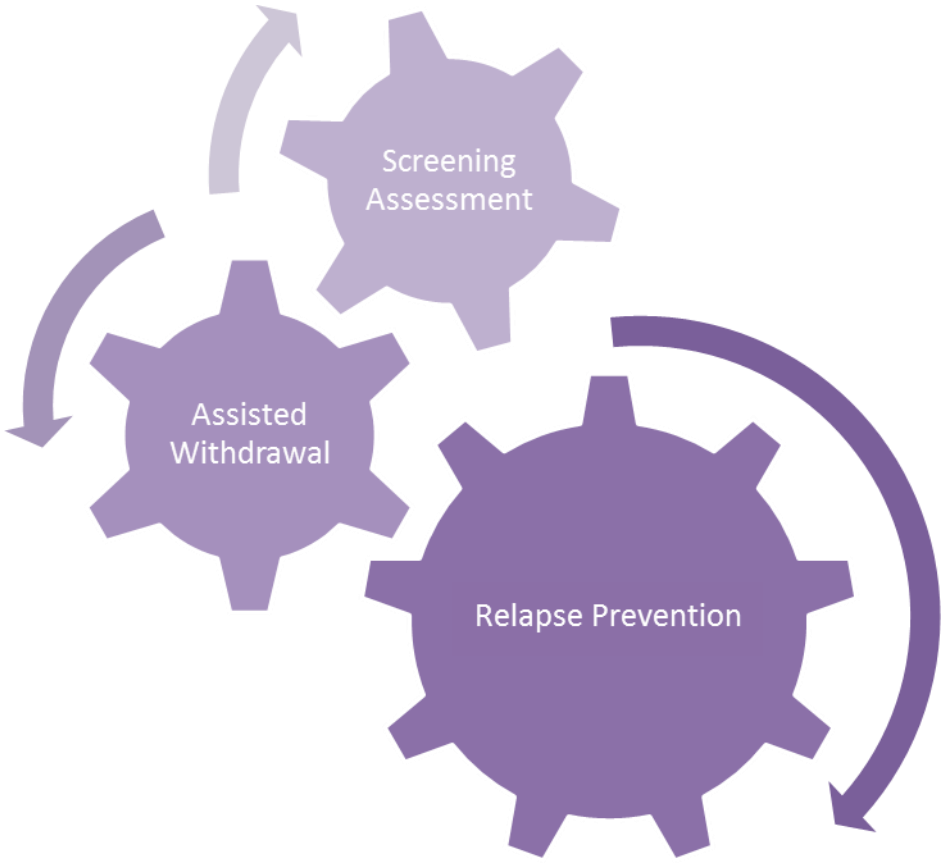
• Tayside services offer a comprehensive range of interventions for people living in Tayside who have primary alcohol or opioid dependence.
• Tayside services empower people to achieve their recovery goals by working within a broad harm reduction framework to reduce biological, psychological or social harms, and may also help people achieve abstinence.
• Tayside services offer a person-centred, needs-led service and will respond appropriately following a full comprehensive assessment.
• Tayside services deliver evidence-based practice within nationally agreed standards
• Tayside services support people to make informed decisions about prescribing interventions
• Tayside services work in partnership
• Tayside services respect individual's right to confidentiality

Quality principles and values

Tayside Substance Use Services prescribing interventions should be delivered by services meeting the standards of care outlined by the Scottish Government Quality Principles;

• You should be able to access the right drug or alcohol service that keeps you safe and supports you throughout your recovery
• You should be offered high quality, evidence informed treatment, care, and support interventions which reduce harm and empower you in your recovery
• You should be supported by workers who have the right attitudes, values, training and supervision throughout your recovery journey
• You should be involved in a full strength based assessment that ensures the choice of recovery model and therapy is based on your needs and aspirations
• You should have a recovery plan that is person centred and addresses your broader health and social care needs and maintains a focus on your safety throughout your recovery journey
• You should be involved in regular reviews of your recovery plan to ensure it continues to meet your needs and aspirations
• You should have the opportunity to be involved in an ongoing evaluation of the delivery of services at each stage of your recovery
• Services should be family inclusive

Alcohol use disorders



Alcohol Use Disorders

INTRODUCTION

TSUS use pharmacological interventions to manage individuals with moderate or severe alcohol dependence, to prevent relapse and as prophylaxis for Wernicke's Encephalopathy. This is delivered in the context of a wider recovery plan. Hazardous and harmful drinking and mild alcohol dependence are managed within primary care and other substance use partner agencies.

KEY GUIDANCE DOCUMENTS

NICE Public Health Guidance 24, Alcohol Use Disorders: preventing harmful drinking. June 2010
NICE Clinical Guideline 115, Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Feb 2011
NICE Clinical Guideline 100, Alcohol Use Disorders: diagnosis and clinical management of alcohol related physical complications. June 2010
NICE Pathway, Alcohol Use Disorders
NICE Technology Appraisal TA325, Nalmefene for reducing alcohol consumption for people with alcohol dependence, November 2014.
British National Formulary
British Association of Psychopharmacology updated guidelines: evidenced based guidelines for the pharmacological management of substance use, harmful use, addiction and comorbidity: recommendations from BAP. Journal of Psychopharmacology 2012.

PATHWAYS

Alcohol Screening Pathway (Pathway 1); The purpose of this pathway is to identify lower risk (lower risk of causing harm), hazardous (increased risk of causing harm), harmful (causing social, psychological or physical harm) and dependent drinking; in order to identify those individuals who are suitable to receive brief interventions, and those requiring to be signposted to specialist alcohol services.

Alcohol Dependence Pathway (Pathway 2); The purpose of this pathway is to identify those requiring medically assisted alcohol withdrawal, and are ready for change, then to identify whether the preferred setting for treatment is inpatient or community based. The pathway also places prescribing in the context of other non-pharmacological interventions.

TOOLS USED

FAST: Fast Alcohol Screening Test for the identification of problem alcohol use.
AUDIT: Alcohol Use Disorder Identification Test for the identification of low risk, harmful, hazardous and possibly dependent drinkers.

SADQ: Severity of Alcohol Dependence Questionnaire to assess the severity of dependence as mild, moderate or severe.
APQ: Alcohol Problems Questionnaire to assess the presence of alcohol related problems
RCQ: Readiness for Change Questionnaire to assess the stage of change as pre-contemplative, contemplative or ready for change.
Specialist Alcohol Assessment Summary – collates the screening tool scores and comorbidity screen and records the intervention.

SUMMARY OF SPECIALIST TREATMENTS

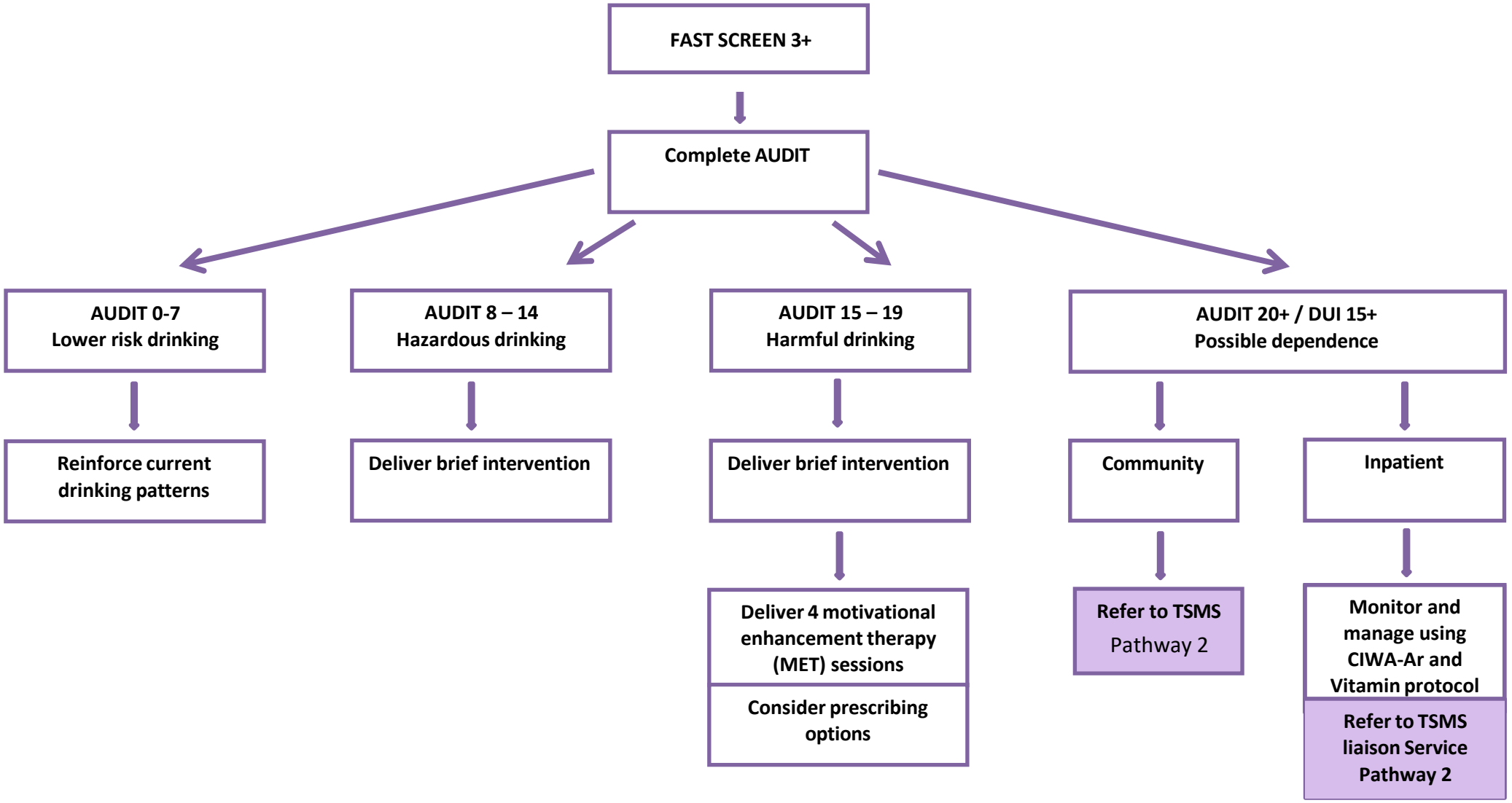
Medically Assisted Alcohol Withdrawal (MAAW):
Fixed dose Chlordiazepoxide regimens are prescribed for MAAW in community settings.
Symptom triggered Chlordiazepoxide regimens are prescribed for MAAW in inpatient settings.

Vitamins:
Prophylactic oral thiamine is prescribed for those at lower risk of developing Wernicke's Encephalpathy (WE). Prophylactic intravenous or intramuscular Pabrinex is prescribed for those at higher risk of developing WE. Overt WE is only managed in acute hospital setting, using intravenous Pabrinex.

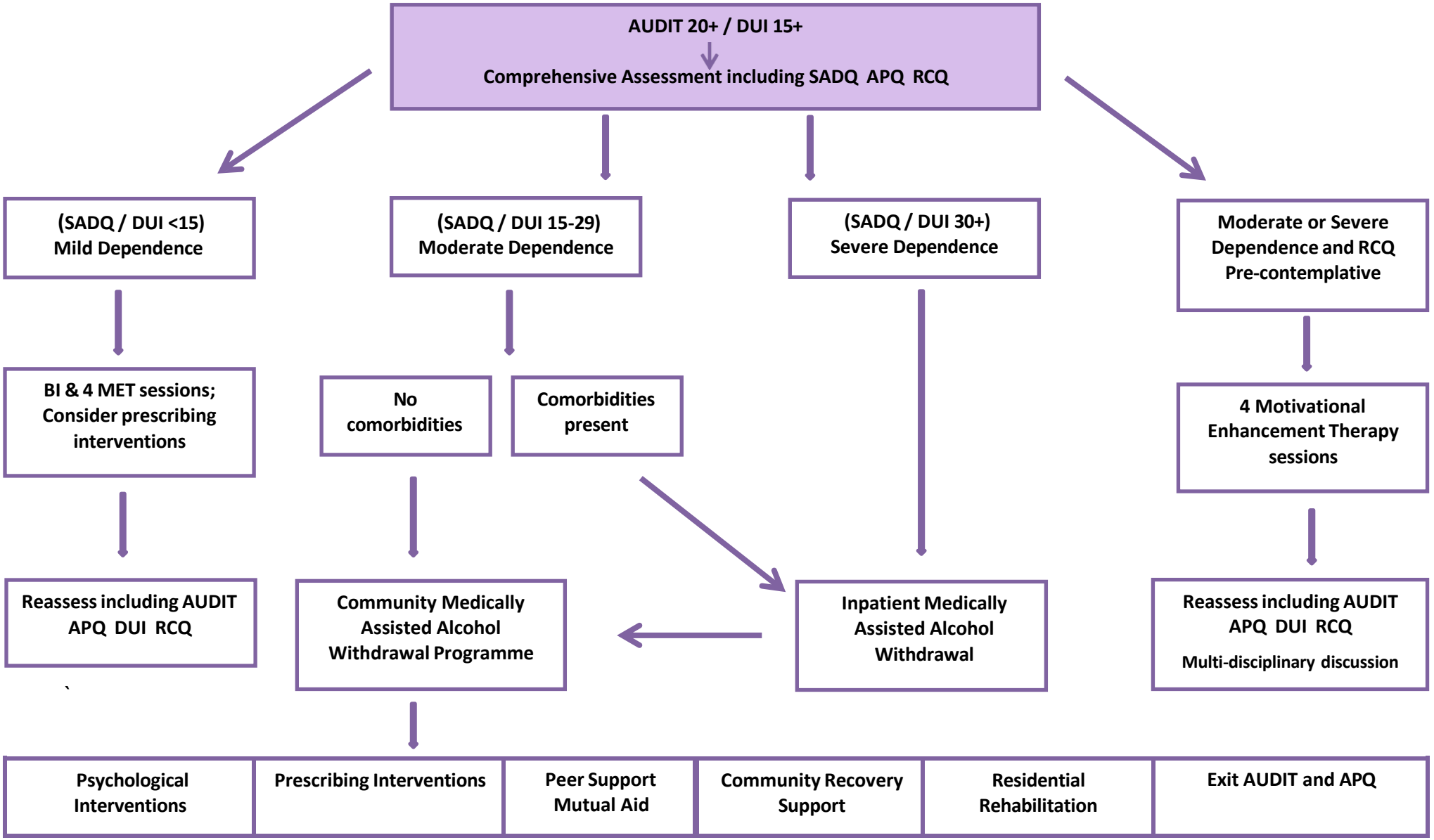
Following Successful Medically Assisted Alcohol Withdrawal:
Consider offering Acamprosate or Naltrexone. If Acamprosate or Naltrexone are not suitable or Disulfiram is preferred, consider offering Disulfiram.

For Harmful drinkers /Mild alcohol dependence (SADQ / daily unit intake <15):
Nalmefene is considered for those who wish to reduce their drinking.
Acamprosate or Naltrexone are considered for those who specifically request a pharmacological intervention or who have not responded to a psychological intervention alone.

Pathway 1: ALCOHOL SCREENING PATHWAY



Pathway 2: ALCOHOL DEPENDENCE PATHWAY



FAST	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Total FAST Score (complete remaining AUDIT questions if score 3+)						

Remaining AUDIT Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 – 4	5 - 6	7 - 8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Total AUDIT Score (Add total FAST score and remaining AUDIT questions scores together)						

Number of units of alcohol on a typical drinking day _____

AUDIT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 – 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: BI = Brief Intervention

0 – 7 Lower risk

8 – 15 Hazardous drinking – BI & 'Alcohol and Me' leaflet

16 – 19 Harmful drinking – BI, 'Alcohol and Me' leaflet, & contact specialist services

20+ Possible dependence – contact specialist alcohol services

Number of units of alcohol on a typical drinking day _____

ALCOHOL PROBLEMS QUESTIONNAIRE

NAME:_____**DATE:** _____

We would like to find out if you have experienced any of the difficulties which other people with alcohol problems sometimes complain of.

Below you will find a list of questions which we would like you to answer. Yes

Read each box carefully and answer either YES or NO by putting a TICK in the appropriate box (e.g. YES) ✓

PLEASE ANSWER ALL THE QUESTIONS WHICH APPLY TO YOU
All the Questions apply to your experiences in the **LAST SIX MONTHS**

IN THE LAST SIX MONTHS

		Yes	No
1.	Have you tended to drink on your own more than you used to?		
2.	Have you worried about meeting your friends again the day after a drinking session?		
3.	Have you spent more time with drinking friends than other kinds of friends?		
4.	Have your friends criticised you for drinking too much?		
5.	Have you had any debts?		
6.	Have you pawned any of your belongings to buy alcohol?		
7.	Do you find yourself making excuses about money?		
8.	Have you been caught out lying about money?		
9.	Have you been in trouble with the police due to your drinking?		
10	Have you lost your driving licence for drinking and driving?		
11	Have you been in prison?		
12	Have you been physically sick after drinking?		
13	Have you had diarrhoea after a drinking session?		
14	Have you had pains in your stomach after a drinking session?		
15	Have you had pins and needles in your fingers or toes?		
16	Have you had any accidents, needing hospital treatment after drinking?		
17	Have you lost any weight?		
18	Have you been neglecting yourself physically?		
19	Have you failed to wash for several days at a time?		
20	Have you felt depressed for more than a week?		
21	Have you felt so depressed that you have felt like doing away with yourself?		
22	Have you given up any hobbies you once enjoyed because of drinking?		
23	Do you find it hard to get the same enjoyment from your usual interests?		

IF YOU ARE NOT MARRIED, MISS OUT QUESTIONS 24-32, GO TO QUESTION 33
(These questions apply to you if you have lived with your spouse or partner during the last six months)

	IN THE LAST SIX MONTHS:	**Yes**	**No**
24	Has your spouse complained of your drinking?		
25	Has your spouse tried to stop you from having a drink?		
26	Has he/she refused to talk to you because you have been drinking?		
27	Has he/she threatened to leave you because of your drinking?		
28	Has he/she had to put you to bed after you have been drinking?		
29	Have you shouted at him/her when you have been drinking?		
30	Have you injured him/her after you have been drinking?		
3	Have you been legally separated from your spouse?		
32.	Has he/she refused to have sex with you because of drinking?…….		

IF YOU HAVE NO CHILDREN MISS OUT QUESTIONS 33-36, GO TO QUESTION 37.
(These questions apply if you have lived with your children during the last six months)

	IN THE LAST SIX MONTHS:	Yes	No
33	Have you children criticised your drinking?		
34	Have you had rows with your children about drinking		
35	Do your children tend to avoid you when you have been drinking		
36	Have your children tried to stop you from having a drink?		

IF YOU HAVE BEEN UNEMPLOYED FOR THE LAST SIX MONTHS, MISS OUT QUESTIONS 37-44

	IN THE LAST SIX MONTHS	Yes	No
37	Have you found your work less interesting than you used to?		
38	Have you been unable to arrive on time for work due to your drinking?		
39	Have you missed a whole day at work after a drinking session?		
40	Have you been less able to do your job because of your drinking?		
41	Has anyone at work complained about you being late or absent?		
42	Have you had any formal warnings from your employers?		
43	Have you been suspended or dismissed from work?		
44	Have you had any accidents at work after drinking?		

PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS WHICH APPLY TO YOU

END OF QUESTIONNAIRE
THANK YOU FOR YOUR HELP

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONAIRE

NAME_____AGE_____

Please recall a typical period of heavy drinking in the last 6 months.

When was this? Month:……. Year……..

Please answer all the following questions about your drinking by circling your most appropriate response.

During that period of heavy drinking…….

1. The day after drinking alcohol, I woke up feeling sweaty.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 7 beers).

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY** **ALWAYS**

14. I drank more than half a bottle of spirits per day (OR 2 bottles of wine OR 15 beers).

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY** **ALWAYS**

15. I drank more than one bottle of spirits per day (OR 4 bottles of wine OR 15 pints of beer / lager).

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY** **ALWAYS**

16. I drank more than two bottles of spirits per day (OR 8 bottles of wine OR 60 beers)

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY** **ALWAYS**

Imagine the following situation:

1 You have been **completely off drink for a few weeks**
2 You then drink **very heavily** for **two days**

How would you feel the **morning after** those two days of drinking?

17. I would start to sweat.

NOT AT ALL **SLIGHTLY** **MODERATELY** **QUITE A LOT**

18. My hands would shake.

NOT AT ALL **SLIGHTLY** **MODERATELY** **QUITE A LOT**

19. My body would shake.

NOT AT ALL **SLIGHTLY** **MODERATELY** **QUITE A LOT**

20. I would be craving for a drink.

NOT AT ALL **SLIGHTLY** **MODERATELY** **QUITE A LOT**

SADQ SCORE :

SCORED BY :

READINESS TO CHANGE QUESTIONNAIRE (TREATMENT VERSION)						
The following questions are designed to identify how you personally feel about your drinking right now. Please think about your current situation and drinking habits, even if you have given up drinking completely. Read each question below carefully and then decide whether you agree or disagree with the statements. Please tick the answer of your choice to each question. If you have any questions please ask the questionnaire administrator.						
	Strongly disagree	**Disagree**	**Unsure**	**Agree**	**Strongly agree**	**Office Use**
It's a waste of time to think about my drinking because I do not have a problem						**PC**
I enjoy my drinking but sometimes I drink too much						**C**
There is nothing seriously wrong with my drinking						**PC**
Sometimes I think I should quit or cut down on my drinking						**C**
Anyone can talk about wanting to do something about their drinking, but I'm actually doing something about it						**A**
I am a fairly normal drinker						**PC**
My drinking is a problem sometimes						**C**
I am actually changing my drinking habits right now (either cutting down or quitting)						**A**
I have started to carry out a plan to cut down or quit drinking						**A**
There is nothing I really need to change about my drinking						**PC**
Sometimes I wonder if my drinking is out of control						**C**
I am actively working on my drinking problem						**A**

SCORING THE READINESS TO CHANGE QUESTIONNAIRE (TREATMENT VERSION)

The scale score codes represent each of the stages of change: PC = Pre-contemplation; C = Contemplation; A = Action.

Items numbered 1,3,6,10 = Pre-contemplation, items numbered 2,4,7,11 = Contemplation, items numbered 5,8,9,12 = Action. All items should be scored on a 5-point scale ranging from:

-2	strongly disagree
-1	disagree
0	unsure
+1	agree
+2	strongly disagree

To calculate the score for each scale, simply add the item scores for the scale in question. The range of each scale is -10 through 0 to +10. A negative scale score reflects an overall disagreement with items measuring the stage of change, whereas a positive score represents overall agreement. The highest scale score represents the Stage of Change Designation.

Note: If two or more scale scores are equal, then the scale farthest along the continuum of change (Pre-contemplation – Contemplation – Action) represents the subject's Stage of Change Designation. For example if the subject scores 6 on the Pre-contemplation scale, 6 on the contemplation scale and -2 on the action scale, then the subject is assigned to the Contemplation stage.

If one of the four items on the scale is missing, the subject's score for that scale should be pro-rated (i.e. multiplied by 4/3 or 1.33). If two or more items are missing, the scale score cannot be calculated. In this case the Stage of Change Designation will be invalid.

SPECIALIST ALCOHOL ASSESSMENT SUMMARY

NAME	
CHI Number	
EPISODE START DATE	

ASSESSMENT SCREEN	
AUDIT score (complete remaining screening questionnaires if score 20+)	
Average daily unit intake (DUI)	
Severity of Alcohol Dependence Questionnaire (SADQ) score	
Alcohol Problems Questionnaire (APQ) score	
Readiness for Change Questionnaire (RCQ) score	

COMORBIDITY SCREEN	**YES**	**NO**
History of epilepsy		
History of seizures or delirium tremens during previous assisted withdrawal		
Benzodiazepine dependence		
Significant psychiatric or physical comorbidity		
Significant learning disability or cognitive impairment		
Homeless		
Age over 65		

INTERVENTION (please tick)	Signpost / Discharge (AUDIT<20)	
	MET x 4 (pre-contemplative)	
	Community Assisted Withdrawal	
	Inpatient Assisted Withdrawal	
	Other prescribing interventions	
	Psychological therapies	
NOTES [If recommended intervention is NOT delivered, record rationale]		

MEDICALLY ASSISTED ALCOHOL WITHDRAWAL

Benzodiazepine regimens are used to manage alcohol withdrawal.

Fixed dose regimens

A fixed dose regimen involves starting treatment with a standard chlordiazepoxide dose determined by the SADQ score and / or typical DUI, followed by reducing the dose to zero usually over 7 to 10 days according to a standard protocol. The response should be monitored using the CIWA-Ar and the dose adjusted upwards or downwards in the early stages of withdrawal. The first dose should be given before withdrawal symptoms emerge, and in severe alcohol dependence withdrawal symptoms can emerge before the breath alcohol concentration drops to zero.

Fixed dose regimens are recommended in the community.

Symptom triggered regimens

A symptom triggered approach involves tailoring the treatment according to the severity of withdrawal symptoms and complications as determined by the CIWA-Ar. The CIWA-Ar is monitored hourly and medication is administered at varying doses according to the score.

Symptom triggered regimens can have more favourable outcomes than fixed dose regimens in inpatient settings if staff have competence in this procedure.

Long acting Benzodiazepines

Long acting Benzodiazepines, e.g. Chlordiazepoxide are preferred for alcohol withdrawal syndrome, as there is a lower risk of breakthrough seizures.

Short acting Benzodiazepines

Short acting Benzodiazepines, e.g. Oxazepam are preferred for people for whom sedation must be avoided, e.g. liver disease, pulmonary insufficiency, reduced GCS. These individuals would usually require treatment in an acute hospital setting.

MEDICALLY ASSISTED ALCOHOL WITHDRAWAL - CHLORDIAZEPOXIDE FIXED DOSE REGIMEN

SADQ / DUI	STARTING DAY
30 – 35	Day 1 (Regimen 1)
26 – 30	Day 2 (Regimen 2)
21 – 25	Day 3 (Regimen3)
16 – 20	Day 4 (Regimen 4)
15	Day 5 (Regimen 5)
Women, elderly, the underweight and those with physical comorbidities, e.g. COPD or liver disease, may require a lower starting dose	

Daily dispense Chlordiazepoxide 10mg tablets plus 30mg PRN if starting on day 1-3	**9am**	**1pm**	**5pm**	**10pm**
Day 1	40mg	30mg	30mg	40mg
Day 2	30mg	30mg	30mg	30mg
Day 3	30mg	20mg	20mg	30mg
Day 4	20mg	20mg	20mg	20mg
Day 5	20mg	10mg	10mg	20mg
Day 6	10mg	10mg	10mg	10mg
Day 7	10mg			10mg
Day 8				10mg

PRIOR TO DISPENSING EACH DAY	ACTION
Confirm history of alcohol intake in the previous 24 hours	From second day if positive history of alcohol consumption **STOP** further dispensing
Check breath alcohol concentration	From second day if positive breath alcohol level **STOP** further dispensing
Complete CIWA-Ar	Manage dose adjustments and PRN according to score

VITAMIN PROPHYLAXIS AND TREATMENT OF WERNICKE'S ENCEPHALOPATHY IN ALCOHOL USE

Pabrinex (parenteral vitamins B & C) is used for the rapid correction of severe depletion or malabsorption in alcohol use.

	OVERT WERNICKE'S (one of the following symptoms present)	**HIGHER RISK OF WERNICKE'S**	**LOWER RISK OF WERNICKE'S**
	Reduced consciousness Confusion, agitation Ataxia Nystagmus, Opthalmoplegia Hypothermia, Hypotension	Alcohol dependence without Wernicke's symptoms Harmful drinkers **with** decompensated liver disease or malnourished (MUST 2+)	Harmful drinkers **with no** liver disease or malnourishment (MUST 2+)
Day 1	Pabrinex 2-3 pairs tds iv	Pabrinex 1 pair od iv/im	Thiamine 100mg tds oral
Day 2	Pabrinex 2-3 pairs tds iv	Pabrinex 1 pair od iv/im	
Day 3	Pabrinex 1 pair od iv/im	Pabrinex 1 pair od iv/im	
Day 4	Pabrinex 1 pair od iv/im	Pabrinex 1 pair od iv/im	
Day 5	Pabrinex 1 pair od iv/im	Pabrinex 1 pair od iv/im (see note 1)	
Day 6	Pabrinex 1 pair od iv/im	Thiamine 100mg tds oral	
Day 7	Pabrinex 1 pair od iv/im (see note 1)		
Day 8	Thiamine 100mg tds oral		

1. Continue Pabrinex 1 pair od iv/im if memory continues to improve
2. Hypomagnesia should be screened for and corrected
3. Pabrinex should be given before glucose or nutritional support
4. Rarely anaphylaxis can occur with Pabrinex, this is less common with IM administration
5. IV Pabrinex should be administered over 30 minutes
6. Facilities for treating anaphylaxis, including resuscitation facilities should be available when parenteral Pabrinex is administered.
7. Review oral Thiamine after three months and discontinue if not drinking harmfully or dependently, and no evidence of malnourishment.
8. If overt Wernicke's is suspected, consider this a medical emergency requiring management in an acute hospital setting.

SUMMARY OF ALCOHOL PRESCRIBING INTERVENTIONS

DRUG	ACTION	TREATMENT START	DOSAGE	DURATION	SUPERVISION
Acamprosate **PIL** **BNF**	Reduced glutaminergic activity reduces alcohol cravings. Used as an adjunct to maintain abstinence	After assisted withdrawal in moderate or severe alcohol dependence In those with harmful drinking or mild dependence who have not responded to psychological interventions, or they request a pharmacological intervention. Test LFT's, GGT and U&E's prior to treatment.	666mg three times daily. If weight less than 60kg; 666mg, 333mg, 333mg daily.	Up to 6 months or longer for those benefiting and wanting to continue. Stop treatment if drinking persists 4-6 weeks after starting Acamprosate.	Check compliance, relapse and side effects monthly for six months, then at reduced but regular intervals. Routine blood tests not required.
Naltrexone **PIL** **BNF**	Opioid receptor antagonism reduces pleasure reinforcing alcohol use. Used to reduce the risk of a lapse becoming a relapse.	After assisted withdrawal in moderate or severe alcohol dependence. In those with harmful drinking or mild dependence who have not responded to psychological interventions, or they request a pharmacological intervention Test LFT's, GGT, and U&E's prior to treatment. Discuss information card issued with oral Naltrexone about its impact on opioid analgesics	Starting dose of 25mg daily, aiming for a maintenance dose of 50mg daily.	Up to 6 months or longer for those benefiting and wanting to continue. Stop treatment if drinking persists 4-6 weeks after commencing Naltrexone. Stop treatment if service user feels unwell.	Check compliance, relapse and side effects monthly for six months, then at reduced but regular intervals. Routine blood tests not required.

Disulfiram **PIL** **BNF**	Induces an unpleasant reaction after alcohol consumption by inhibiting acetaldehyde dehydrogenase. Used as an adjunct to maintain abstinence.	After assisted withdrawal in moderate or severe alcohol dependence, at least 24hours after last alcoholic drink. Test LFT's, GGT and U&E's prior to treatment. Contraindicated in pregnancy, severe mental illness, stroke, heart disease and hypertension. A family member/carer to preferably administer.	Usually 200mg daily. For those who continue to drink and do not experience an unpleasant reaction after one week on this dose, consider a dose increase.	Stop treatment and seek urgent medical attention if service user feels unwell, develops fever or jaundice, as hepatotoxicity can occur rarely. Disulfiram can remain active for up to one week after treatment stops.	Check compliance, relapse and side effects monthly for six months, then at reduced but regular intervals.
Nalmefene **PIL** **BNF**	Mu & delta opioid receptor antagonist and kappa receptor partial agonist Used to reduce alcohol consumption	In those with mild alcohol dependence or hazardous drinking who do not require an immediate medically assisted alcohol withdrawal. Commence two weeks after initial assessment if still drinking >7.5 units (for men), or >5 units (for women) per day. Avoid if recent alcohol withdrawal or seizure history	18mg on each day there is a risk of drinking alcohol. Taken 1-2 hours before anticipated drinking, or as soon as possible after drinking.	An individual may stop taking Nalmefene when there is no longer a perceived need. In the absence of data caution if continued longer than one year.	Check compliance, relapse and side effects monthly for six months, then at reduced but regular intervals. Routine blood tests not required.

All prescribing interventions should be delivered with psychosocial interventions

GLOSSARY

FAST: Fast Alcohol Screening Test for identification of problem alcohol use

AUDIT: Alcohol Use Disorder Test for identification of hazardous, harmful and dependent drinking and outcome monitoring.

Lower risk drinking: A pattern of drinking with a lower risk of causing harm

Hazardous drinking: A pattern of drinking that increases someone's risk of harm

Harmful drinking: A pattern of alcohol drinking that causes harm including psychological, physical problems, accidents.

Dependence: Characterised by craving, tolerance, withdrawal, preoccupation with alcohol and continued drinking despite the harmful consequences.

Brief Intervention includes brief advice, feedback and agreeing actions

Motivational Enhancement Therapy to develop and maintain readiness for change

TSUS: NHS Tayside Substance Use Service

SADQ Severity of Alcohol Dependence Questionnaire is used to assess the severity of dependence as mild, moderate or severe.

APQ Alcohol Problems Questionnaire is used to assess the presence of alcohol related problems and for outcome monitoring

RCQ Readiness for Change Questionnaire

CIWA-Ar Clinical Institute Withdrawal Assessment of Alcohol scale to assess the severity of alcohol withdrawal

Comorbidity includes physical, psychological and social problems in addition to alcohol use.

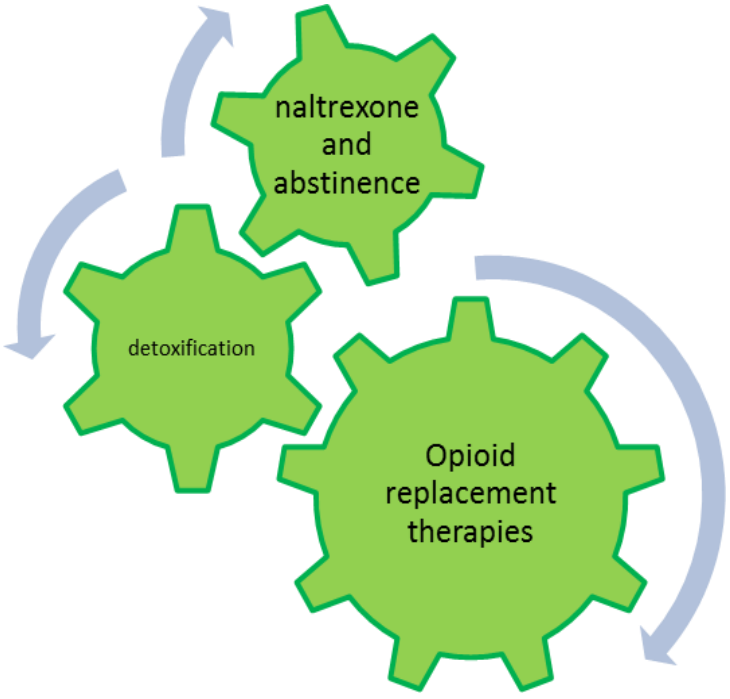
Comprehensive Assessment is completed in specialist alcohol services and includes an assessment of alcohol use, other substance use, comorbidity, cognitive function and readiness for change.

Psychological Interventions include cognitive behaviour therapies, behavioural therapies or social network and environment based therapies

Peer Support includes self - help groups e.g. twelve steps groups, Alcoholics Anonymous and SMART recovery

Community Recovery Support includes interventions to build recovery capital

Opioid Dependence



Opioid Dependence

Introduction

TSUS prescribes Medication Assisted Treatments (MAT) methadone, buprenorphine or buprenorphine/naloxone, as opioid replacement therapy to support people dependent on opiates to reduce harm and enable recovery. MAT is prescribed as a reducing or maintenance regimen. Finally the opiate antagonist naltrexone is prescribed to prevent relapse. Prescribed treatments are delivered subject to recovery plans alongside a psychosocial programme of care, delivered by TSUS staff or other organisations.

Key guidance documents

NICE Guideline 52 Drug Misuse: Opiate Detoxification 2007
NICE Guideline 51 Drug Misuse: Psychosocial Interventions 2007
NICE technology Appraisal 114, Methadone and buprenorphine for the management of opioid dependence 2007
NICE Technology Appraisal 115, Naltrexone for the management of opioid dependence 2007
NICE Pathway: Drug Misuse Management in Over 16's
Drug Misuse and Dependence, UK guidelines on clinical management 2017
Medications in Recovery, National Treatment Agency 2012
Medication Assisted Treatment Standards, Drug Death Task Force 2020
British National Formulary
British Association of Psychopharmacology updated guidelines: evidenced based guidelines for the pharmacological management of substance use, harmful use, addiction and comorbidity: recommendations from BAP. Journal of Psychopharmacology 2012
(1) The impact of buprenorphine and methadone on mortality: a primary care cohort study in the United Kingdom. Hickman, Steer, Tilling. Addictions: 2018, 113(8), p.1461 – 1476.
(2) The relative risk of fatal poisoning by methadone or buprenorphine within the wider population of England and Wales. Marteau, McDonald, Patel. BMJ Open 2015;5: e007429

MAT standards underpinning ORT include;

1. All people accessing services have the option to start MAT from the same day of presentation
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose
3. All people at high risk of drug related harm are proactively identified and offered support to commence, recommence or continue MAT
4. All people are offered evidenced based harm reduction at the point of MAT delivery
5. All people will receive support to remain in treatment for as long as requested
6. The system that provides MAT is psychologically and trauma informed (Tier1); routinely delivers evidenced based low intensity psychosocial interventions (Tier2); and supports the development of social networks
7. All people have the option of MAT shared with primary care
8. All people have access to advocacy and support for housing, welfare and income needs
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery
10. All people receive trauma informed care

Summary of specialist treatments:

Opioid replacement therapies (ORT)
ORT involves the prescribing of opioid drugs to dependent individuals using the principle of cross-tolerance to stop withdrawal symptoms. This gives people the opportunity to reduce the biological, psychological and social harm associated with their drug use. ORT has a number of phases: induction aiming to start treatment safely; optimization to maximize the effectiveness of treatment; maintenance involves remaining on a level dose; and reduction/detoxification involves reducing the dose to zero. The drugs used in TSUS include methadone, buprenorphine and buprenorphine/naloxone.

Treatment Choice
Both methadone and buprenorphine are cost-effective and recommended by NICE for the purposes of ORT. There is accumulating evidence that buprenorphine is associated with reduced risk of fatal opiate overdose compared to treatment with methadone (1) and is safer than methadone with regard to opiate overdose risk in the general population (2) There is also evidence that methadone is more effective in retaining patients in treatment and so may indirectly reduce risks in the longer term. Factors that would be taken into account to help reach a decision on ORT choice include:

- A patient`s informed choice for either drug
- The potential value of rapid and safer induction with buprenorphine
- Previous response to treatment with either medicine
- Specific safety concerns (diversion, overdose, previous early disengagement from treatment, QTC prolongation)
- Drug interactions and contraindications
- Local factors such as lack of geographical availability of supervised consumption or daily dispensing and drug death mortality trends in the local population
- Alternate day dispensing is preferred
- Access to a depot preparation is preferred or being considered

Detoxification
This is a discreet, usually time-limited process which aims to render a dependent individual drug-free in as safe and comfortable a manner as possible. Detoxification often but not exclusively follows a period of ORT, and those with short uncomplicated histories with good recovery capital may choose to move directly to this approach or briefly stabilise on ORT. Detoxification treatments used in Tayside include Lofexidine, methadone or buprenorphine.

Maintenance of Abstinence
Once a person is drug free they may choose to access prescribing support to maintain their abstinence. The opioid antagonist Naltrexone may be used with psychosocial interventions.

Overdose treatment
To avoid fatal overdose, all patients should receive overdose awareness training and will also be offered the short acting, parenteral opioid antagonist Naloxone.

Care Pathways

Pathway 3: Opioid Dependence Medical Treatment Access Pathway – Opiate Replacement Therapy. This pathway details the assessment and prescribing of substitute opioid therapy, including initiation, optimization and maintenance therapy.

Pathway 4: Opioid Dependence Pathway – Detoxification – Community. This pathway details the pharmacological management of opioid withdrawal.

Pathway 5: Substitute Opiate Dispensing Pathway

Pathway 6: Monitoring Opiate Replacement Therapy

Tools used

Clinical Opiate Withdrawal Scale is used to assess the severity of opioid withdrawal. This informs the assessment of opioid dependence and also confirms withdrawal when transferring from methadone to buprenorphine.

The guidelines describe whenever possible the standards expected of prescribers and clinical staff in TSUS. This field, however, also requires good clinical judgement to ensure treatment is delivered in a personalised way. National treatment guidance reflects that given the diversity of local circumstances/delivery arrangements, clinicians should take cognisance of the best available evidence base to guide their decision-making. Discussion with colleagues to form a consensus is valuable and deviation from normal practice should be discussed with a Consultant Psychiatrist and recorded in the clinical records.

Pathway 3: OPIOD DEPENDENCE MEDICAL TREATMENT ACCESS PATHWAY-OPIATE REPLACEMENT THERAPY

Comprehensive assessment and;

- Deliver overdose awareness training and offer take home naloxone kit
- Deliver NHS Inform benzodiazepine harm reduction advice
- Deliver harm reduction advice regarding intravenous substance use
- Offer blood borne virus testing
- Give methadone and buprenorphine PIL
- Care plan
- Risk assessment and management plan
- Getting Our Priorities Right for Every Child form

Prescriber assessment

Assess dependence including;

- Opiate use on a regular basis, usually daily
- Minimum of one opiate positive drug screen in the previous week
- Signs of opiate withdrawal, COWS>8 or history of withdrawal symptoms
- Signs of intravenous substance use
- If significant co-morbidity assessment by medical or psychiatric staff

Each of these features is suggestive of opiate dependence but are not diagnostic on their own. The more that are present, the more likely dependence is. The absence of any feature does not exclude diagnosis

- Establish treatment goal, detox or maintenance
- Support informed decision regarding ORT treatment choice and record informed consent and treatment plan

Treatment Goal Opiate Replacement Treatment

Induction and optimisation

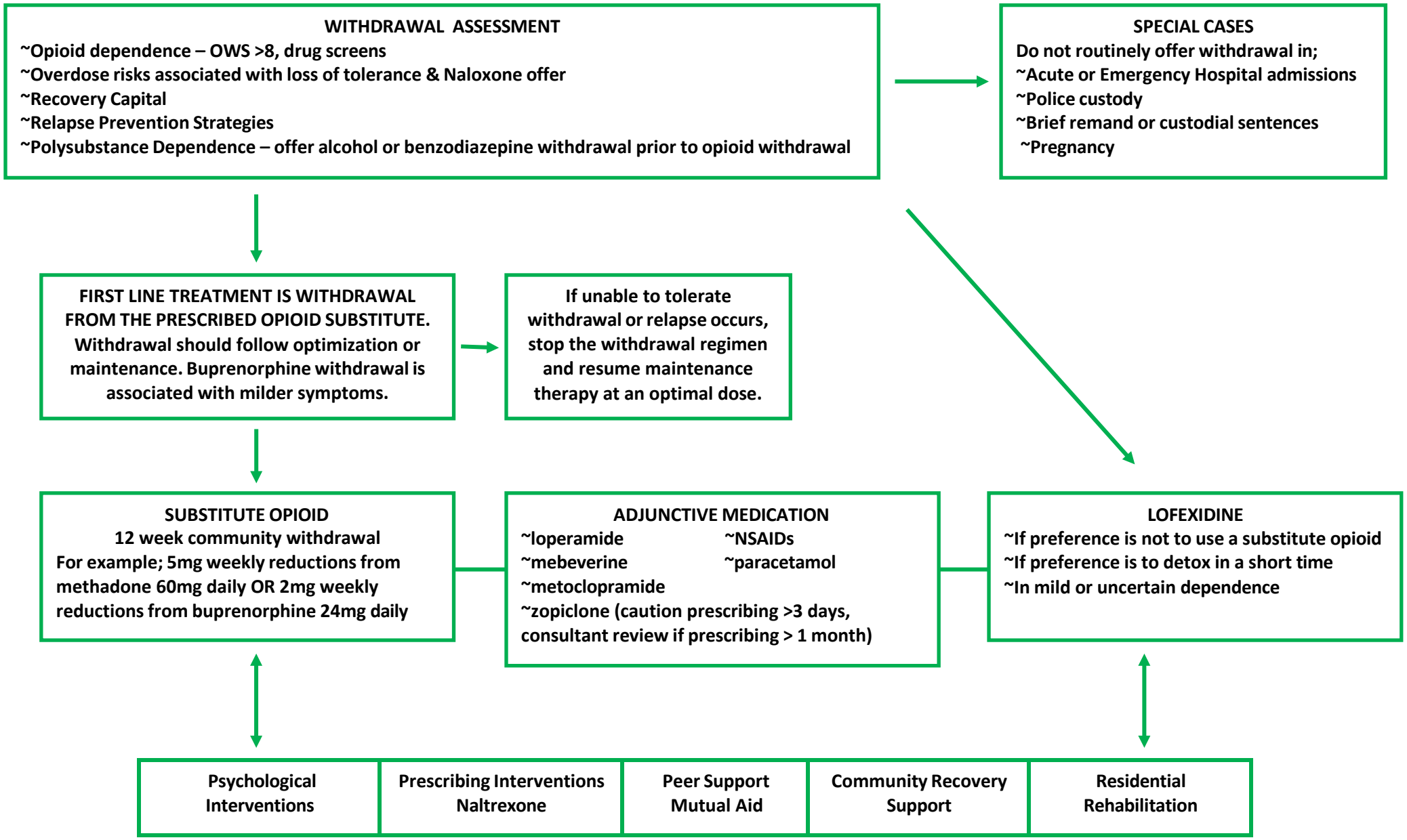
Weekly assessment of substance use and discussion with prescriber

Maintenance phase

- Keyworker sessions to assess substance use and progress recovery goals, minimum quarterly
- Strategic reviews six monthly or if risks /needs indicate
- Psychosocial interventions and input from other professionals and agencies

Treatment Goal Opiate detoxification or mild / uncertain dependence go to Pathway 4

Pathway 4: OPIOID DEPENDENCE PATHWAY: DETOXIFICATION - community



Clinical Opiate Withdrawal Scale (COWS)

For each item, record 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 increased pulse rate would not add to the score.

Resting Pulse Rate: _____beats/minute Measured after patient is sitting or lying for 1 minute 0 = pulse rate 80 or below 1 = pulse rate 81-100 2 = pulse rate 101-120 4 = pulse rate greater then 120	**GI Upset:** *over last ½ hour* 0 = no GI symptoms 1 = stomach cramps 2 = nausea or loose stools 3 = vomiting or diarrhoea 5 = multiple episodes of diarrhoea or vomiting
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 = no report of chills or flushing 1 = subjective report of chills or flushing 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 four 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 = pilo-erection of skin can be felt or hairs standing up on arms 5 = prominent pilo-erection
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	**Score:** **8-12 = mild** **13-24 = moderate** **25-36 = moderately severe** **> 36 = severe withdrawal**

Level of Sedation for each item, record the number that best describes the patient's signs or symptom.

Concentration	**Sedation**
0 = Good concentration 1 = Slightly distracted 2 = Very distracted 3 = Extremely distracted	0 = Alert 1 = Heavy Eyed 2 = Eyes closed for 30-60 seconds 3 = Sleeping for more than 1 minute
Gauching Patient motionless and drowsy with eyes closed for >1min. ***Record Yes/No***	

PATHWAY 5: SUBSTITUTE OPIATE DISPENSING PATHWAY

- **Daily supervised dispensing six or seven days per week**
- Supervised dispensing when ORT commenced for minimum three months unless assessed as lower risk since commencing treatment. Initial buprenorphine doses may be collected, (day one standard induction or microdosing induction)
- Prior to six days per week dispensing observe a lockable box and discuss safe storage

↓

- **Risk assessment considering;**

1. Risks of noncompliance assessed by pharmacy and multiagency feedback, compliance with recovery plan, and drug screens (lower risk demonstrated by consecutive screens negative for illicit substances)
2. Risks of overdose, e.g. alcohol use, illicit substance use, misuse of prescription depressant medications, injecting, overdose history
3. Risks of diversion, e.g. samples negative for prescribed medicine, diversion history
4. Risks around safe storage, e.g. homelessness, vulnerable adults, children
5. Significant unstable mental illness or risk of harm to self
6. Risks of erratic compliance, e.g. cognitive impairment
7. Risks of disengagement due to supervised regime, e.g. working/mobility/health issues

↓

Unsupervised daily dispensing

- Lower risk
- Caution with methadone doses than 90mg daily
- Not prescribed diazepam by TSUS
- If lower risk status is maintained and there is engagement in objectively confirmed structured daily activities, consider progressing to three times weekly dispensing, twice weekly dispensing after a further period of stability, and if stability maintained weekly dispensing.

↓

Risk assessment and drug screening should be reviewed and if risk status changes discuss with a prescriber.

Pathway 6: Monitoring Opioid Replacement Therapies (ORT)

Governance Review Standards for Maintenance ORT									
These are minimum standards and can be implemented more frequently as required (excluding SMR25)									
Appointment	**SBAR**	**Care plan**	**Risk assessment**	**GOPR**	**SMR25**	**Drug screens**	**Naloxone**	**BBV SH**	**GP update**
3/12	3/12	6/12	6/12	6/12	Annual	3/12	Annual	Annual	6/12

Overdose awareness training and take home naloxone

Always deliver :

- prior to commencing ORT
- when assessed as Overdose risk
- when prescribed diazepam
- annually

Seek consent to also train other contacts

Drug screening tests

Routine testing - Weekly during optimization; three monthly during maintenance, monthly during detox. Self-reporting may suffice in some situations based on clinical judgement.

Reactive tests - Should be prompted by clinical concerns/risks, poly-substance use, changes in mental state, sedation etc.

Prescription non-collection

A further dose should not be dispensed until situation assessed by specialist service if 3 consecutive collections are missed

THEN

Case should be assessed and discussed with prescriber

Missed appointments

Explore barriers to engagement and agree care plan actions to address barriers. Consider assertive outreach. Consider delaying dispensing until after appointment if there are concerns about the safety of OST prescribing, or child protection concerns

Reviews minimum standards

Weekly during optimisation phase
Three monthly during maintenance phase
Monthly during reduction phase
If destabilises at any stage - increase contact
Strategic reviews six monthly

Prescription Changes

Holiday prescriptions should firstly be dispensed in a pharmacy at the holiday location. Collected holiday prescriptions are not provided if usual dispensing is supervised, the holiday is within the UK and there is a suitable pharmacy

SUMMARY OF OPIOID PRESCRIBING INTERVENTIONS

DRUG	ACTION	TREATMENT START	DOSAGE
Methadone mixture 1mg/ml	Adjunct in the treatment of opioid dependence. Opioid receptor agonist.	For patient who based on factors listed on page 28, would be more suited to methadone than buprenorphine	BNF - Start 10-40mg on day 1, then increase by 10mg daily (maximum weekly increase 30mg) until no signs of intoxication or withdrawal. Usual dose range 60-120mg daily. [NB clinical judgement] Optimal dose is associated with no signs of intoxication or withdrawal, and illicit opioid use has been eliminated.
Buprenorphine	Adjunct in the treatment of opioid dependence. Opioid receptor partial agonist.	For patients who, based on factors listed on page 28, would be more suited to buprenorphine than methadone. Baseline liver function testing and documentation of viral hepatitis status is recommended prior to treatment with regular liver function tests during treatment. In mild to moderate impairment use lower initial doses and titrate carefully and avoid in severe impairment. Caution if concomitant use of hepatotoxic drugs. Waiting for the results of LFTs should not unnecessarily delay starting treatment where the risks of delay outweigh the relatively small risks of a hepatic reaction.	Dependence on high dose opioids (e.g.>1g heroin injected daily) increases the risk of precipitated withdrawal. To minimise precipitated withdrawal risks administer the first dose when signs of withdrawal observed OWS >8, 6-12 hours after last heroin use; or 24-48 hours after last methadone dose. BNF - Start up to 8mg on day 1, increasing by 2-4mg daily to usual dose of 12-24mg daily. Maximum dose 32mg buprenorphine, 24mg buprenorphine/naloxone and 18mg espranor. On day one multiple 2mg doses up to the maximum of 8mg may be suitable. [NB clinical judgement up to 8mg on day 1 in divided doses] Methadone dose should be reduced to maximum of 30mg daily with at least 24 hours since last methadone dose before commencing buprenorphine. For doses greater than 30mg Methadone in-patient transfer may be

			considered. Methadone dose <10mgs, start at 2mg buprenorphine and titrate. Methadone dose 10-30mg, start at 4-8mg buprenorphine and titrate. For those unable to tolerate opioid withdrawal prior to commencing buprenorphine or for those requiring high dose methadone transfer consider microdosing; Day 1 - 200mcg od Day 2 - 400mcg od Day 3 - 400mcg bd Day 4 – 1mg od Day 5 – 1mg bd Day 6 – 2mg bd Day 7 – 4mg bd Day 8 – 12mg od (stop other opiates)
Buprenorphine + Naloxone (Suboxone)	Adjunct in the treatment of opioid dependence. Opioid receptor partial agonist.	See buprenorphine for indications and start-up recommendations. Buprenorphine + Naloxone can be prescribed where there is a risk of; dose diversion; parenteral administration; seven day dispensing is not available. The naloxone component precipitates withdrawal if the preparation is injected. Switch to buprenorphine in pregnancy.	See buprenorphine for start-up dosages. Maximum dose 24mg
Buprenorphine oral lyophilisate (Espranor)	Adjunct in the treatment of opioid dependence. Opioid receptor partial agonist	As per buprenorphine. A rapid dissolve formulation of buprenorphine. For patients suitable for buprenorphine and who are supervised, and • are at risk of diverting and/or misusing medication despite supervision; or	Dependence on high dose opioids (e.g.>1g heroin injected daily) increases the risk of precipitated withdrawal. To minimise precipitated withdrawal risks administer the first dose when signs of withdrawal observed OWS >8, 6-12 hours after last heroin use; or 24-48 hours after last methadone dose. The recommended starting dose is Espranor 2mg. An

		• compliance with dispensing regime is poor due to time taken for buprenorphine supervision; or • rapid dosing is preferred due to time constraints e.g. prison healthcare.	additional one to two Espranor 2 mg oral lyophilisates may be administered on day one depending on the individual patient's requirement. The dosage can be titrated up or down according to assessment of the clinical and psychological status of the patient in steps of 2-6 mg until the minimum effective maintenance dose is achieved, but should not exceed a maximum single daily dose of 18 mg
Buprenorphine depot Buvidal®	Adjunct in the treatment of opioid dependence. Partial opioid receptor agonist	As per buprenorphine For patients suitable for buprenorphine and • are at risk of diverting and/or misusing medication despite supervision, or where supervision or daily dispensing is not available; or • compliance with dispensing regime is poor with frequent missed doses of ORT or disengagement from treatment; or • patient preference is for less frequent dispensing to promote engagement in social and occupational activities conducive to their recovery.	See page 40 for guidance on Buvidal® prescribing
Lofexidine **(Note – no currently licensed preparation of lofexidine available in the UK. Use of unlicensed preparations is through approval of a**	Alleviates some physical symptoms of opioid withdrawal.	As an alternative to opioid substitute in those with mild or uncertain dependence or a short history of illicit drug use. Assess for cardiac and cerebrovascular disease prior to initiation and monitor heart rate and blood pressure on initiation and in the first 72 hours or until a stable dose is achieved.	Test dose with 0.2mg in opiate withdrawal and observe for two hours including BP & HR. If tolerated increase to max 0.2mg x6 on day 1. Increase as necessary in steps of 0.4-1.2mg to a maximum dose of 2.4mg. Recommended duration of treatment 7-10 days if opioid free but longer may be required.

non formulary Request form	Alpha2 adrenergic agonist.	Withdraw gradually over 2-4 days to avoid rebound hypertension.	Consider adjunctive therapy with loperamide, mebeverine, metoclopramide, paracetamol, NSAID's and zopiclone (limit zopiclone to three days due to potential for abuse).
Naltrexone	An aid to prevent relapse. Opioid receptor antagonist	Adjunct to prevent relapse in formerly opioid dependent people who are motivated to remain in a supportive abstinence programme. 7-10 days opioid free (3-5 days post buprenorphine withdrawal). Assess with history and drug screens three days prior to naltrexone initiation and on day of initiation. Test LFT's and U&E's prior to treatment. Discuss information card issued with oral Naltrexone about its impact on opioid analgesics. Warn that any attempt to overcome blockade could result in overdose.	Start 25mg tablet orally day 1, and observe for one hour. Increase to 50mg daily from day 2 if well tolerated and dispense weekly. Review 3 monthly and monitor LFT's. If restarting ORT, substitute prescribing can be initiated at low doses 3 days after stopping naltrexone. Patient should be monitored closely for signs of opiate withdrawal during re-titration.
Naloxone	To reverse opioid overdose.	Opioid receptor antagonist administered IV, IM, S/C, Intranasal. People likely to be present at the scene of an opiate overdose can be supplied with a take home naloxone kit to be used in the event of an emergency. Overdose awareness training should be offered to all patients, family members and carers	

Buvidal® : Weekly and Monthly Buprenorphine Depot Preparations

Introduction
Buvidal® is a prolonged release buprenorphine product which is administered as a subcutaneous injection either weekly or monthly, and is indicated for the treatment of opioid dependence within a framework of medical, social and psychological support. Treatment is intended for use in adults and adolescents aged 16 years or over. The administration of Buvidal® must be carried out by a healthcare professional competent in the administration of subcutaneous depot injections.

Preparation for prescribing
- Patient has had a comprehensive substance misuse assessment
- Patient must be counselled on potential risk/benefits of Buvidal®
- Patient must consent to treatment with Buvidal®

Precautions
Baseline LFTs and viral hepatitis status recommended pre-treatment. Patients who are positive for viral hepatitis, taking other medicines and/or existing liver dysfunction are at greater risk of liver injury. Regular monitoring of liver function is recommended.

Contraindications
- Hypersensitivity to buprenorphine or to any excipients of Buvidal®.
- Severe respiratory insufficiency
- Severe hepatic impairment
- Acute alcoholism or delirium tremens

Interactions with other medicines, side effect profile etc, are the same as other buprenorphine products (as per current SPC/BNF)

Initiating treatment in patients not already receiving buprenorphine
To avoid precipitating symptoms of withdrawal, treatment with Buvidal® should be started when objective and clear signs of mild to moderate withdrawal are evident.

For patients using heroin or short-acting opioids, the initial dose of Buvidal® must not be administered until at least 6 hours after the patient last used opioids.

For patients receiving methadone, the methadone dose should be reduced to a maximum of 30mg/day before starting treatment with Buvidal® which should not be administered until at least 24 hours after the patient last received a methadone dose

Patients who have not previously been exposed to buprenorphine should receive an oro-dispersible buprenorphine 4mg dose and be observed for an hour post administration before the first administration of weekly Buvidal® to confirm tolerability to buprenorphine. To avoid precipitating an opioid withdrawal syndrome, the first dose of buprenorphine should be started only when objective signs of mild to moderate withdrawal are evident.

Treatment with monthly Buvidal® can be started once patients have been stabilised on weekly treatment (four weeks or more where practical)

Starting dose recommendations

Day 1	During week 1	Week 2
16 mg injection	One or two additional 8mg doses at least one day apart. The target dose during the first week of treatment is 24mg or 32 mg	The recommended dose for the second treatment week is the total dose administered during the week of initiation

Switching from oro-dispersible buprenorphine products to Buvidal®
Patients treated with other formulations of buprenorphine may be switched directly to weekly or monthly Buvidal® starting on the day after the last daily buprenorphine sublingual treatment dose in accordance with the dosing recommendations. Close monitoring of patients is recommended during the dosing period after transition.

Oral buprenorphine daily treatment doses and recommended corresponding doses of weekly and monthly Buvidal®

Dose of daily sublingual buprenorphine (espranor)	Dose of weekly Buvidal®	Dose of monthly Buvidal®
2-6mg (2-4mg)	8mg	-
8-10mg (6-8mg)	16mg	64mg
12-16mg (10-12mg)	24mg	96mg
18-24mg (14-18mg)	32mg	128mg
24-32mg	-	160mg

Method of Administration

Buvidal® is intended for subcutaneous administration only. It should be injected slowly and completely into the subcutaneous tissue of different areas (buttock, thigh, abdomen, or upper arm), provided there is enough subcutaneous tissue.

Each area can have multiple injection sites. Injection sites should be rotated for both weekly and monthly injections. A minimum of 8 weeks should be left before re-injecting a previously used injection site with the weekly dose. Administered dose should be as a single

injection and not divided. The dose must not be administered intravascularly (intravenously), intramuscularly or intradermally (into the skin).
The product must not be used if the safety syringe is broken or the packaging is damaged. The syringe must be handled carefully to avoid a needle stick injury. The safety syringe includes a needle protection safety device that will activate at the end of the injection. The cap should not be removed until ready to inject; once uncapped, never try to recap the needle. The safety syringe should be disposed of immediately after use. Do not re-use. The needle shield of the syringe may contain rubber latex that may cause allergic reactions in latex-sensitive individuals.

Maintenance treatment and dose adjustments
Doses may be adjusted up or down, and patients can be switched between weekly and monthly products when the next dose is due. A maximum of one supplemental Buvidal® 8mg dose may be administered at an unscheduled visit between regular weekly or monthly doses, based on individual patients' temporary needs.

The maximum dose per week for patients who are on weekly Buvidal® treatment is 32mg with an additional 8mg dose.

The maximum dose per month for patients who are on monthly Buvidal® treatment is 160mg. No additional 8mg dose is allowed.

Missed doses
To avoid missed doses:

- Weekly Buvidal® doses may be administered up to two days before or after the weekly scheduled appointment
- Monthly Buvidal® doses may be administered up to one week before or after the monthly scheduled appointment.

If a dose is missed, the next dose should be administered as soon as practically possible following consultation with a prescriber.

Termination of treatment
If Buvidal® treatment is discontinued, its prolonged-release characteristics and any withdrawal symptoms experience by the patient must be considered. If the patient is switched to treatment with sublingual buprenophine, this should be done one week after the last weekly dose or one month after the last monthly dose of Buvidal® according to recommended dose equivalencies in first table above.

Adverse reactions
The adverse reactions most frequently reported for buprenorphine, including Buvidal® are headache, nausea, hyperhidrosis, insomnia, drug withdrawal syndrome and pain. The most common injection site reactions are injection side pain, injection site pruritis, and injection site erythema. The injection site reactions are normally mild or moderate in severity, and most events are transient.

PREGNANCY

Acute withdrawal of opioids should be avoided in pregnancy because it can cause fetal death. Opioid substitution therapy is recommended during pregnancy because it carries a lower risk to the fetus than continued use of illicit drugs. If a woman who is stabilised on methadone or buprenorphine for treatment of opioid dependence becomes pregnant, therapy should be continued (buprenorphine is not licensed for use in pregnancy].

Many pregnant patients choose a withdrawal regimen, but withdrawal during the first trimester should be avoided because it is associated with an increased risk of spontaneous miscarriage. Withdrawal of methadone or buprenorphine should be undertaken gradually during the second trimester; for example, the dose of methadone may be reduced by 2–3 mg every 3–5 days. If illicit drug use occurs, the patient should be re-stabilised at the optimal maintenance dose and consideration should be given to stopping the withdrawal regimen.

Further withdrawal of methadone or buprenorphine in the third trimester is not recommended because maternal withdrawal, even if mild, is associated with fetal distress, stillbirth, and the risk of neonatal mortality. Drug metabolism can be increased in the third trimester; it may be necessary to either increase the dose of methadone or change to twice-daily consumption (or a combination of both strategies) to prevent withdrawal symptoms from developing. Monitor for signs of intoxication following delivery.

Buprenorphine with naloxone should be switched to buprenorphine as reproductive toxicity has been found in animal studies.

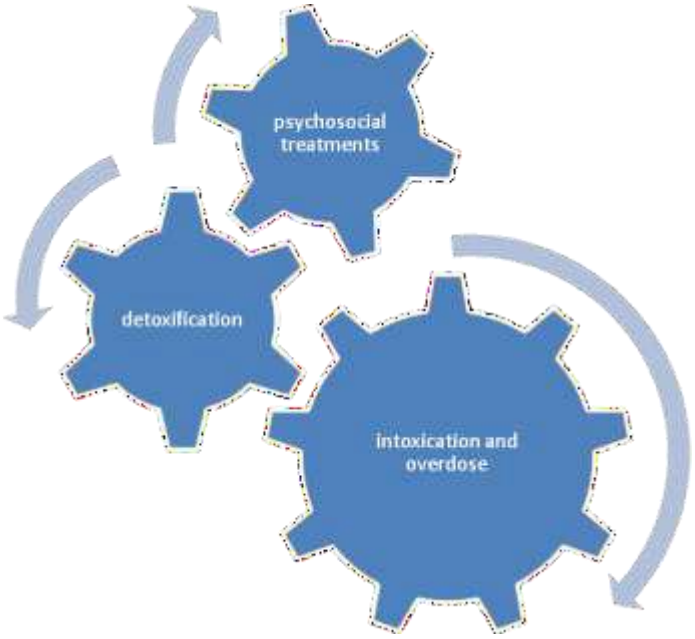
BREAST FEEDING

The dose of methadone should be kept as low as possible in breast-feeding mothers and the infant should be monitored for sedation (high doses of methadone carry an increased risk of sedation and respiratory depression in the neonate).

Buprenorphine is excreted in low concentrations in breast milk and has low oral bioavailability; however, neonates should be monitored for drowsiness, adequate weight gain, and developmental milestones. The naloxone in buprenorphine with naloxone is not orally bioavailable.

Increased sleepiness, breathing difficulties, or limpness in breast-fed babies of mothers taking opioid substitutes should be reported urgently to a healthcare professional.

Benzodiazepine Use



Benzodiazepine Use

Introduction

Some individuals receiving opiate replacement therapy (ORT) from TSUS also use illicit Benzodiazepines. Some will use in a binge pattern and some will use dependently and may be considered for a prescribed Diazepam reduction regimen. Normally, harm reduction interventions should be delivered, the care plan and ORT should be optimised and heroin and other substance use should be eliminated prior to assessment for diazepam prescribing to reduce the risks associated with co-prescribing. Diazepam prescribing should only be delivered alongside psychosocial interventions.

Key guidance documents

FDA labelling requirements for prescription opioids and benzodiazepines 2016
CMDh text warning about the concomitant use of benzodiazepines or benzodiazepine like drugs and opioids 2018
MHRA /CHM advice: Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression 2020
PHE Evidence of harm from illicit or fake benzodiazepines 2020 (Harm reduction advice)
NHS Inform Benzodiazepines (benzos, diazepam, valium) Public Health Scotland Harm Reduction Advice 2020
NICE Key Therapeutic Topic; Hypnotics 2015
Benzodiazepines Risks and benefits. A reconsideration. Baldwin et al. Journal of Psychopharmacology 2013
BAP updated guidelines: evidenced-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. AR Lingford-Hughes et al. Journal of Psychopharmacology. 2012
Drug Misuse and Dependence, UK guidelines on clinical management 2017
British National Formulary
BMJ editorials: The growing problem of co-treatment with opioids and benzodiazepines 2017

Summary of specialist treatments

TSUS prescribes Diazepam for the purpose of assisting Benzodiazepine withdrawal for those wishing to achieve abstinence from illicit Benzodiazepine use.

Brief intervention maps should be used as an educational and motivational tool prior to engaging with the TSUS Benzodiazepine Handbook.

The TSUS Benzodiazepine Handbook is used collaboratively in keyworking sessions during the assessment period and during prescribed withdrawal.

The Benzodiazepine Comparable Dose Table [p48] is used to inform conversion of any *prescribed* Benzodiazepines to the comparable Diazepam dose prior to prescribing.
Psychological interventions should support the prescribed Diazepam regimen.

Benzodiazepine detoxification
Diazepam withdrawal regimens with 1mg, 2mg, 5mg and 5mg/2mg reductions are detailed in this document, the intervals between reductions can be specified. The withdrawal regimen is agreed in partnership and the service user signs and retains the document for reference as required. The BNF suggests smaller decrements with longer intervals for those on longer term maintenance prescriptions e.g. 1-2mg fortnightly to monthly decrements, whereas those commencing new prescriptions can reduce more rapidly e.g. 5mg fortnightly or 2mg weekly decrements.

The addition of beta blockers, antidepressants and antipsychotics should be avoided where possible. Consult the BNF for advice when considering prescribing in hepatic or renal impairment, pregnancy or breastfeeding.

Pathways
The Diazepam pathway describes how to manage illicit Benzodiazepine use.

Harm Reduction:

- Arrange overdose awareness training and take home Naloxone
- Use NHS Inform Benzodiazepines to deliver Harm Reduction Advice
- Deliver safer self reduction advice; split dose twice daily and small gradual reductions, avoid suddenly stopping treatment

⇩

Psychosocial interventions

- Complete *MAPs 1 and 2* [p 46 &47 below]
- Complete TSMS Benzodiazepine Handbook/ MET sessions

⇩

Optimise current care

- Strategic review to include social work, psychology, nursing, pharmacist, medical and third sector staff and patient
- Optimise ORT to eliminate illicit opioid use
- Optimise care plan and eliminate other substance use

⇩

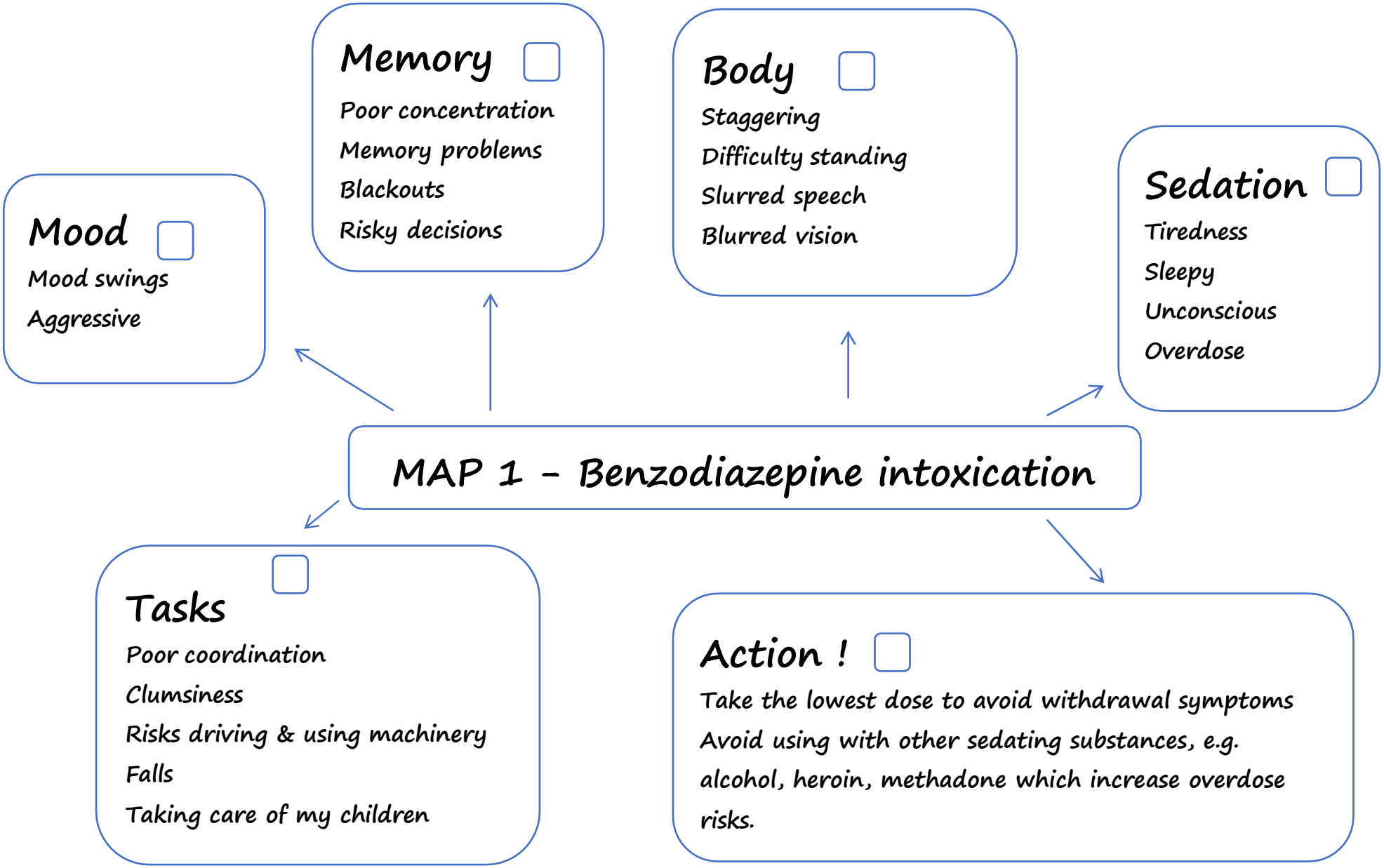
Prescribing Assessment

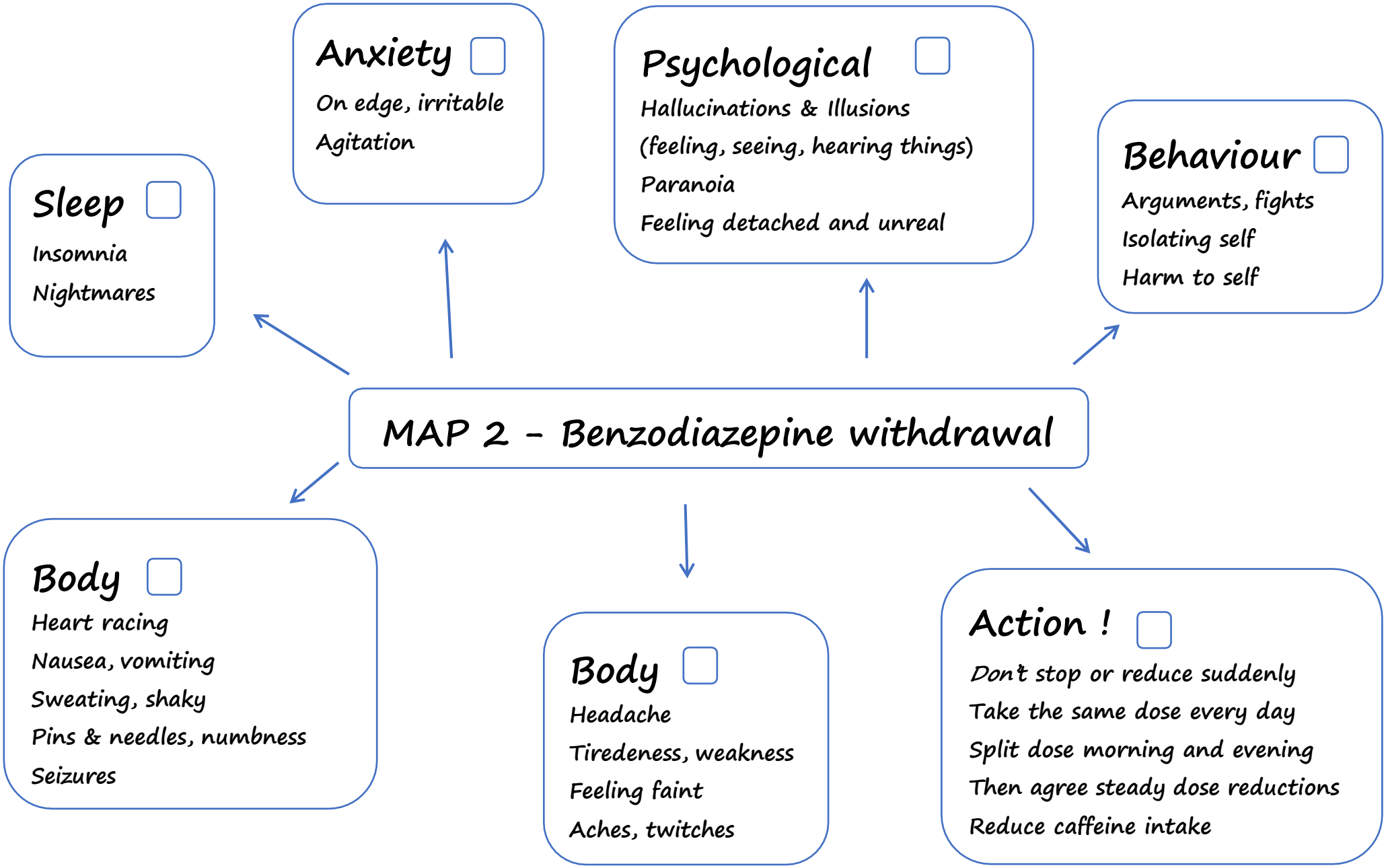
- If illicit benzodiazepine use persists and the goal is abstinence assess for a prescribed Diazepam withdrawal.
- Confirm daily dependent benzodiazepine use by history/diaries and 2 x drug screens positive for benzodiazepines and negative for other illicit substances.
- The MHRA reminds healthcare professionals that opioids co-prescribed with benzodiazepines can produce additive CNS effects, thereby increasing the risk of sedation, respiratory depression, coma, and death
- Consider prescribing Diazepam only if there is no alternative, and if necessary the lowest possible doses should be given for the shortest duration
- Provide information to support informed decision making and record informed consent
- Maximum starting dose 30mg daily
- Agree a reducing regimen [see pages below]
- No maintenance diazepam prescribing
- Daily collection of diazepam and supervised ORT dispensing
- No collected holiday prescriptions
- If continued illicit use or overdose / intoxication review the planned duration of treatment

⇩

Service monitoring:

- Patients should be closely monitored for respiratory depression at initiation of treatment and any changes such as doses adjustments or new interactions
- With methadone monitor for two weeks after initiation and dose adjustments
- Monitor drug screens for benzodiazepine, gabapentoids, opioids
- Discuss any concerns with a prescriber


Memory
Poor concentration
Memory problems
Blackouts
Risky decisions
Body
Staggering
Difficulty standing
Slurred speech
Blurred vision
Mood
Mood swings
Aggressive
Sedation
Tiredness
Sleepy
Unconscious
Overdose
MAP 1 - Benzodiazepine intoxication
Tasks
Poor coordination
Clumsiness
Risks driving & using machinery
Falls
Taking care of my children
Action !
Take the lowest dose to avoid withdrawal symptoms
Avoid using with other sedating substances, e.g. alcohol, heroin, methadone which increase overdose risks.


Anxiety
On edge, irritable
Agitation
Psychological
Hallucinations & Illusions
(feeling, seeing, hearing things)
Paranoia
Feeling detached and unreal
Behaviour
Arguments, fights
Isolating self
Harm to self
Sleep
Insomnia
Nightmares
MAP 2 - Benzodiazepine withdrawal
Body
Heart racing
Nausea, vomiting
Sweating, shaky
Pins & needles, numbness
Seizures
Body
Headache
Tiredeness, weakness
Feeling faint
Aches, twitches
Action !
Don't stop or reduce suddenly
Take the same dose every day
Split dose morning and evening
Then agree steady dose reductions
Reduce caffeine intake

Benzodiazepine Comparable Doses to Diazepam 5mg
Alprazolam 250 micrograms
Clobazam 10mg
Clonazepam 250 micrograms
Flurazepam 7.5mg – 15mg
Chlordiazepoxide 12.5mg
Loprazolam 0.5 – 1mg
Lorazepam 500 micrograms
Lormetazepam 0.5 – 1mg
Nitrazepam 5mg
Oxazepam 10mg
Temazepam 10mg

When TSUS takes over prescribing of Benzodiazepines from other services, compliance with their Benzodiazepine prescription will always be confirmed by drug screening prior to prescribing. All medications should be converted to the equivalent Diazepam dose and prescribed as a Diazepam withdrawal regimen. No other Benzodiazepines are prescribed by TSUS except to manage alcohol withdrawal.

In the rare circumstance where a confirmed prescription of over 30mg of Benzodiazepines is in place during a service transfer/taking over GP case, TSUS will prescribe higher doses pending commencement of a reduction regimen. This process will not exceed 4 weeks.

NB Caution is required if patients report use of illicit "street valium" - as dosages cannot be validated. It is also important, when making prescribing decisions, to be aware of drug interactions involving other prescribed drugs.

DIAZEPAM WITHDRAWAL REGIMEN 5mg decrements

	Morning	2pm	Night	Total Daily Dosage
Stage 1	10mg	10mg	10mg	30mg
Stage 2	10mg	5mg	10mg	25mg
Stage 3	10mg		10mg	20mg
Stage 4	5mg		10mg	15mg
Stage 5	5mg		5mg	10mg
Stage 6			5mg	5mg
Daily dispensing		**Frequency of reductions:**		

I agree to the above diazepam withdrawal schedule dispensed daily
I understand collected holiday prescriptions will not be provided for diazepam
I understand substance use will increase my risks and my schedule will be reviewed

Name:

Signature: *Date:*

DIAZEPAM WITHDRAWAL REGIMEN 5mg / 2mg decrements

	Morning	2pm	Night	Total Daily Dosage
Stage 1	10mg	10mg	10mg	30mg
Stage 2	10mg	5mg	10mg	25mg
Stage 3	10mg		10mg	20mg
Stage 4	8mg		10mg	18mg
Stage 5	8mg		8mg	16mg
Stage 6	6mg		8mg	14mg
Stage 7	6mg		6mg	12mg
Stage 8	4mg		6mg	10mg
Stage 9	4mg		4mg	8mg
Stage 10	2mg		4mg	6mg
Stage 11	2mg		2mg	4mg
Stage 12			2mg	2mg
Daily dispensing		**Frequency of reductions:**		

I agree to the above diazepam withdrawal schedule dispensed daily
I understand collected holiday prescriptions will not be provided for diazepam
I understand substance use will increase my risks and my schedule will be reviewed

Name:

Signature: *Date:*

DIAZEPAM WITHDRAWAL REGIMEN 2mg decrements

	Morning	2pm	Night	Total Daily Dosage
Stage 1	10mg	10mg	10mg	30mg
Stage 2	10mg	8mg	10mg	28mg
Stage 3	10mg	6mg	10mg	26mg
Stage 4	10mg	4mg	10mg	24mg
Stage 5	10mg	2mg	10mg	22mg
Stage 6	10mg		10mg	20mg
Stage 7	8mg		10mg	18mg
Stage 8	8mg		8mg	16mg
Stage 9	6mg		8mg	14mg
Stage 10	6mg		6mg	12mg
Stage 11	4mg		6mg	10mg
Stage 12	4mg		4mg	8mg
Stage 13	2mg		4mg	6mg
Stage 14	2mg		2mg	4mg
Stage 15			2mg	2mg
Daily dispensing		**Frequency of reductions:**		

I agree to the above diazepam withdrawal schedule dispensed daily
I understand collected holiday prescriptions will not be provided for diazepam
I understand substance use will increase my risks and my schedule will be reviewed

Name:

Signature: *Date:*

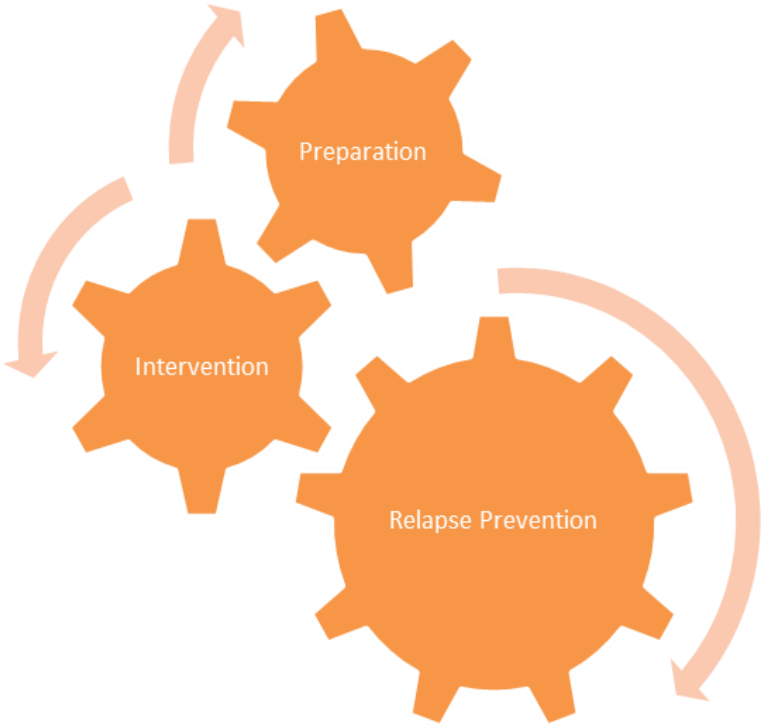
DIAZEPAM WITHDRAWAL REGIMEN 1mg decrements

	Morning	2pm	Night	Total Daily Dosage
Stage 1	10mg	10mg	10mg	30mg
Stage 2	10mg	9mg	10mg	29mg
Stage 3	10mg	8mg	10mg	28mg
Stage 4	10mg	7mg	10mg	27mg
Stage 5	10mg	6mg	10mg	26mg
Stage 6	10mg	5mg	10mg	25mg
Stage 7	10mg	4mg	10mg	24mg
Stage 8	10mg	2mg	11mg	23mg
Stage 9	10mg	2mg	10mg	22mg
Stage 10	10mg		11mg	21mg
Stage 11	10mg		10mg	20mg
Stage 12	9mg		10mg	19mg
Stage 13	8mg		10mg	18mg
Stage 14	7mg		10mg	17mg
Stage 15	6mg		10mg	16mg
Stage 16	5mg		10mg	15mg
Stage 17	5mg		9mg	14mg
Stage 18	5mg		8mg	13mg
Stage 19	5mg		7mg	12mg
Stage 20	5mg		6mg	11mg
Stage 21	5mg		5mg	10mg
Stage 22	4mg		5mg	9mg
Stage 23	4mg		4mg	8mg
Stage 24	2mg		5mg	7mg
Stage 25	2mg		4mg	6mg
Stage 26			5mg	5mg
Stage 27			4mg	4mg
Stage 28			3mg	3mg (1 ½ x 2mg tablets)
Stage 29			2mg	2mg
Stage 30			1mg	1mg (½ x 2mg tablet)
Daily dispensing		**Frequency of reductions:**		

I agree to the above diazepam withdrawal schedule dispensed daily
I understand collected holiday prescriptions will not be provided for diazepam
I understand substance use will increase my risks and my schedule will be reviewed
Name:

Client signature: *Date:*

Inpatient Interventions



TSUS Inpatient Unit Prescribing Guidance

INTRODUCTION

The TSUS inpatient unit uses pharmacological interventions in order to deliver opiate and alcohol detoxification, and initiation and stabilisation on to opiate replacement therapy, for patients who are unable to receive similar interventions in the community. Simultaneous procedures are possible such as stabilisation on to opiate replacement therapy whilst undergoing alcohol detoxification.

Adjunctive pharmacological interventions are also provided such as prophylaxis for Wernicke`s Encephalopathy and prescribing to support relapse prevention (e.g. Acamprosate, naltrexone, and disulfiram). These interventions are detailed in the main protocol.

All patients undergoing detoxification should be at the action stage as measured by the readiness for change questionnaire. In exceptional circumstances this may not be necessary for those with alcohol dependence however such cases should be discussed with senior clinical staff on the ward.

KEY GUIDANCE DOCUMENTS

NICE Public Health Guidance 24, Alcohol Use Disorders: preventing harmful drinking. June 2010
NICE Clinical Guideline 115, Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Feb 2011
NICE Clinical Guideline 100, Alcohol Use Disorders: diagnosis and clinical management of alcohol related physical complications. June 2010
NICE Pathway, Alcohol Use Disorders, June 2014
NICE Technology Appraisal TA325, Nalmefene for reducing alcohol consumption for people with alcohol dependence, November 2014.
SIGN Guideline 74, the management of harmful drinking and alcohol dependence in primary care, Dec 2004
British National Formulary
British Association of Psychopharmacology updated guidelines: evidenced based guidelines for the pharmacological management of substance use, harmful use, addiction and comorbidity: recommendations from BAP. Journal of Psychopharmacology 2012.
Maudsley Prescribing Guidelines 9th Edition. Taylor, Paton, Kerwin.
NICE Pathway: Drug Misuse Overview, April 2014
NICE Pathway; Opioid detoxification for drug misuse, April 2014
NICE Pathway; Pharmacological interventions in opioid detoxification for drug misuse, April 2014
Drug misuse and dependence. UK guidelines on clinical management. DoH. 2007.
Medications in Recovery, National Treatment Agency 2012

PATHWAYS

Alcohol Dependence Pathway (Pathway 2 – Page 11). The purpose of this pathway is to identify those requiring a medically assisted alcohol, and are ready for change, then to identify whether the preferred setting for treatment is inpatient or community based. The pathway also places prescribing in the context of other non-pharmacological interventions

TOOLS USED

SADQ: Severity of Alcohol Dependence Questionnaire to assess the severity of dependence as mild, moderate or severe.
RCQ: Readiness for Change Questionnaire to assess the stage of change as pre-contemplative, contemplative or action.
Specialist Alcohol Assessment Summary – collates the screening tool scores and comorbidity screen and records the intervention.
COWS: Clinical Opiate Withdrawal Scale to assess the severity of opiate withdrawal symptoms.
CIWAA: Clinical Institute Withdrawal Assessment for Alcohol to assess the severity of alcohol withdrawal symptoms.

SUMMARY OF SPECIALIST TREATMENTS

Medically Assisted Alcohol Withdrawal (MAAW):
Symptom triggered Chlordiazepoxide regimens are prescribed for MAAW in inpatient settings.

Opiate detoxification:
Fixed dose lofexidine regime titrated to the specific type and dose of opiate used, and adjusted according to side effects.

Opiate replacement therapy initiation and optimisation:
ORT will be initiated in line with the symptom triggered inpatient opiate initiation protocol, with optimisation beginning in the inpatient environment and continuing into the community.

Vitamins:
Prophylactic intramuscular Pabrinex is prescribed for those at higher risk of developing Wernicke`s Encephalopathy (WE). This will be all patients undergoing alcohol detoxification. Oral Vitamin B is prescribed for all patients prior to discharge. Overt WE is only managed in acute general hospital setting, using intravenous Pabrinex, and transfer should be effected as soon as this is suspected.

Following Successful Medically Assisted Alcohol Withdrawal:
Consider offering Acamprosate or Naltrexone. If Acamprosate or Naltrexone are not suitable or Disulfiram is preferred, consider offering Disulfiram.

Following successful medically assisted opiate withdrawal:

Once a person is drug free they may choose to access medical support to maintain their abstinence. The opioid blocker drug Naltrexone may be used for this purpose, alongside appropriate psychosocial interventions.

Overdose prevention:
To reduce the risk of fatal overdose, all patients undergoing opiate detoxification should receive overdose awareness training and will also be offered the short acting, opioid blocker Naloxone

Protocol for lofexidine based opiate detoxification

Lofexidine is used for the management of symptoms of opioid withdrawal. It is non-opioid and therefore less liable to misuse and diversion. Its use in detoxification is more likely to be successful for patients with a low level of heroin use, for non-polydrug users and for those with shorter drug and treatment histories, or for those at an end stage of methadone detoxification (patients taking not more than 20mg daily). Lofexidine combats symptoms of opiate withdrawal mediated by adrenergic overstimulation. It does not replicate the effects of an opiate substitute.
Note – Currently there is no licensed preparation of lofexidine available in the UK. The use of an unlicensed preparations is through approval of a non formulary Request form.

Precautions

1) severe coronary insufficiency
2) recent MI
3) bradycardia
4) hypotension
5) cerebrovascular disease
6) chronic renal failure
7) pregnancy and breast feeding
8) QT prolongation has been reported

Side effects

1) Drowsiness
2) Dryness of mouth, throat and nose
3) Hypotension
4) Bradycardia
5) Rebound hypertension on withdrawal

Pre-treatment assessment

1) Take baseline bloods specifically LFTs if naltrexone considered post detox
2) Record baseline blood pressure and pulse (including lying and standing BP)
3) General physical examination
4) Urine drug screen

Pre- treatment advice

1) Patients should be advised regarding postural hypotension during first few hours of treatment before tolerance to this develops. Give advice regarding careful standing from sitting position and ensuring adequate fluid intake.
2) Give advice regarding other physical and psychological symptoms of withdrawal and how to manage them
3) Give advice regarding reduction in tolerance following detoxification and increased risk of opiate overdose that may be potentiated by use of alcohol or benzodiazepines.

4) The importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat comorbid mental health problems, and reduce the risk of adverse outcomes (including death).

Drug	Withdrawals appear	Withdrawals peak
Heroin	6-12 hours	Day 2-3
Dihydrocodeine	12-24 hours	Day 3-4
Methadone	36-48 hours	Day 4-5

In-Treatment assessment

1) Check BP and pulse half hourly for 2 hours following test dose
2) Check BP and pulse twice daily prior to drug administration.
3) Monitor BP and pulse regularly after any episodes of bradycardia or hypotension until indicators normalise.
4) Check BP and pulse following any complaints of faintness/dizziness.

If systolic less than 90mmHg or 30mmHg below baseline, or pulse below 55, lofexidine should be withheld until normal measurements are obtained and then reintroduced at a dose 0.2mg lower than before. Medical staff to review ongoing medication regime.

Adjunctive medication

1) Insomnia

This is helped by weighting lofexidine dosage to the evening.
If required, zopiclone 7.5mg nocte can be prescribed although no later than day 7.

2) Diarrhoea and stomach cramps

Loperamide 4mg initially then 2mg after each loose stool.
Usual dosage: 8 mg per day
Maximum dosage: 16mg per day

3) Muscular pains and headaches

Paracetamol 1 gram 4-6 hourly max 4 grams in 24 hours.
Ibuprofen 400mg 6 hourly max 2.4 grams in 24 hours

4) Nausea and vomiting

Metoclopramide 10mg eight hourly

Lofexidine prescribing regime

One day or 24hr period runs from 8am to 8am the following day.

`Test dose day` is the first day they score high enough on the OWS to receive lofexidine. **This is not necessarily the first day of the programme.**

Test dose day

- Once patient scores >8 on the OWS give Lofexidine test dose – 0.2mg
- Then up to three more doses of lofexidine in first 24 hours (max 0.8mg in 24hours including test dose)
- The patient then moves to Day 1 of the appropriate dosing regime

On going prescription should be written up by the ward doctor using the pre-printed dosing regimens that are based on the following chart. These regimes take into account the drug and dose they are detoxifying from... If, due to adverse effects, a patient requires to deviate from the standard dosing regimens, a blank chart should be filled out specifying the tailored lofexidine dosing regimen required. This may need to be updated on a daily basis.

If patient has no physical health issues, the final 2-3 days of the lofexidine detoxification may be completed at home.

Short ½ life opioid *	0.8 mg	1.6 mg	2.4 mg	2.4 mg	2.4 mg	1.6 mg	1.2 mg	0.8 mg	0.4 mg	0.2 mg								
Modified release opioid **		0.8 mg	1.6 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	1.6 mg	1.2 mg	0.8 mg	0.4 mg	0.2 mg						
Methadone: <30mg		0.8 mg	1.6 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	1.6 mg	1.2 mg	0.8 mg	0.4 mg	0.2 mg					
30-80mg		0.8 mg	1.2 mg	1.6 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	1.6 mg	1.2 mg	0.8 mg	0.4 mg	0.2 mg		
>80mg		0.8 mg	0.8 mg	1.2 mg	1.6 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	2.4 mg	1.6 mg	1.2 mg	0.8 mg	0.4 mg	0.2 mg
Buprenorphine: <8mg		0.8 mg	1.2 mg	1.6 mg	1.6 mg	1.6 mg	1.6 mg	1.6 mg	1.2 mg	0.8 mg	0.4 mg	0.2 mg						
>8mg		0.8 mg	1.2 mg	1.6 mg	1.6 mg	1.6 mg	1.6 mg	1.6 mg	1.6 mg	1.2 mg	0.8 mg	0.4 mg	0.2 mg					
Last opioid use		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
		Days since last opioid dose →																	

If commencing naltrexone, initiate at day 10 as per naltrexone prescribing protocol.

Premature discharge

To prevent rebound hypertension lofexidine should not be stopped immediately. In the event of a patient being discharged early, maintain them on their current dose for up to 3 days (dispensing medication in form of a `To Take Out `pack) until they are seen by community staff for review and onward prescribing/reductions. Contact community staff immediately if a patient is discharged early.

LOFEXIDINE DETOXIFICATION – Test Dose Day.

Patients Name.....DOB/CHI.....Ward.....

Day One of the appropriate regime starts once the test dose day is completed.
Complete Lofexidine Test Dose after observations completed and score added. The Score should be ≥8 before test dose is given. < 8 then observations should be re-assessed prior to next drug round.

Lofexidine Test Dose is 0.2mg. Two further doses of Lofexidine 0.2mg should be given at the subsequent drug rounds on test dose day. These subsequent doses may not be required if the patient gets the first test dose late on in the day.

.....

If systolic is less than 90mmHg or 30mmHg below the clients baseline or pulse is below 55 Lofexidine should be withheld until normal measurements are obtained and then reintroduced at a dose of 0.2mg lower than before. Medical staff to review on-going medication regime**.**

Scoring Chart – Test dose day

Date/Time				
Resting Pulse				
GI Upset				
Sweating				
Tremors				
Restlessness				
Pupil Size				
Bone/Joint ache				
Runny Nose/Tearing				
Yawning				
Anxiety/Irritability				
Gooseflesh Skin				
Total				
Sign				

BP/Pulse Chart

Time	Pre-test dose BP	½ hr BP	1 hr BP	1.5 hr BP	2 hr BP			
Sitting								
Standing								
Pulse								
Test dose date	**.....**	**OWS .....**						
Time	Dose	Sign						
	0.2mg							
	0.2mg							
	0.2mg							
	0.2mg							

Extra BP/Pulse if required

A 24 hour period runs from 8am to 8am the following day.

Doctor`s name ..... Signature ..... Date .....

Lofexidine Regime - Clients on short half life opioids prior to detox

Patient name…….. CHI……

DAY 1 commences after the test dose day

Date	0800					1400			1800				2200		
	Day	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials
	TEST DOSE DAY – See separate sheet														
	1	0.2mg				0.2mg			0.4mg				0.4mg		
	2	0.4mg				0.4mg			0.4mg				0.4mg		
	3	0.6mg				0.6mg			0.6mg				0.6mg		
	4	0.6mg				0.6mg			0.6mg				0.6mg		
	5	0.4mg				0.4mg			0.4mg				0.4mg		
	6	0.2mg				0.2mg			0.4mg				0.4mg		
	7	0.2mg				0.2mg			0.2mg				0.2mg		
	8					0.2mg							0.2mg		
	9												0.2mg		
	10														
	11														
	12														

If systolic less than 90mmHg or 30mmHg below baseline, or pulse below 55, lofexidine should be withheld until normal measurements are obtained. Medical staff to review ongoing medication regime. Advise client to lie down with feet raised and not to make any sudden movements. Encourage fluids. Commence hourly recordings.

Chart Commencement Date ……..

Doctors Name …….. Drs Signature ……..

Lofexidine Regime - Clients on Methadone Less Than 30mg prior to admission for detox

Patient Name..... CHI.....

Day 1 commences after the test dose day

Date	0800					1400			1800				2200		
	Day	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials
	TEST DOSE DAY – See separate sheet.														
	1	0.2mg				0.2mg			0.4mg				0.4mg		
	2	0.4mg				0.4mg			0.4mg				0.4mg		
	3	0.6mg				0.6mg			0.6mg				0.6mg		
	4	0.6mg				0.6mg			0.6mg				0.6mg		
	5	0.6mg				0.6mg			0.6mg				0.6mg		
	6	0.6mg				0.6mg			0.6mg				0.6mg		
	7	0.4mg				0.4mg			0.4mg				0.4mg		
	8	0.2mg				0.2mg			0.4mg				0.4mg		
	9	0.2mg				0.2mg			0.2mg				0.2mg		
	10					0.2mg							0.2mg		
	11												0.2mg		
	12														

If systolic less than 90mmHg or 30mmHg below baseline, or pulse below 55, lofexidine should be withheld until normal measurements are obtained. Medical staff to review ongoing medication regime. Advise client to lie down with feet raised and not to make any sudden movements. Encourage fluids. Commence hourly recordings.

Chart Commencement Date .....

Doctors Name ..... Drs Signature .....

Lofexidine Regime - Clients on methadone 30mg - 80mg prior to admission for detox

Patient Name..... CHI.....

Day 1 starts after the test dose day

Date	0800					1400			1800				2200		
	Day	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials
	TEST DOSE DAY – See separate sheet														
	1	0.2mg				0.2mg			0.4mg				0.4mg		
	2	0.4mg				0.4mg			0.4mg				0.4mg		
	3	0.6mg				0.6mg			0.6mg				0.6mg		
	4	0.6mg				0.6mg			0.6mg				0.6mg		
	5	0.6mg				0.6mg			0.6mg				0.6mg		
	6	0.6mg				0.6mg			0.6mg				0.6mg		
	7	0.6mg				0.6mg			0.6mg				0.6mg		
	8	0.6mg				0.6mg			0.6mg				0.6mg		
	9	0.6mg				0.6mg			0.6mg				0.6mg		
	10	0.4mg				0.4mg			0.6mg				0.6mg		
	11	0.2mg				0.2mg			0.4mg				0.4mg		
	12	0.2mg				0.2mg			0.2mg				0.2mg		
	13					0.2mg							0.2mg		
	14												0.2mg		

If systolic less than 90mmHg or 30mmHg below baseline, or pulse below 55, lofexidine should be withheld until normal measurements are obtained. Medical staff to review ongoing medication regime. Advise client to lie down with feet raised and not to make any sudden movements. Encourage fluids. Commence hourly recordings.

Chart Commencement Date .....

Doctors Name ..... Drs Signature .....

Lofexidine Regime - Adjusted according to BP and Pulse Requirements

Patient Name..... CHI.....

Day 1 starts after the test dose day

Date	0800					1400			1800				2200		
	Day	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials	Dose	BP/Pulse Sitting	BP/Pulse Standing	Initials	Dose	BP/Pulse Standing	Initials
	TEST DOSE DAY- See separate sheet														
	1														
	2														
	3														
	4														
	5														
	6														
	7														
	8														
	9														
	10														
	11														
	12														

If systolic less than 90mmHg or 30mmHg below baseline, or pulse below 55, lofexidine should be withheld until normal measurements are obtained. Medical staff to review ongoing medication regime. Advise client to lie down with feet raised and not to make any sudden movements. Encourage fluids. Commence hourly recordings.

Chart Commencement Date .....

Doctors Name ..... Drs Signature .....

TSUS In-patient alcohol detoxification protocol

Introduction

When someone is physically dependent on alcohol, their body has undergone physiological changes to adapt to the continuous presence of alcohol. When this person stops drinking, the level of alcohol in their body gradually decreases and, as a result of the aforementioned physiological changes, the body then starts to exhibit withdrawal symptoms. These usually start 3 to 12 hours after the last drink of alcohol. Alcohol withdrawal symptoms can range from mild and self limiting, to severe and life threatening. Detoxification involves the administration of medication to help prevent the withdrawal symptoms from occurring when someone who is physically dependent on alcohol stops drinking. The most commonly used medicine for this is a benzodiazepine such as chlordiazepoxide.

When is medication for withdrawal appropriate?

Cessation of drinking is unlikely to be complicated in mild alcohol dependence. Medication is usually not necessary if:

- the patient reports consumption is less than 15units/day for a man and less than 10 units/day for a woman.
- If a patient has scored 0 on an alcohol breath test and has no signs and symptoms of alcohol withdrawal
- They score less than 15 on the Severity of Alcohol Dependence Questionnaire (SADQ).
- A binge drinker whose last drinking episode was less than 7 days unless binge included drinking over 20 units daily.

Inpatient detoxification rather than community detoxification is indicated if:

- They drink more than 30 units of alcohol a day
- They have a score of greater than 30 on the SADQ
- They have a history of epilepsy, or withdrawal related seizures or delirium tremens during previous assisted withdrawal programmes
- They need concurrent withdrawal from benzodiazepines and alcohol
- They regularly drink 15-30 units of alcohol per day AND have
    - Significant psychiatric or physical co-morbidities
    - A significant learning disability or cognitive impairment.

Consider a lower threshold for admission in vulnerable groups e.g. elderly, homeless

When medication for withdrawal is not likely to be needed it is important to advise the patient that they may still experience some mild symptoms such as anxiety and insomnia upon stopping drinking, and that these will be self limiting. They are also likely to experience craving for alcohol as a result of psychological dependence. This is not to be confused with alcohol withdrawal and therefore an accurate assessment should be obtained.

Medication for withdrawal should always be considered when consumption is over 20 units daily.

<u>If in doubt, the patient should be place on the CIWAA chart for detecting emergent symptoms of alcohol withdrawal</u>

Assessment (to be completed at point of admission by registered nurse)

- History of previous severe withdrawal
- History of Seizures or Delirium Tremens (DT's)
- Drinking history
- Any past alcohol detoxifications and outcome of these
- Co-morbidities - physical and/or psychiatric
- BrAC and time taken, ensure this is done at point of admission to avoid any discrepancies
- Obtain routine urinalysis and act accordingly – include drug screen if indicated.
- LFT's, FBC, Coag to be done within first 2 days of admission by venepuncture qualified staff.

Assessment (to be completed by medical staff at point of admission)

- Complete assessment focusing in particular on a full substance misuse history, as well as co-existing physical and psychiatric disorders. Time of last intake of alcohol should be recorded as well as presence and severity of symptoms of alcohol withdrawal (especially symptoms suggestive of acute confusion).

- Physical examination – full physical examination. Observe for severity of withdrawal symptoms and presence of signs suggestive of Wernicke's Encephalopathy.

- Initiate Chlordiazepoxide withdrawal regime.

- Develop acute management plan for any other co-morbid substance misuse problem, physical disorder or psychiatric disorder.

- Assessment for IM Pabrinex – All patients that are alcohol dependent should receive parenteral B vitamins and oral B vitamins. If Wernicke's Encephalopathy is suspected this requires an increase dose of parenteral B Vitamins and transfer to an acute medical ward (appendix X)

- Significant liver impairment can lead to poor metabolism of chlordiazepoxide, which will lead to accumulation of the drug in the body and over sedation. If patient is known to have severe liver impairment consider using Oxazepam for withdrawal. This has a shorter half-life and is less reliant on hepatic metabolism. It may however lead to a greater risk of seizures. A separate

prescribing chart is included in this guidance.

Signs and symptoms of alcohol withdrawal

These should be measured using a rating scale e.g. Clinical institute Withdrawal for Alcohol Assessment

Tachycardia – Pulse of 80 and above may be a sign of alcohol withdrawal
Tremor – May be visible in outstretched hands to a full body tremor
Perspiration – From moist palms to drenching sweats
Anxiety – mildly nervous to panic
Agitation – mild restlessness to constant pacing
Perceptual disturbance – Blurred vision to constant hallucination
Nausea and vomiting – mild nausea to severe vomiting and dry heaves
Headaches – mild to severe

Symptoms will usually peak within 24-48 hours unless complications occur.

The withdrawal process can last 5-7 days (in severe cases longer) and patient will require medication during this time. Daily doses should be reducing after day 5.

Initiation of detoxification regime

There is no set time frame of when to initiate the alcohol withdrawal scale, instead it should be down to the trained nurses discretion e.g. when the patient begins to display signs of withdrawal this would be an opportunity to score them for their first dose of Chlordiazepoxide using symptom triggered regime.

A repeat BrAC prior to dispensing medication may be useful to ensure alcohol is clearing the body. It is a relative reduction in the BrAC that will trigger the emergence of symptoms, rather than the complete clearance (i.e. achieving BrAC of 0%) of alcohol from the body.
Therefore, a patient can receive withdrawal medication if they still have alcohol in their system, as withdrawal can occur quickly in someone with severe dependence as their alcohol blood levels start to reduce. If medication is dispensed in such a circumstance a patient should be closely monitored for signs of intoxication.

Within the first 72 hours of admission a patient should be closely observed using the trained nurse's clinical judgement. It is advised they are checked hourly during the night and regularly during the day. A patient should be asked to remain in the clinical area/ward if their withdrawal is severe due to risk of seizure/collapse.

Complications

In cases of severe alcohol withdrawal patient can experience:

Withdrawal seizures - can occur up to 72 hours after alcohol cessation. In most cases these are generalised tonic clonic seizures and can be prevented by increasing the dose of chlordiazepoxide following recovery from seizure.

Patients who suffer a prolonged seizure (lasting more than 5 minutes) or repeated (3 or more in an hour) convulsive seizures should receive immediate emergency care including:

- assessing and stabilising the patients airway
- administration of high concentration oxygen
- checking blood glucose levels
- assessment of cardiac and respiratory function
- administration of rectal diazepam 10mg repeated once after 15 minutes if seizure continues
- secure intravenous access in a large vein

A medic should always be called to examine the patient following a seizure or if a seizure is lasting more than 5 minutes. An ambulance should also be called if immediate medical assistance is not available for a prolonged seizure.

Delirium Tremens (DT's) – essentially an acute confusion state that occurs in 5% of alcohol dependent patients following alcohol cessation. This is a medical emergency with a high mortality rate (5%) and will require emergency transfer to a general hospital for IV diazepam, IV fluids and electrolyte replacement, treatment of co-morbid conditions (e.g. infection) and parenteral thiamine. Signs and symptoms of DT's include anxiety, agitation, marked tremor, restlessness, confusion, delusions, hallucinations of every modality, autonomic hyperactivity (tachycardia/hypertension/sweating/fever). Symptoms typically peak between 72 and 96 hours after last drink. Prodromal symptoms include night time insomnia, restlessness, fear and confusion.

Risk factors for delirium tremens and seizures:

- Severe alcohol dependence
- Past history of delirium tremens or withdrawal seizures
- Long history of alcohol dependence with multiple previous episodes of inpatient treatment
- Blood alcohol concentration >200 mg/dL on admission
- Older age (>40)
- Concomitant acute medical illness
- Severe withdrawal symptoms when presenting for treatment

Alcohol hallucinosis – Can occur following sudden cessation of drinking in the form of visual, auditory and/or tactile hallucinations, usually in clear consciousness (i.e. the patient is not disorientated or confused). This can often be mistaken for delirium tremens therefore careful assessment is important.

Wernicke's encephalopathy – the classic triad of opthalmoplegia, ataxia and confusion is rarely present in Wernicke's encephalopathy. A presumptive diagnosis should therefore be made, and further assessment carried out, in any patient undergoing detoxification that experiences any of the following:

- Ataxia
- Hypothermia and hypotension
- Confusion
- Opthalmoplegia/nystagmus
- Memory disturbance
- Coma/unconsciousness

NB – alcohol and benzodiazepines can cause ataxia and nystagmus, which may be confused with Wernicke`s encephalopathy.

Adjunctive medication

Thiamine (see page 23)

- Pabrinex i.m. 1 pair once daily for 5 days
- Thiamine 100mg x 3 daily - split doses increases absorption of Thiamine compared to once daily dosing.

Other Vitamins & minerals: Valupak multivitamins and mineral 1 tablet once daily
Metoclopromide : 10mg im or oral 8 hourly (max 30mg/24hr) for nausea and vomiting
Loperamide : 4mg initially then 2mg (max 16mg/24hr) after each loose stool
Rectal diazepam: Diazepam 10mg PR for seizure, repeated once after 15 minutes if no response.

Medications to promote abstinence:

These include naltrexone, acamprosate, and disulfiram. See page 23 for more details

Early discharge and/or returning to alcohol use during detoxification

If a patient is found to be drinking during detoxification in most cases this should result in cessation of the detoxification and discharge from the unit. If there are concerns about the patient's physical or mental health (including evidence of a confusional state) a doctor should be requested to review the patient prior to discharge.

Some patients may wish to take early discharge from the unit and complete their detoxification at home. This should be agreed in consultation with a doctor and plan put in place to continue the provision of medication in the community. Factors to consider include the stage of detoxification that the patient is at and any other risk factors e.g. risk of delirium tremens, seizures or other physical and mental health issues.

Chlordiazepoxide	Tuesday					Wednesday						Thursday						Friday						Saturday					Sunday				Monday				Tues	
Date																																						
Time	14	18	22			08	14	18	22			08	14	18	22			08	14	18	22			08	14	18	22		08	14	18	22	08	14	18	22	08	
Pulse																																					
Tremor																																					
Perspiration																																					
Anxiety																																					
Agitation																																					
Nausea/Vomiting																																					
Perception																																					
Headache																																					
Total Score																																					
Dose Given																																					
Initials																																					
Daily Total																																					

Symptom Scoring Guide	Pulse	Tremor	Perspiration	Agitation	Anxiety	Perceptual Disturbance	Nausea/Vomiting	Headache	Score	Oral Chlordiazipoxide Dosage		Maximum 300mg in 24hr period Contact Dr if more required
0	79 or below	None	None	None	None	None	None	None	**0-1**	-	**No Medication**	
1	80-110	Not visible but palpable	Palms moist	Mild Restlessness	Mildly Anxious	Present but minimal	Mild nausea -no vomiting	Mild Headache	**2-3**	-	**5mg**	Start Date
2	111-130	Visible in extended arm	Beads of sweat on forehead	Moderate Restlessness	Moderately Anxious	Frequent	Intermittent nausea with dry heaves	Moderate Headache	**4-5**	-	**15mg**	
3	131 or above	Visible in flexed arm	Drenching Sweats	Pacing or thrashing about	Constant panic like anxiety	Constant Hallucinations	Constant nausea,frequent dry heaves and vomiting	Severe Headache	**6-7**	-	**30mg**	Dr Signature

Last Drink		Multiple Detoxes		Previous Seizures			**8-10**	-	**45mg**	
BrAC		Known liver Impairment		Previous Hallucinations			**Over 10**	-	**60mg**	
Client Name		**DoB/CHI**		**Consultant**	Dr T Elworthy					

Oxazepam	**Tuesday**					**Wednesday**						**Thursday**						**Friday**						**Saturday**					**Sunday**				**Monday**				**Tues**	
Date																																					
Time	14	18	22			08	14	18	22			08	14	18	22			08	14	18	22			08	14	18	22		08	14	18	22	08	14	18	22	8	
Pulse																																					
Tremor																																					
Perspiration																																					
Anxiety																																					
Agitation																																					
Nausea/Vomiting																																					
Perception																																					
Headache																																					
Total Score																																					
Dose Given																																					
Initials																																					
Daily Total																																					

Symptom Scoring Guide	Pulse	Tremor	Perspiration	Agitation	Anxiety	Perceptual Disturbance	Nausea/Vomiting	Headache	**Score**	**Oral Oxazepam Dosage**		Maximum 250mg in 24hr period Contact Dr if more required
0	79 or below	None	None	None	None	None	None	None	**0-1**	-	**No Medication**	Start Date
1	80-110	Not visible but palpable	Palms moist	Mild Restlessness	Mildly Anxious	Present but minimal	Mild nausea -no vomiting	Mild Headache	**2-5**	-	**10 mg**	
2	111-130	Visible in extended arm	Beads of sweat on forehead	Moderate Restlessness	Moderately Anxious	Frequent	Intermittent nausea with dry heaves	Moderate Headache	**6-7**	-	**25mg**	Dr Signature

3	131 or above	Visible in flexed arm	Drenching Sweats	Pacing or thrashing about	Constant panic like anxiety	Constant Hallucinations	Constant nausea,frequent dry heaves and vomiting	Severe Headache	**8-10**	-	**35 mg**	
Last Drink			Multiple Detoxes		Previous Seizures				**Over 10**	-	**50mg**	TSUS In Patient Unit – Rannoch Alcohol Withdrawal Chart
BrAC			Known Liver Impairment		Previous Hallucinations							
Client Name			**DoB/CHI**		**Consultant**		Dr T Elworthy					