

Opioid Dependent Persons Admitted to Hospitals in NSW - Management

Summary This policy directive applies to the management of opioid dependent persons in public or private hospitals. It addresses both the clinical and legal issues of prescribing drugs of dependence for opioid dependent persons and has been prepared to assist medical practitioners in dealing with this situation by outlining the procedures to be followed.

Document type Policy Directive

Document number PD2006_049

Publication date 05 July 2006

Author branch Centre for Alcohol and Other Drugs

Branch contact (02) 9424 5938

Review date 30 June 2018

Policy manual Not applicable

File number 06/4294

Previous reference N/A

Status Active

Functional group Clinical/Patient Services - Medical Treatment, Pharmaceutical

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Private Hospitals and day Procedure Centres, Public Hospitals

Distributed to Public Health System, Government Medical Officers, Health Professional Associations and Related Organisations, NSW Ambulance Service, Ministry of Health, Public Hospitals, Private Hospitals and Day Procedure Centres

Audience All clinical staff in public and private hospitals caring for opioid dependent persons.

Opioid Dependent Persons Admitted to Hospitals in NSW - Management

Document Number PD2006_049

Publication date 05-Jul-2006

Functional Sub group Clinical/ Patient Services - Medical Treatment
Clinical/ Patient Services - Pharmaceutical

Summary This policy directive applies to the management of opioid dependent persons in public or private hospitals. It addresses both the clinical and legal issues of prescribing drugs of dependence for opioid dependent persons and has been prepared to assist medical practitioners in dealing with this situation by outlining the procedures to be followed.

Replaces Doc. No. Opioid Dependent Persons Admitted to Public Hospitals in NSW - Management [PD2005_049]

Author Branch Mental Health and Drug and Alcohol Office

Branch contact Mental Health & Drug and Alcohol Office 02 9391 9005

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Private Hospitals and Day Procedure Centres, Public Hospitals

Audience All clinical staff in public and private hospitals caring for opioid dependent persons.

Distributed to Public Health System, Government Medical Officers, Health Professional Associations and Related Organisations, NSW Ambulance Service, Ministry of Health, Public Hospitals, Private Hospitals and Day Procedure Centres

Review date 01-Jul-2014

Policy Manual Not applicable

File No. 06/4294

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

MANAGEMENT OF OPIOID DEPENDENT PERSONS ADMITTED TO HOSPITALS IN NEW SOUTH WALES

This policy directive supersedes PD2005_049 (Circular 92/27). It should be read in conjunction with PD 2005_206 (Circular 2001/64) 'Policy on the Handling of Medication in New South Wales Public Hospitals' and the New South Wales Opioid Treatment Program Guidelines.

This policy directive applies to the management of opioid dependent persons in public or private hospitals.

1 INTRODUCTION

From time to time, opioid dependent persons are admitted to hospitals for the treatment of acute or life threatening medical conditions or injuries or for the management of drug toxicity or withdrawal.

In such cases the prescribing of opioid drugs, including methadone or buprenorphine, may need to be considered. However, without prior proper investigation of the patient's history and physical condition, the immediate prescribing of an opioid drug may be contraindicated.

The policy addresses both the clinical and legal issues of prescribing drugs of dependence for opioid dependent persons and has been prepared to assist medical practitioners in dealing with this situation by outlining the procedures to be followed.

In short, the policy provides for the management of opioid dependent persons:

- ◆ who are on an opioid treatment program and who have been admitted to a hospital for the treatment or assessment of:
 - ⇒ a medical condition and need to continue with their authorised methadone or buprenorphine dose, or
 - ⇒ a painful medical condition and need to continue with their authorised methadone or buprenorphine dose together with such opioid analgesics as are necessary to control pain. In such cases, there should be a clearly identifiable cause of pain or other strong clinical indication requiring analgesia.
- ◆ who are **not** on an opioid treatment program and who have been admitted to a hospital for the treatment or assessment of a medical condition, and require opioid treatment where:
 - ⇒ controlling withdrawal symptoms with opioids is a necessary part of the management of a serious medical condition, and / or
 - ⇒ there is a clearly identifiable cause of pain or other strong clinical indication requiring analgesia.

This policy should be brought to the attention of all hospital staff involved in the management of inpatients who are opioid dependent persons. Additionally, each hospital should ensure that protocols or mechanisms

exist for obtaining expert advice on a 24 hour basis on the clinical management of opioid dependent persons.

2 LEGAL RESTRICTIONS ON THE PRESCRIBING OF DRUGS OF ADDICTION TO DRUG DEPENDENT PERSONS

Under the provisions of Section 28 of the Poisons and Therapeutic Goods Act 1966 the authority of the NSW Department of Health is required to prescribe for or supply to a drug dependent person¹ any drug of addiction (listed in Schedule 8 of the Poisons List²)

Therefore, a medical practitioner may not prescribe or supply any drug of addiction (listed in Schedule 8 of the Poisons List) for a person who, in the practitioner's opinion, is a drug dependent person¹ without the prior authority of the NSW Department of Health. The intent of this legislation is to prevent drug dependent persons from "shopping around" to obtain drugs and consequently receiving treatment from more than one medical practitioner concurrently.

In order to facilitate the management of persons admitted to hospitals in New South Wales, an exemption to the above requirement allows a medical practitioner to prescribe a drug of addiction, for up to 14 days, to a person who is an **inpatient** in a **public or private hospital**, without the need to obtain authority from the Department to do so, even when the patient is known or suspected to be a drug dependent person.

3 CLASSIFICATION OF THE OPIOID DEPENDENT PERSON

Opioid dependent persons fall into the following distinct categories:

- (a) On NSW Opioid Treatment Program (methadone or buprenorphine),
and
 - (i) Not requiring additional opioids for analgesia, or
 - (ii) Requiring opioid analgesia
- (b) Not on NSW Opioid Treatment Program and
 - (i) Requiring opioids to manage withdrawal, and / or
 - (ii) Requiring opioids to manage pain

¹ A 'drug dependent person' means a person who has acquired, as a result of repeated administration of a drug of addiction or a prohibited drug within the meaning of the Drug Misuse and Trafficking Act 1985, an overpowering desire for the continued administration of such a drug.

² A list of commonly used substances and preparations classified as drugs of addiction (Schedule 8 of the New South Wales Poisons List) – TG 13 is available at http://www.health.nsw.gov.au/public-health/psb/publications/pdf/drugsofaddiction_schedule8.pdf or from Pharmaceutical Services Branch. Contact the Duty Pharmacist on (02) 9879 3214

4 TREATMENT OF AN IN-PATIENT CURRENTLY ON AN OPIOID TREATMENT PROGRAM

These are persons for whom a medical practitioner holds an authority to prescribe methadone or buprenorphine for the treatment of opioid dependence under the NSW Opioid Treatment Program.

After verifying the patient's identity, contact **must** be made with both the authorised prescriber and the opioid treatment dosing point, i.e. the place where the patient attends for dosing, to confirm the current actual dose and the date & time of the last dose, including any take-away doses given. It is important to establish these facts as administration of a dose of an opioid drug may lead to overdose if the patient has received a dose recently or the wrong dose is given.

If there is any difficulty in obtaining details of the authorised prescriber from the patient, Pharmaceutical Services Branch may be contacted during office hours on (02) 9879 5246 for assistance

(a) Not requiring additional opioids for analgesia

Provided that there is **no medical contraindication** to the administration of an opioid, methadone or buprenorphine should be continued in hospital. It must be prescribed by the patient's hospital medical practitioner in accordance with the dosage regimen prescribed by the patient's authorised methadone or buprenorphine prescriber.

Methadone, in oral liquid form, is administered as a once daily dose. Buprenorphine is a sublingual tablet and may be administered as a daily, second daily or third daily dose. The patient's authorised prescriber should be advised of the approximate length of stay in hospital in order to prevent the patient being exited from the program through 'non-attendance'.

When the patient is discharged, the authorised prescriber and the opioid treatment dosing point must be informed in advance of the discharge to ensure that appropriate arrangements are in place for the patient's continuation on the program.

Note: Patients on methadone or buprenorphine are unlikely to exhibit withdrawal symptoms until at least 24 hours after the last dose was administered. In the event that withdrawal symptoms occur and neither the authorised prescriber nor the opioid treatment dosing point can be contacted (e.g., after-hours), the objective signs of withdrawal should be managed, **until such time as contact can be made with the prescriber or opioid treatment dosing point**, as follows:

Methadone - the patient should be administered 30mg methadone orally. If required, further doses of 5mg may be given, titrated against observable signs of withdrawal, up to a maximum daily dose of 40mg.

Buprenorphine – the patient should be administered 4 mg of buprenorphine sublingually with further doses of 2mg, titrated against observable signs of withdrawal. (Note: the maximum dose of buprenorphine on any day should not exceed 32mg)

(b) Requiring opioid analgesia

Administration of opioid analgesia to persons on a methadone or buprenorphine program must be carried out in consultation with a local Drug and Alcohol specialist. Where contact cannot be made with a Drug and Alcohol specialist, advice on clinical management can be obtained (24 hours a day) from the NSW Drug and Alcohol Specialist Advisory Service, on 9361 8006 (Sydney Metro) or 1800 023 687 (Outside Sydney)

(i) Patient is on a methadone program

Methadone should be administered as in (a) above and additional opioids may be prescribed to relieve pain. If analgesia is not achieved with normal dosage regimens, consultation **must** be undertaken with the patient's authorised methadone prescriber or a local Drug and Alcohol specialist.

(ii) Patient is on a buprenorphine program

Patients maintained on buprenorphine will have a diminished response to opioids prescribed for analgesia, i.e. patients on buprenorphine who suffer severe acute or chronic pain will require higher doses of opioid analgesia than individuals not on buprenorphine treatment. This is because of the 'blocking' effect of the buprenorphine on full opioid agonists.

Generally, if acute or sub-acute analgesia is required, a temporary increase in the buprenorphine dose may provide the additional analgesic cover. Where additional opioid analgesia is required, non-opioid analgesic options should be considered and either used alone or in concert with additional opioid analgesia (e.g. morphine), the dose of which should be titrated according to clinical response.

Patients who develop chronic pain, which does not respond to buprenorphine, may require transfer to methadone. Drug and Alcohol specialist advice on a safe transfer between treatments should be sought if this course is contemplated. The dose of analgesic should be closely monitored if buprenorphine is reduced or stopped. This is because there is the potential for over-sedation, or even overdose, from a high opioid dose as the

buprenorphine levels reduce (with a corresponding reduction in the 'blocking' effects of buprenorphine). Where the buprenorphine treatment is stopped completely, the dose of opioid will need to be closely monitored every day for at least 4 - 5 days after the last buprenorphine dose and will probably have to be reduced over time, to avoid an overdose. If in doubt, Drug and Alcohol specialist advice should be sought to ensure safe and effective treatment of pain.

When the patient is discharged, the authorised prescriber and the opioid treatment dosing point must be informed, in advance of the discharge, of the dose and the date of last dose in hospital to ensure that appropriate arrangements are in place for the patient's continuation on the buprenorphine or methadone program.

If there is a need to continue opioid analgesia, the patient's authorised buprenorphine or methadone prescriber should be advised in addition to their general or treating practitioner.

5 TREATMENT OF AN IN-PATIENT DRUG DEPENDENT PERSON NOT CURRENTLY ON AN OPIOID TREATMENT PROGRAM

(a) Where Opioid Analgesia IS NOT Required But Symptoms Of Withdrawal Are Evident

Wherever possible, withdrawal symptoms should be symptomatically treated with non-opioids only.

However, opioids (i.e. methadone in oral liquid form, or buprenorphine sublingual tablets) may be used to treat withdrawal symptoms where:

- (i) withdrawal symptoms could reasonably be expected to interfere with the optimum medical management of the patient, or
- (ii) the patient is suffering from a serious or life-threatening illness and the patient's premature self-discharge before completion of therapy would prejudice optimum management.

Where methadone is prescribed for the treatment of withdrawal to a person not on an opioid treatment program, 10mg to 20mg per day, in oral liquid form, should be administered in divided doses. The dose may be gradually increased, by 5mg increments titrated against objective signs of withdrawal, to a maximum daily dose of 40mg. The dose may be combined into a single daily dose when stabilized. Doses should not be increased above 40mg daily unless consultation has taken place with a specialist in the management of drug dependence. Patients should be advised that this treatment does not constitute entry to the methadone program. Entry to this program **must** be through approved prescribers.

An alternative strategy is to use buprenorphine sublingually in a dose of 2mg every two to four hours if required to control withdrawal symptoms on day 1. On day 2, the total dose for day 1 should be given as a single dose, and then reduced by 2mg per day thereafter. This is a simpler form of withdrawal management and withdrawal is achieved more rapidly than with methadone. A Drug and Alcohol specialist should be consulted to facilitate this schedule. Patients should be advised that this treatment does not constitute entry to the buprenorphine program. Entry to this program **must** be through approved prescribers.

All patients given methadone or buprenorphine to allay symptoms of withdrawal from opioids should be slowly withdrawn from methadone or buprenorphine prior to discharge from hospital wherever possible. Where it is not possible to complete the withdrawal in hospital or where it is considered appropriate to extend the use of methadone or buprenorphine after discharge, arrangements for continuation should be made following consultation with an approved prescriber. This should be done well in advance of the patient's discharge.

(b) Where Opioid Analgesia IS Required

Tolerance to drugs may necessitate higher doses and/or greater frequency of administration in some cases to achieve satisfactory analgesia compared to an opioid naive patient with a similar condition.

Therefore, for acute problems with a clear diagnosis (e.g. trauma), opioid analgesia, within normal dosage regimens, should be provided in the first instance; above normal dosage or unduly prolonged prescribing should take place only after consultation with a specialist in the management of drug dependence. If contact cannot be made, advice on clinical management can be obtained (24 hours a day) from the NSW Drug and Alcohol Specialist Advisory Service, on 9361 8006 (Sydney Metro) or 1800 023 687 (Outside Sydney)

6 FURTHER INFORMATION

Advice regarding the nearest approved methadone or buprenorphine prescriber can be obtained from the Pharmaceutical Services Branch of the NSW Department of Health (phone (02) 9879 5246).

General information may be obtained from the Duty Pharmaceutical Adviser, Phone (02) 9879 3214 or at the Branch website - http://www.health.nsw.gov.au/pubs/subs/sub_pharma.html

Robyn Kruk
Director-General