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Medical management of patients at risk of opioid withdrawal Clinical Guideline

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Government of South Australia
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Contents

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1. Introduction

This guideline provides information on the management of opioid-tolerant adult patients admitted to acute care hospitals and aims to guide clinical practice only. Clinical judgment should be used to determine the optimal medical management for each patient. When there is doubt about management, confer with senior colleagues, the Drug and Alcohol Services South Australia Consultation Liaison Service (DASSA CLS) where available, or the Drug and Alcohol Clinical Advisory Service (DACAS) Ph 7087 1742. This guideline should be used in conjunction with the appropriate opioid withdrawal assessment and observation charts.

2. Background

A significant number of South Australians consume opioids (either prescribed or illicit) on a regular basis and are at risk of withdrawal.

This Clinical Guideline was developed to optimise management of these people when they present in acute hospitals, to avoid severe withdrawal and enable adequate pain management where they are experiencing pain.

It applies to all SA Health employees, including consultants and contractors, working in acute care hospitals.

This Guideline was developed by Drug and Alcohol Services South Australia (DASSA), in consultation with clinicians in all Local Health Networks, with oversight by Dr Will Liaw, Director of Clinical Partnerships, Drug and Alcohol Services South Australia.

3. Definitions

In the context of this document:

- drug withdrawal means the group of symptoms that occur upon the abrupt discontinuation or decrease in intake of medications or drugs. In order to experience the symptoms of withdrawal, the person must have first developed a physical dependence on the drug.
- opioids mean substances that act on opioid receptors to produce morphine-like effects. Opioids include opiates, an older term that refers to such drugs derived from opium, including morphine and codeine. Other opioids are semi-synthetic and synthetic drugs such as oxycodone and fentanyl.

4. Principles of the standards

The principle of this guideline is to ensure a consistent approach to the medical management of opioid-tolerant adult patients admitted SA Health acute hospitals.

5. General

Roles & Responsibilities

- Chief Executive, SA Health is responsible for ensuring there is a consistent approach to managing patients at risk of opioid withdrawal in acute hospitals.
- Chief Executive Officers of the Local Health Networks (LHNs) are responsible for ensuring effective implementation of this guideline.
- Clinical Directors and Managers are responsible for ensuring all clinical staff (including contractors and consultants) are aware of the content of this guideline and have access to it.

6. Determining risk factors

People who consume opioids on a regular basis will develop tolerance and will experience withdrawal if the opioids are discontinued. Therefore, anyone prescribed regular opioids (for management of pain, or for the management of opioid dependence) are at risk of withdrawal.

People who have recently been injecting drugs in South Australia have either been injecting methamphetamine or opioids. Be vigilant for emerging withdrawal in these patients.

7. Models of care

Generally, people solely experiencing opioid withdrawal can be managed in the community, and do not need admission to an acute hospital.

If there are other indications for acute hospital admission (trauma, sepsis, other medical issues, surgery) then they should be admitted, and their health concerns appropriately addressed. This Clinical Guideline outlines the necessary care related to opioid management.

If acute pain is a significant issue they should always be treated accordingly. Liaison with the Acute Pain Service may be required.

8. Workforce implications

Nil

9. Safety, quality and risk management

National Safety and Quality Health Service Standards

National Standard 1 Clinical Governance	National Standard 2 Partnering with Consumers	National Standard 3 Preventing & Controlling Healthcare-Associated Infection	National Standard 4 Medication Safety	National Standard 5 Comprehensive Care	National Standard 6 Communicating for Safety	National Standard 7 Blood Management	National Standard 8 Recognising & Responding to Acute Deterioration
☐	☒	☐	☒	☐	☐	☐	☐

10. Pathway / Protocol

Patients who have been taking opioids long-term may develop tolerance. This means that they may need progressively larger doses to maintain the same effect. Patients tolerant to one opioid will usually be tolerant to all other opioids. The degree of cross-tolerance that occurs is unpredictable and appears to be incomplete.

These patients may also develop a physical dependence on the opioid, meaning that if the opioid is antagonised (by opioid antagonists), suddenly stopped, or abruptly reduced in dose, they may develop a withdrawal (or abstinence) syndrome.

Tolerance and physical dependence are natural biological consequences of repeated opioid use and do not imply misuse, abuse or addiction. Addiction (a psychological dependence) refers more to a pattern of drug-taking behaviours and compulsive drug use despite the risk of physical, psychological, or social harm. Unlike tolerance and physical dependence, addiction is not a predictable effect of a drug.

Opioid tolerant or physically dependent patients are frequently seen in hospitals. In general, these patients fall into any one of three groups:

1. **Patients taking prescription opioids as prescribed for long-term pain management (e.g. chronic pain, palliative care)**

2. **Patients in a MATOD ('medication assisted treatment for opioid dependence') program who are prescribed:**
   - **methadone or**
   - **buprenorphine/naloxone sublingual film (Suboxone®) or**
   - **depot buprenorphine (Buvidal® or Sublocade®)**

3. **Patients taking illicit opioids (prescription opioids or heroin) for non-medical purposes**

For patients in groups 1 and 2, who have been admitted for reasons other than their opioid use (e.g. after trauma or surgery), the aim will generally be to prevent opioid withdrawal while the patient is in hospital.

In patients with an immediate past history of illicit opioid use, withdrawal may need to be managed in the hospital setting. This is usually best accomplished over 5 to 7 days using the procedure outlined later in this document.

Opioid withdrawal is assessed and recorded using the Clinical Opioid Withdrawal Scale (COWS) – see Appendix A

Opioid-tolerant or dependent patients in acute pain

Regardless of the group to which the opioid-tolerant patient belongs, analgesia for acute pain **should not** be withheld. Non-opioid analgesia should be maximised; however, if opioids are required, these patients may require higher-than-usual doses to adequately manage their pain. Specialist advice about acute pain management can be sought from the hospital's acute pain service (APS), or, if no APS, the responsible anaesthetist.

Buprenorphine has a high mu-opioid receptor affinity and as such can reduce the effects of morphine or oxycodone in acute pain. Thus, acute pain management in a patient prescribed buprenorphine products (sublingual or depot formulation) with routine opioid

analgesics at regular doses may be less effective. It is important that the patient's pain is effectively managed.

Higher doses of traditional opioids may be required but careful monitoring and titration is recommended, as the degree of tolerance is variable. The use of potent mu-opioid receptor agonists such as fentanyl may be effective. Consultation with an APS or anaesthetist is advised in all these circumstances.

Similar approaches are to be used in patients on depot or SL buprenorphine products to achieve adequate analgesia in emergency situations. However, the depot products cannot be rapidly discontinued, it is not possible to reverse or rapidly reduce the plasma levels from the depot buprenorphine products.

Patients requiring high opioid doses should only be managed in wards where the nursing and staff have received the appropriate education about acute pain management using opioids and the monitoring required, and where appropriate medical staff are available to advise.

Some patients with acute pain who appear to be exhibiting drug-seeking behaviours may genuinely need increased pain relief.

10.1 Description of opioid withdrawal syndrome

Onset

In patients with a physiological opioid dependence, withdrawal may occur as soon as 4–6 hours after the last dose of a short-acting opioid but can occur later if methadone or slow-release opioid preparations or patches are ceased.

Clinical Features

Opioid withdrawal syndrome is characterised by some or all of the following signs and symptoms:

- increased pulse rate
- dilated pupils
- gastrointestinal upsets
- anxiety or irritability
- restlessness
- perspiration
- bone or joint aches
- tremor of outstretched hands
- piloerection ('gooseflesh')
- runny nose
- yawning

The presence and degree of each of these signs and symptoms will vary with the severity of withdrawal.

Opioid withdrawal is assessed and recorded using the COWS – see Appendix A.

10.2 Confirmation and prescription of a patient's 'usual' opioid

When a patient's 'usual' long-term prescribed opioids are to be continued, whether the patient is taking the drug for treatment of their chronic cancer or non-cancer pain, or as part of a MATOD program, the dose must be confirmed, and that confirmation documented. **The time the last dose was taken should also be checked.**

Confirmation of the drug and its dose can be obtained from:

- The dispensing label on the box of opioids (the label should be a recent one)
- ScriptCheckSA
- The dispensing pharmacy, in particular for patients on MATOD where medications are administered or dispensed on a day-by-day basis.
- The prescriber (the patient's GP or specialist including DASSA – see "Contacts" section below for clinics).
- The Drugs of Dependence Unit (ph. 1300 652 584 or email: HealthDrugsofDependenceUnit@sa.gov.au) which issues Authorities for patients on longterm prescription opioids for pain, or MATOD.

NOTE: It is desirable for the usual opioid dose to be checked with two sources, including the patient or their carer. If there is any discrepancy between information sources, advice should be sought on how to proceed from the Drug and Alcohol Clinical Liaison Service (where available) or DACAS (ph. 7087 1742). A clinical pharmacist (if available) can also assist in the confirmation of the patient's usual opioid.

What if the patient's dose cannot be confirmed?
There may be times when the dose that a patient is taking cannot be confirmed straight away – for example, if the patient presents to the hospital after-hours. Suggestions for management will depend on whether the patient is an inpatient or is being managed in the Emergency Department. Doses should be confirmed at the earliest opportunity.

There is no urgency to recommence buprenorphine depot until confirmation of the dose can be obtained.

a) Inpatients

> If the patient has acute pain, then titration with immediate-release opioids for pain relief will also help to avoid/treat withdrawal.

> If the patient does not have acute pain and therefore does not need opioid analgesia,

- commence monitoring with COWS and repeat every 4 hours, and
- if COWS ≥13 then prescribe the opioid that the patient says they are taking BUT at one-quarter of the dose stated by the patient.
- continue monitoring COWS, along with sedation scores and vitals post-dose

> In MATOD patients on methadone or sublingual buprenorphine/naloxone (Suboxone®) the doses (i.e. the one-quarter of the dose stated by the patient) should be limited to a maximum of 20 mg methadone or 4 mg/1 mg buprenorphine/naloxone (Suboxone®). The

intention is to moderate or avoid development of withdrawal, while at the same time avoid toxicity from an inadvertent excessive dose.

- This dose of opioid (including methadone or buprenorphine/naloxone [Suboxone®] but noting the above dose limits for these two drugs) can be repeated after 4 hours if COWS ≥ 13.

- The patient's 'usual' opioid dose should be confirmed as soon as possible.

  NOTE: MATOD patients taking methadone syrup may express their dose in "mL". Ensure the dose is confirmed in milligrams.

b) Patients in the Emergency Department

- If the patient is not withdrawing, then no opioid is needed. Address the patient's presenting problem. If suitable for discharge, then the patient can be advised to return later if needed if withdrawal symptoms develop.

- If the patient has acute pain, then titration with immediate-release opioids for pain relief will also help to avoid/treat withdrawal.

- If the patient is withdrawing (COWS ≥ 13):

  - give 2-4 mg/0.5-1 mg buprenorphine/naloxone (Suboxone®)
  - monitor for 2 hours using COWS and sedation scores
  - address the patient's presenting problem

  They can then be discharged if symptoms have resolved.

  NOTE 1 As buprenorphine/naloxone (Suboxone®) cannot legally be prescribed outside hospital without authorisation, these patients will need to be admitted.

  NOTE 2 Inform authorised prescriber of ED presentation and temporary treatment with buprenorphine/naloxone (Suboxone®).

10.3 Management of patients taking prescription opioids (as prescribed) long-term for pain

Patients who are taking prescription opioids for long-term (i.e. > 1 month) treatment of their chronic cancer or non-cancer pain may be at risk of withdrawal if the opioid is suddenly ceased or reduced in dose. Their opioids should therefore be continued at their usual dose, or at a reduced dose as clinically appropriate, **after that dose has been confirmed**. This prescription will prevent opioid withdrawal while the patient is in hospital.

If the 'usual' opioids cannot be taken (e.g. a patient who is prescribed an oral opioid is not able to take any oral medications) then the appropriately adjusted dose of that opioid, or another opioid, should be given by another route.

If required, advice about opioid conversions and equivalent doses can be sought from the hospital's acute pain service, [or in country areas local anaesthetist, or GP anaesthetist] (APS), or, if no APS, the responsible anaesthetist.

The Faculty of Pain Medicine/ANZCA has an online opioid calculator for simplifying the calculation of equianalgesia expressed as total oral morphine equivalent daily dose (oMEDD). www.opioidcalculator.com.au

EQUIANALGESIC/ EQUIPOTENT DOSES OF SOME COMMONLY USED OPIOIDS		
Opioid	*IV/IM/subcut*	*Oral*
Morphine	10 mg	30 mg
Oxycodone	10 mg	20 mg
Fentanyl	0.15 mg	-
Buprenorphine	0.3 to 0.4 mg (& patch)	0.8 mg (sublingual)
Codeine	-	200 to230mg
Hydromorphone	1.5 to2 mg	6 to7.5 mg
Methadone	Complex; discuss with a pain medicine or addiction medicine specialist	

Notes

- The table has been compiled from values obtained from multiple references including Therapeutic Guidelines Pain & Analgesia (2020) and Australian Medicines Handbook (January 2025). Clinical pharmacists are also able to be contacted for advice about opioid conversions and equivalent doses.
- Published reports vary in the suggested doses considered to be equianalgesic to morphine. Therefore, titration to clinical response in each patient is necessary.
- Suggested doses are often based on single dose studies only. Therefore, use of the data to calculate total daily dose requirements may not be appropriate.
- These are doses that are thought to be equianalgesic. They are not recommended initial doses and pharmacokinetics will vary with the different injecting routes (IV/IM/subcut). Therefore, titration to clinical response in each patient is necessary.
- There may be incomplete cross-tolerance between these drugs. In patients who have been receiving one opioid for a prolonged period**, it is usually necessary to use a dose lower than the expected equianalgesic dose when changing to another opioid, and to titrate to effect**.

10.4 Management of patients in a MATOD program

Patients in a MATOD (medication assisted treatment for opioid dependence) program and prescribed methadone or buprenorphine/naloxone (Suboxone®) should have these medications continued once the doses have been confirmed (see above) in order to avoid withdrawal while in hospital.

In general, a patient taking methadone or buprenorphine/naloxone (Suboxone®) as part of a MATOD program will not experience severe withdrawal if one dose is missed.

Always ask the patient:

- The name of their medication
- The time of their last dose and the dose taken
- The name of their prescriber
- Which pharmacy dispenses their medication
- Do they have any MATOD takeaways (unsupervised doses) with them or at home?

Always contact:

- The patient's prescribing GP or staff at their prescribing DASSA clinic (see "Contacts" section below for details of individual DASSA Clinics)

AND

- The patient's dispensing pharmacy. The treating home team within the hospital must request the community pharmacy to fax the current script and signing/dosing sheet as confirmation of dose and time/date of last dose in the community.

Always check:

- ScriptCheckSA

OR

- The Drugs of Dependence Unit

If these contacts are unavailable, phone DACAS (ph. 7087 1742).

If the patient is prescribed a depot buprenorphine formulation (Sublocade; Buvidal weekly or Buvidal monthly) and it is anticipated that they are to be admitted for a length of time – similar precautions should be employed as above – dose confirmation; communication with the community prescriber; date of last dose and the next due depot formulation. It is recommended that they continue the depot formulations whilst admitted on the due dates as per information from the community prescriber.

This contact may enable the dose to be confirmed so that the correct dose is given in hospital, and also ensures that patient is not inadvertently removed from the MATOD program for failure to attend for their supervised in-pharmacy dose.

While there are few if any situations in hospital when a patient cannot continue their usual sublingual buprenorphine/naloxone (Suboxone®) film, there may be time when oral methadone cannot be continued. In this case, parenteral methadone may be given (in a smaller dose) or another opioid can be given by another route. It is suggested that advice about the opioid conversions and equivalent doses for patients who cannot take their oral methadone be sought from the hospital's acute pain service, pain management unit, Drug and Alcohol Consultation Liaison Service where available, or DACAS.

When the patient is discharged from the hospital after their admission communication with the prescriber (private, specialist or DASSA clinic) as well as the community pharmacy they are dosing their MATOD at is essential. Any changes in dose, as well as the date and time of last dose provided by the hospital must be communicated to these providers of care.

10.5 Management of patients taking illicit opioids (prescription opioids or heroin) not in opioid withdrawal presenting for other reasons

Patients who are regular users of prescription opioids (e.g. as whole tablets/capsules/patches, or chewing, snorting or injecting them) or heroin, may be admitted to hospital for a variety of reasons and are therefore at risk of opioid withdrawal. They should be monitored according to COWS (Appendix A) and any withdrawal treated according to the guidelines outlined in the next section.

If the patient has moderate to severe acute pain requiring treatment, then the standard aged-based opioid doses should be prescribed in the first instance and adjusted as needed thereafter. Advice about acute pain management can be sought from the hospital's acute pain service, pain management unit, Drug and Alcohol Consultation Liaison Service, or DACAS. The opioid doses used for management of acute pain may be enough to prevent withdrawal and further measures may not be required.

10.6 Management of patients using illicit opioids and presenting in opioid withdrawal

Patients who are regular users of prescriptions opioids (e.g. as whole tablets/capsules/patches, or chewing, snorting or injecting them) or heroin may present to the hospital in withdrawal. Patients presenting with opioid withdrawal may be using a variety of different opioids with varying half-lives and routes of administration that may require different approaches.

Addressing opioid withdrawal and minimizing the risks linked to opioid use are crucial. The following treatment strategies could be considered:

- Five-day protocol for management of withdrawal with sublingual buprenorphine/naloxone (Suboxone ®)
- Symptomatic treatment of opioid withdrawal
- Medication Assisted Treatment of Opioid Dependence (MATOD)

The choice of treatment will be guided by patient presentation, history and preference. A substantial body of research evidence supports a conclusion that both methadone and buprenorphine are safe and effective in the treatment of opioid dependence. Consider discussion with Drug and Alcohol Consultation Liaison Service where available or DACAS [ph. 7087 1742] to explore options regarding management.

Five-day protocol for management of withdrawal with sublingual buprenorphine/naloxone (Suboxone®)

This is usually at least a 5-day regimen, so if the patient is likely to be discharged within this timeframe. Discuss with Drug and Alcohol Consultation Liaison Service where available, or ring DACAS [ph. 7087 1742] regarding discharge planning.

All patients should be monitored using COWS shown in Appendix A. Each Local Health Network will have a specific chart outlining the monitoring and management requirements for these patients.

It is recommended that that a UDS be done prior to Suboxone® dosing to provide objective evidence of opioid use.

The 5-day buprenorphine/naloxone (Suboxone®) regimen outlined in the table below should be commenced when:

- the COWS score is ≥ 6
  AND
- there is objective evidence of withdrawal including piloerection/goose bumps or dilated pupils >3mm (See Appendix B for Pupil Size Chart).

5-DAY SUBLINGUAL BUPRENORPHINE/NALOXONE (SUBOXONE®) REGIMEN		
1. Monitor COWS 4 hourly **2. Prescribe buprenorphine/naloxone (Suboxone®) in the doses, frequency and maximum doses listed below (dose is given for buprenorphine only)** **3. If COWS ≥ 13, give as needed up to the maximum doses stated for each day and for up to 5 days only**		
DAY	**Dose/ frequency**	**Maximum dose**
Day 1	**4mg at onset of withdrawal & additional 2-4mg 4-6 hours later prn, if COWS still ≥ 13**	**8 mg**
Day 2	**4mg mane, additional 2-4mg evening dose prn, if COWS still ≥ 13**	**8 mg**
Day 3	**4mg mane, additional 2 mg evening prn, if COWS still ≥ 13**	**6 mg**
Day 4	**2mg mane, additional 2mg evening prn, if COWS still ≥ 13**	**4 mg**
Day 5	**2mg once only then cease**	**2 mg**

Buprenorphine/naloxone (Suboxone®) is administered sublingually as an observed dose. Patients may elect to take lesser amounts at any stage.

If the patient is discharged before the treatment is finished, ring the Drug and Alcohol Consultation Liaison Service where available or DACAS (7087 1742) to assist with planning.

NOTE: Arrangements will need to be made for the prescription and dispensing of buprenorphine/naloxone (Suboxone®) in the community. Hospital pharmacies do not generally dispense buprenorphine/naloxone (Suboxone®) to outpatients. Therefore, a community-based

pharmacy will need to be engaged as will a prescriber. Any GP can obtain authority to prescribe Suboxone® film for opioid dependence for up to 10 patients.

An authority from the Drugs of Dependence Unit will need to be obtained (DDU Duty Officer, ph. 1300 652 584) if the patient is to be discharged on this medication.

Symptomatic treatment

Symptomatic medications may be useful in patients with mild/moderate withdrawal (COWS 5-12) instead of the 5-day buprenorphine/naloxone (Suboxone®) regimen.

These may include:

Nausea & vomiting	Antiemetics
Gut cramps	Hyoscine butylbromide
Diarrhoea	Loperamide
Headache, muscle aches and pains	Paracetamol and/or NSAIDs Paracetamol/orphenadrine
Insomnia, anxiety/agitation	Benzodiazepines (caution when also prescribing an opioid)

Clonidine:

Clonidine (an alpha-2 adrenergic agonist) may be used in an inpatient setting if Suboxone is inappropriate or unavailable. It can provide relief to many of the physical symptoms of opioid withdrawal including sweating, diarrhoea, vomiting, abdominal cramps, chills, anxiety, insomnia, and tremor. BP monitoring should be undertaken (pre-dose) and clonidine should be withheld if systolic BP <90mm Hg.
Suggested dosing regimen:

- Initial test dose of 50mcg - if systolic BP remains above 90mm Hg, administer a further 50mcg after one hour
- First day 1.5 mcg per kg QID (for example 70kg patient dose is 100mcg QID)
- Subsequent days 3 to 4mcg per kg QID (for example 70kg patient dose is 200 to 250mcg QID).

Opioid dependence treatment

Opioid Dependence Treatment (ODT) or Medication Assisted Treatment of Opioid Dependence (MATOD) is an effective, evidenced-based approach to treating patients with Opioid Use Disorder that may be considered appropriate in some cases. Medication Assisted Treatment of Opioid Dependence has prevented people from suffering fatal overdose, reduced HIV and hepatitis C infection, made communities safer and allowed people to rejoin society.

DACAS (7087 1742) can be contacted for advice regarding patient appropriateness for ODT and clinical guidance.

10.7 Authority to prescribe drugs of dependence (e.g. Schedule 8 opioids for pain or dependence/addiction)

INDICATION - PAIN: In South Australia, under Section 18A of the Controlled Substances Act 1984, a prescriber **must have an authority** to prescribe or supply a Schedule 8 opioid for a patient for **regular treatment that exceeds two months**. Treatment provided by other prescribers must be taken into account when calculating the 2-month period.

Exemptions – see Regulation 22 (2) of the South Australia Controlled Substances (Poisons) Regulations 2011:

- Patients aged 70 years or more (unless the drug is pethidine or dextromoramide).
- A Patient whose life expectancy is reasonably believed to be 12 months or less and the Drugs of Dependence Unit have been notified of that fact (unless the drug is pethidine or dextromoramide).
- Where a patient is already being prescribed an opioid for pain management is admitted and another prescriber is already authorised and the hospital prescriber notifies the authorised prescriber of the treatment; and the drug is only administered while the patient is in hospital.
- [Where this person is being discharged from the hospital, the prescriber notifies the authorised prescriber that they have prescribed/supplied the drug on discharge (or their intention to do this)]
- Where a patient is already being prescribed an opioid for pain management is admitted and an authority does not exist provided the duration of treatment does not exceed 14 days. In the case of the patient being discharged from hospital, the duration with the discharge drug does not exceed 14 days.

  NOTE: If the duration in hospital exceeds 2 weeks and the total duration of the opioid for managing pain exceeds 2 months, then an authority needs to be obtained.

INDICATION - DEPENDENCE OR ADDICTION: It is an offense under Section 18A of the *Controlled Substances Act* 1984 to prescribe a drug of dependence (Schedule 8 drug) to 'a person who the practitioner or dentist knows or has reasonable cause to believe is dependent on drugs' unless prescribing in accordance with an authority.

Prescribers of methadone, buprenorphine/naloxone (Suboxone®) or buprenorphine depot to patients in a MATOD program for treatment of an opioid addiction must have an authority to prescribe in order to comply with Section 18A above, from the time of commencement of treatment.

Exemptions to this include:

- An inpatient of a hospital where another prescriber is authorised and the hospital prescriber notifies the authorised prescriber of the treatment; and the drug is only administered while the patient is in hospital; and if the drug is solely to treat drug dependence, the dose does not exceed the original dose.

- Where this person is being discharged from the hospital, the prescriber notifies the authorised prescriber that they have prescribed/supplied the drug on discharge (or their intention to do this); and if the drug is solely for treatment of drug dependence, the dose does not exceed the original dose.

- An inpatient of a hospital where an authority does not exist provided the duration of treatment does not exceed 14 days. An authority must be obtained in order to continue this treatment in the community after discharge.

  When discharging a patient who is on MATOD, discuss the discharge plan with the community prescriber OR if this is not possible call DACAS (08 70871742) for advice prior to discharging with any provided MATOD doses.

10.8 Specific situations

Pregnant patients

If the patient is pregnant seek specialist advice from:

> Obstetrics and Gynaecology registrar where available (regarding obstetric management)

> Drug and Alcohol Clinical Advisory Service (DACAS) ph. 7087 1742 regarding alcohol or drug management.

Abrupt opioid withdrawal in pregnancy is associated with significant obstetric risks. Perinatal outcomes are better when opioid- dependant mothers are receiving MATOD.

Buprenorphine/naloxone (Suboxone®) can be used in pregnant patients.

Patients identified as Aboriginal or Torres Strait Islanders and other patients from culturally and linguistically diverse backgrounds

Ensure that:

> They understand any questions asked

> They are supported by an Aboriginal Liaison Officer or family as appropriate wherever possible

> An interpreter is used where appropriate.

Patients not able to take anything by mouth – 'nil oral intake'

If the patient's 'usual' opioid cannot be administered (e.g. a patient who is prescribed an oral opioid is not able to take any oral medications) then the equivalent dose of that opioid, or another opioid, should be given by an alternative route. If required, advice about opioid

conversions and equivalent doses can be sought from the hospital's acute pain service, or pain management unit; Drug and Alcohol Consultation Liaison Service where available; or from the responsible anaesthetist. Advice can also be obtained from the Drug and Alcohol Clinical Advisory Service (ph. 7087 1742).

NOTE: 'Nil oral intake' is NOT the same as 'fasting'. A fasting patient may be given their oral medications as normal unless there are specific reasons not to take then (e.g. a diabetic patient fasting for theatre who usually takes oral hypoglycaemic agents).

10.9 Advice on regulatory aspects of opioid prescribing or on patients suspected of trying to obtain opioids

Advice can be obtained only in office hours from The Duty Officer, Drugs of Dependence Unit, Clinical Regulation, Department for Health and Wellbeing (ph. 1300 652 584). This is an office hours service only 9AM to 5PM Monday to Friday.

10.10 Drugs used for opioid substitution therapy in MATOD programs

Buprenorphine

Buprenorphine is classified as a partial mu-opioid agonist. However, it appears to behave as a full mu-opioid agonist for analgesia in humans where no evidence of a 'ceiling effect' for pain relief has been found. In contrast there appears to be a ceiling to its respiratory and cardiovascular suppressant effects, when used on its own.

It also has a very high receptor affinity which was thought might interfere with the analgesic effects of pure agonist opioids such as morphine and oxycodone. However, this has been shown not to be the case. Good pain relief with additional pure agonist opioids can be achieved in patients currently taking buprenorphine. It has low oral bioavailability, so is administered sublingually or buccally, or as a long-acting depot injection.

Buprenorphine is an effective analgesic agent.

Buprenorphine/naloxone (Suboxone®) film

Suboxone® film contains buprenorphine with naloxone as a 4:1 mix in an attempt to reduce its intravenous abuse potential. It has a half-life (t½) of more than 24 hours and is used in substitution programs for the treatment for opioid addiction [MATOD].

Due to its high receptor affinity and partial mu-agonism it can precipitate an opioid withdrawal syndrome in patients who are opioid dependent, and who still have a substantial proportion of their receptors occupied by pure opioid agonists. The usual recommendation is that buprenorphine should only be commenced when the patient is in opioid withdrawal. However, this may not be possible when patients are requiring additional opioids for analgesia. In these cases, specialist advice should be sought as the titration of buprenorphine, starting with small doses only and slowly increasing the doses, may allow the patient to be started on buprenorphine without any signs and symptoms suggestive of withdrawal.

Long-acting injectable buprenorphine (Buvidal® or Sublocade®)
The depot buprenorphine formulations Buvidal weekly; Buvidal monthly and Sublocade - are new generation extended release, medium to high dose buprenorphine formulations indicated for the treatment of opioid dependence. They are given to patients via subcutaneous injection.

The slow release of buprenorphine from the depot injections results in an extended duration of action of these products.

The terminal half-life after a single injection of the depot formulations varies: Buvidal weekly – 3-5 days; Buvidal monthly 19-25 days and Sublocade 43-60 days.

Side effects of depot buprenorphine are similar to the known safety profile of sublingual buprenorphine products – with the exception of adverse events directly related to the injectable nature of these formulations. Please contact DACAS 70871743 with queries related to possible adverse events or complications suspected to be related to the depot buprenorphine products in patients presenting hospital prescribed these products.

Methadone

Methadone is an orally bioavailable synthetic full mu-opioid agonist with a long t½ also used in MATOD substitution programs. Its metabolism is varied with an average t½ of 24 hours (it can vary from 6 hours to over 150 hours). Drugs that are also metabolised by the CYP450 enzymes may also interfere with its metabolism. Due to its longer, variable t½ it can accumulate over several days. Use with caution in severe liver disease.

10.11 Consider provision of take-home naloxone

People who are dependent on opioids are at higher risk of an overdose if their tolerance to the drug is reduced. This can happen if they stop taking opioids for a while (for example if they have been in drug treatment or in prison).

Other risk factors include:

- using opioids in high doses with other sedatives — for example, benzodiazepines
- some medical conditions — for example
    - depression
    - HIV
    - liver disease
    - sleep apnoea
    - lung disease, such as chronic obstructive pulmonary disease or pneumonia
- living in a home where opioids are stored

Naloxone can be obtained at no cost and without a prescription, from community pharmacies and hospitals registered for the Take Home Naloxone (THN) Program. More information about take-home naloxone can be found here.

10.12 Contacts

> Hospital Drug and Alcohol Consultation Liaison Services where available

> Alcohol and Drug Information Service (ADIS): **Ph 1300 13 13 40**

- Drug and Alcohol Clinical Advisory Service (DACAS): Ph **7087 1742**
- DASSA **Central** Services (Stepney): Ph **7425 5168**
- DASSA **Northern** Services (Elizabeth): Ph **7485 4600**
- DASSA **Southern** Services (Morphett Vale): Ph **8325 8111**
- DASSA: www.sahealth.sa.gov.au/dassa
- The Duty Officer, Drugs of Dependence Unit: **Ph: 1300 652 584. Fax: 1300 658 447. Email: healthdrugsofdependenceunit@sa.gov.au**

11. General considerations

As above. Nil additional

12. Eligibility criteria

Inclusion

People attending Emergency Departments or admitted inpatients at risk of opioid withdrawal. These people will have been consuming opioids regularly prior to admission.

Exclusion

People only consuming opioids on an intermittent basis and therefore not tolerant, are unlikely to experience withdrawal.

13. Administration

As above. Nil additional

14. Observations

COWS (Clinical Opioid Withdrawal Scale)
Sedation Score

15. Appendix A: Clinical Opioid Withdrawal Scale (COWS)

CLINICAL OPIATE WITHDRAWAL ASSESSMENT SCALE (COWS) 1

Government of South Australia
SA Health

DRUG & ALCOHOL SERVICES SOUTH AUSTRALIA

SURNAME:

OTHER NAMES:

GENDER: ☐ M ☐ W ☐ Self Described

UR NUMBER:

PHOTO

The Withdrawal chart is to be used in conjunction with the Rapid Detection and Response Chart at all times throughout the admission

Date															
Time															
1	Resting pulse rate *														
2	Sweating *														
3	Restlessness														
4	Pupil size *														
5	Bone or joint aches														
6	Runny nose or tearing *														
7	GI upset: over last 1/2 hour														
8	Tremor *														
9	Yawning observation *														
10	Anxiety or irritability														
11	Gooseflesh: skin *														
TOTAL SCORE															

Do not commence Suboxone / Subutex regime until score is above 5 and there is evidence of objective opiate withdrawal including at least one of those marked with an * (Goosebumps or dilated pupils greater than 3mm).

- Mandatory: a urine drug screen is required on admission prior to medicaiton administration.
- record the observations prior to each opioid administration.

Key for scoring withdrawal			
5-12: Mild	13-24: Moderate	25-36: Moderate to Severe	Greater than 36: Severe

Resting pulse rate: Record beats per minute			
0: pulse rate 80 or below	1: pulse rate 81 - 100	2: pulse rate 101 - 120	4: pulse rate greater than 120

Sweating: over past 1/2 hour not accounted for by room temp or patient activity			
0: No report of chills or flushing	1: Subjective report of chills or flushing	2: Flushed or observable moistness on face	3: Beads of sweat on brow or face
4: Sweat streaming off face			

Restlessness observation during assessment	
0: Able to sit still	1: Reports difficulty sitting still, but able to do so
3: Frequent shifting or extaneous movements of legs/arms	5: Unable to sit still for more than a few seconds

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

Bone or joint aches if patient was having pain previously, only the additional component attributed to opiate withdrawal is scored	
0: Not present	1: Mild diffuse discomfort
2: Patient reports sever diffuse aching joints/muscles	4: Patient is rubbing joints/muscles and is unable to sit still because of discomfort

Runny nose or tearing not accounted for by cold symptoms or allegies			
0: Not present	1: Nasal stuffiness or unusally moist eyes	2: Nose running or tearing	4: Nose constantly running/tears streaming down cheeks

GI upset: over last 1/2 hour				
0: No GI symptoms	1: Stomach cramps	2: Nausea or loose stool	3: Vomiting or diarrhoea	5: Multiple episodes of diarrhoea or vomiting

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

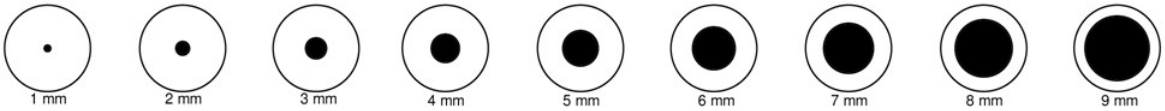
Yawning observation during assessment			
0: No yawning	1: Yawning once or twice during assessment	2: Yawning three or more times during assessment	4: Yawning several times/minute

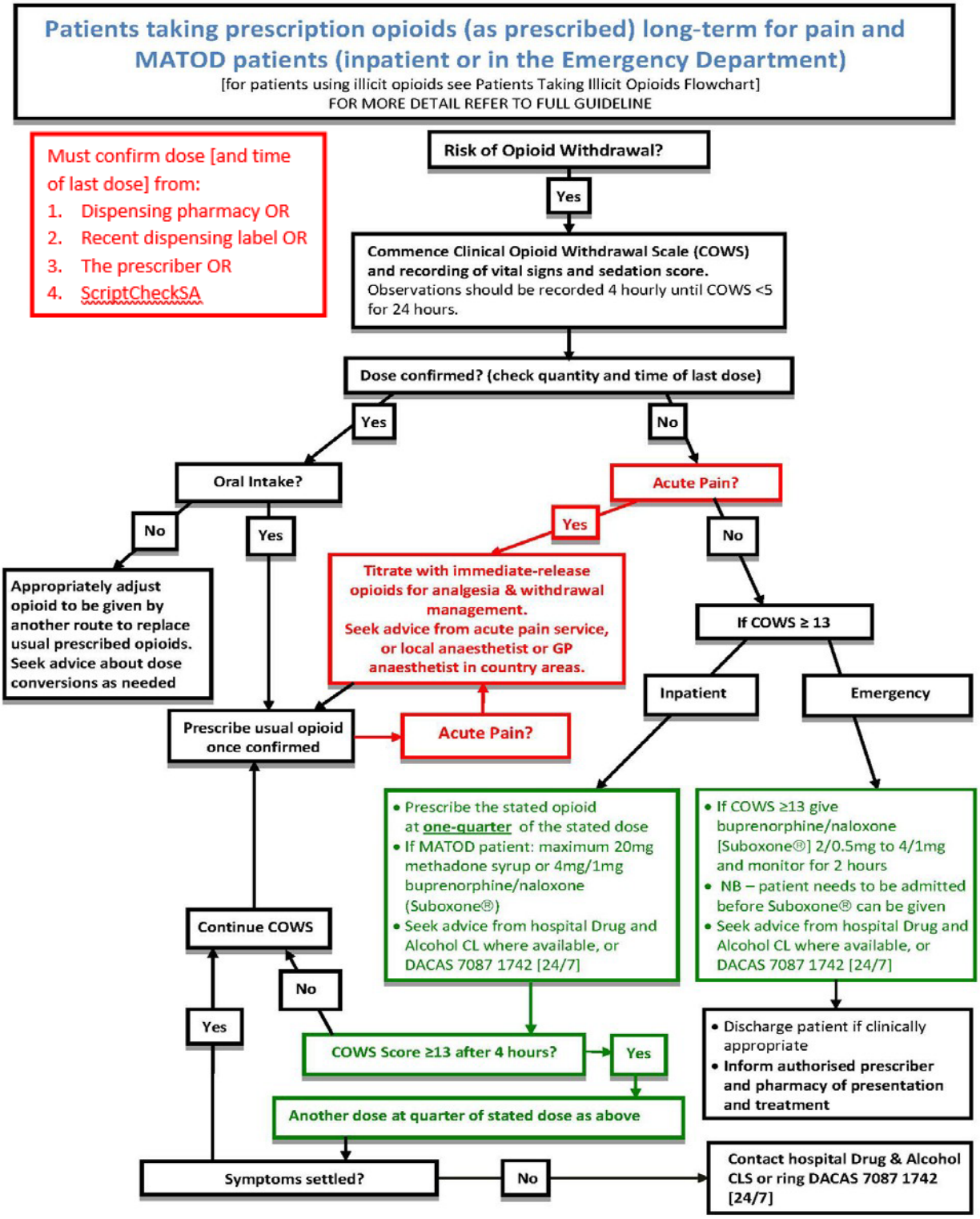
Anxiety or irritability	
0: None	1: Patient reports increasing irritability/anxiousness
2: Obviously anxious or irritable	4: So anxious or irritable that participation in assessment is difficult

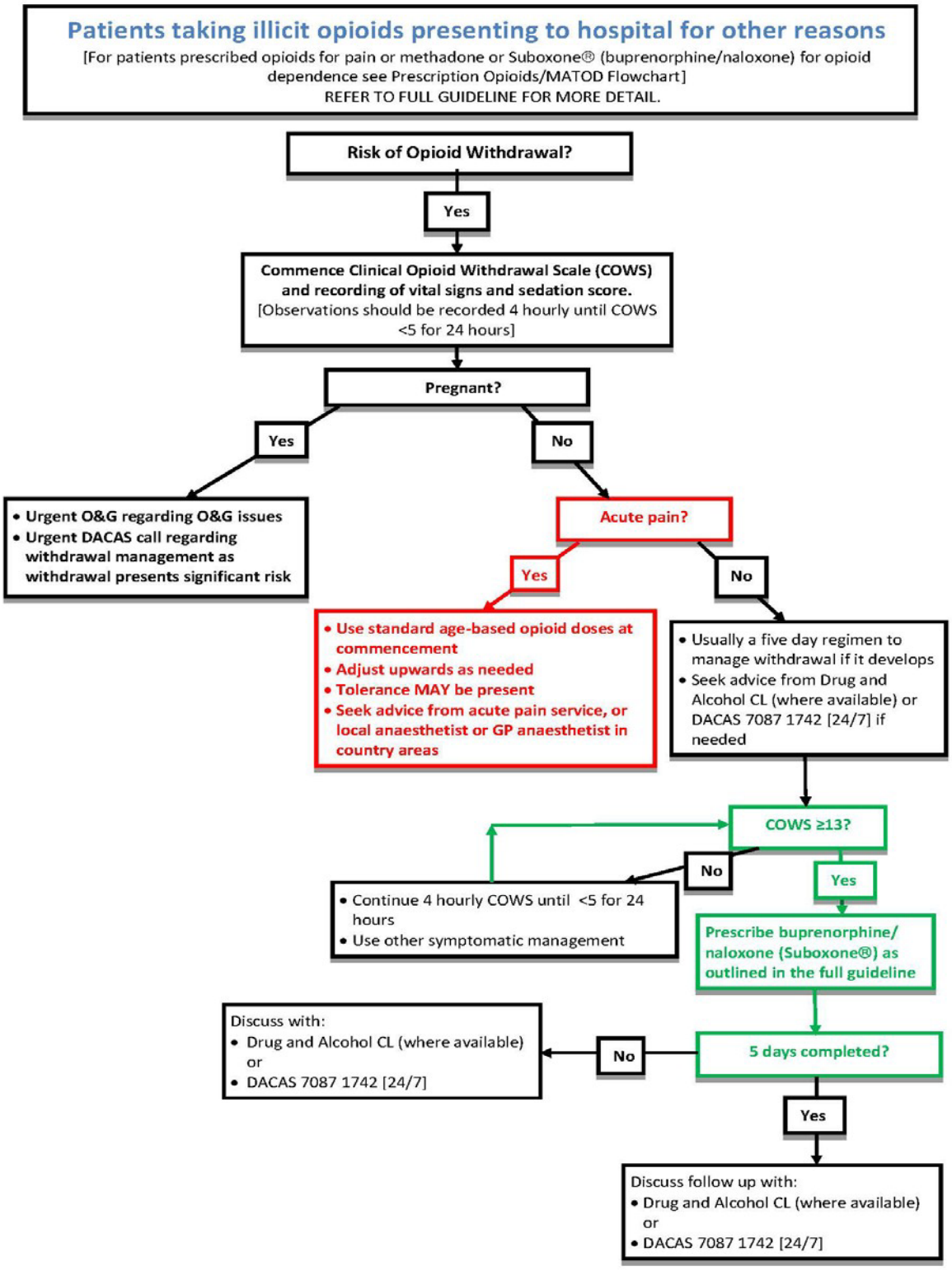
Gooseflesh: skin		
0: Skin is smooth	3: Piloerection can be felt or hair standing up on arms	5: Prominent piloerection

Reference: Wesson D, Ling W *The Clinical opiate Withdrawal Scale (COWS)* Journal of Psychoactive Drugs (2003) 35 (2) 253-259

Appendix B: Pupil size chart




Patients taking prescription opioids (as prescribed) long-term for pain and MATOD patients (inpatient or in the Emergency Department)
[for patients using illicit opioids see Patients Taking Illicit Opioids Flowchart]
FOR MORE DETAIL REFER TO FULL GUIDELINE
Must confirm dose [and time of last dose] from:
1. Dispensing pharmacy OR
2. Recent dispensing label OR
3. The prescriber OR
4. ScriptCheckSA
Risk of Opioid Withdrawal?
Yes
Commence Clinical Opioid Withdrawal Scale (COWS) and recording of vital signs and sedation score.
Observations should be recorded 4 hourly until COWS <5 for 24 hours.
Dose confirmed? (check quantity and time of last dose)
Yes
No
Oral Intake?
No
Yes
Appropriately adjust opioid to be given by another route to replace usual prescribed opioids. Seek advice about dose conversions as needed
Acute Pain?
Yes
No
Titrate with immediate-release opioids for analgesia & withdrawal management.
Seek advice from acute pain service, or local anaesthetist or GP anaesthetist in country areas.
If COWS ≥ 13
Inpatient
Emergency
Prescribe usual opioid once confirmed
Acute Pain?
• Prescribe the stated opioid at one-quarter of the stated dose
• If MATOD patient: maximum 20mg methadone syrup or 4mg/1mg buprenorphine/naloxone (Suboxone®)
• Seek advice from hospital Drug and Alcohol CL where available, or DACAS 7087 1742 [24/7]
• If COWS ≥13 give buprenorphine/naloxone [Suboxone®] 2/0.5mg to 4/1mg and monitor for 2 hours
• NB – patient needs to be admitted before Suboxone® can be given
• Seek advice from hospital Drug and Alcohol CL where available, or DACAS 7087 1742 [24/7]
Continue COWS
No
Yes
COWS Score ≥13 after 4 hours?
Yes
• Discharge patient if clinically appropriate
• Inform authorised prescriber and pharmacy of presentation and treatment
Another dose at quarter of stated dose as above
Symptoms settled?
No
Contact hospital Drug & Alcohol CLS or ring DACAS 7087 1742 [24/7]


Patients taking illicit opioids presenting to hospital for other reasons
[For patients prescribed opioids for pain or methadone or Suboxone® (buprenorphine/naloxone) for opioid dependence see Prescription Opioids/MATOD Flowchart]
REFER TO FULL GUIDELINE FOR MORE DETAIL.
Risk of Opioid Withdrawal?
Yes
Commence Clinical Opioid Withdrawal Scale (COWS) and recording of vital signs and sedation score.
[Observations should be recorded 4 hourly until COWS <5 for 24 hours]
Pregnant?
Yes
No
• Urgent O&G regarding O&G issues
• Urgent DACAS call regarding withdrawal management as withdrawal presents significant risk
Acute pain?
Yes
No
• Use standard age-based opioid doses at commencement
• Adjust upwards as needed
• Tolerance MAY be present
• Seek advice from acute pain service, or local anaesthetist or GP anaesthetist in country areas
• Usually a five day regimen to manage withdrawal if it develops
• Seek advice from Drug and Alcohol CL (where available) or DACAS 7087 1742 [24/7] if needed
COWS ≥13?
No
Yes
• Continue 4 hourly COWS until <5 for 24 hours
• Use other symptomatic management
Prescribe buprenorphine/ naloxone (Suboxone®) as outlined in the full guideline
5 days completed?
No
Discuss with:
• Drug and Alcohol CL (where available) or
• DACAS 7087 1742 [24/7]
Yes
Discuss follow up with:
• Drug and Alcohol CL (where available) or
• DACAS 7087 1742 [24/7]

16. Reference

National Guidelines for Medication-Assisted Treatment of Opioid Dependence [2014] available at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/AD14DA97D8EE00E8CA257CD1001E0E5D/$File/National_Guidelines_2014. pdf

17. Document Ownership & History

Developed by: Drug and Alcohol Services South Australia (DASSA)
Contact: Dr Willy Liaw, Clinical Partnerships, DASSA SALHN
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Approval Date	Version	Who approved New/Revised Version	Reason for Change
02/04/2025	V1.3	Clinical Guideline Domain Custodian	Expiry of previous clinical guideline. Added in information about take home naloxone. Re-ordered and updated the opioid equianalgesic table. Added in link to opioid calculator. Updated the 5-day suboxone protocol and COWS score form. Added ScriptCheckSA as a source of prescribing/dispensing information throughout document. Details of long-acting injectable buprenorphine updated in document.
01/05/2020	V1.2	Medical Director DASSA	Incorporation of the new buprenorphine depot formulation.
23/09/2019	V1.1	A/Director Safety & Quality	Transferred to correct template and minor amendments re contacts.
20/04/2016	V1	S&QSGC	Original S&QSGC approved version.