Document Title:	**ACUTE PAIN MANAGEMENT FOR PATIENTS WITH A HISTORY OF SUBSTANCE MISUSE**		
Document Reference/Register no:	06005	**Version Number:**	5.0
Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	Medical and Nursing staff
Ratification Issue Date: (Date document is uploaded onto the intranet)	31st October 2018	**Review Date:**	30th October 2021
Developed in response to:	Best Practice		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**	4 & 9		
Issuing Division/Directorate:	Integrated Pain Management Service		
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Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	☑ MEHT □ BTUH □ SUH		
Consultation:	(Refer to page 2)		
Approval Group / Committee(s):	n/a	**Date:**	n/a
Professionally Approved by: (Asset Owner)	Dr Mark Alexander-Williams Lead Consultant, IPMS	**Date:**	15/10/2018
Ratification Group(s):	DRAG Chairman's Action	**Date:**	23rd October 2018
Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** November 2018	**Distribution Method:**	Trust Intranet/ Internet

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Related Trust Policies (to be read in conjunction with)	Policy for the use of Medicines 06000 Use of Entonox in Procedural Pain 06001 Management of Procedural Pain 06007 Severe Pain Management 06010 Patient Controlled analgesia 11027 Pain Assessment & Management on the wards 11063 Neuropathic Pain 12035 Local Anaesthetic Peripheral Nerve Blocks 06056 Drug & Alcohol use in Pregnancy

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	L Mustard/K Tighe		August 2000
1.1	L Mustard/K Tighe		March 2002
1.2	L Mustard/ K Tighe		August 2002
2.0	L Mustard/K Tighe		October 2002
2.1	L Mustard/K Tighe		January 2004
2.2	L Mustard/K Tighe		August 2004
3.0	L Mustard/K Tighe		October 2004
3.1	L Mustard/M Finn		October 2007
4.0	Jayne Somerset		September 2014
5.0	Jayne Somerset	Full Review	31st October 2018

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1. Purpose

1.1 These guidelines were written to provide non-specialists with appropriate information to assess the needs of and manage pain in patients who are, or have been substance misusers. The principles of pain management in this population are the same; all current MEHT Pain Guidelines may be applied. Additional management for this population is enclosed in this guideline.

2. Scope

2.1 The guideline has been developed to assist in the assessment and management of patients who are 16 years or older and who are, or have been, substance misusers. This guideline is primarily aimed at opiate misuse but other substances of misuse also need to be considered. These may include; alcohol, benzodiazepines, cocaine, cannabis, drugs that come under the heading of 'legal highs'. It can be used by medical, nursing, and allied professional staff within the Trust. It can be applied to patients admitted to any area of the Trust.

3. Background

3.1 Several issues influence the level of care a patient with a history of substance misuse receives from health care professionals. Providers tend to undertreat in this population due to biases, misconceptions, and systems issues. The tendency is to use opioids sparingly for pain, resulting in both poor pain management and withdrawal phenomena.

3.2 The prevalence of drug misuse in Britain is difficult to assess. A British household survey in 2000 reported that 7% of 16 to 74 year olds were dependent on alcohol. In the same survey, 2% of the population were dependent on cannabis alone and a further 1% on other drugs with or without cannabis. The most frequently used drug was cannabis, with only one per cent of the population reporting the use of heroin and crack-cocaine. Only a minority of those who try drugs will develop problems and require drug treatment but it is particularly the opioid misusing population that poses challenges to the adequate and appropriate management of pain (British Pain Society). Despite the low reported usage of heroin, in a further study it was estimated that in 2006-07, for every 1000 people aged 15-64 years in England, an estimated 8·1 were heroin users (NTA, 2012). Between April 2005 and 2011, 229,788 patients were treated for heroin addiction at some point in the UK; their median length of stay in treatment was about four years. In view of this time treatment line, heroin users represent 2/3 of all people being treated with drug problems. It is one of the most difficult addictions from which to abstain.

3.3 Drug misusers present with a myriad of other health and social problems, particularly in relation to physical and psychiatric co-morbidity and social care needs. Drug users are more likely to suffer from accidental and non-accidental injury, and medical complications related to their drug use. This places them at high risk from physical problems that may require analgesia (British Pain Society).

3.4 Essentially, each patient admitted to hospital is entitled to expect effective pain management. Balanced analgesia remains the optimal approach in practice, and is no different in principle for the drug misuser. Preconceptions, prejudices, and a lack of knowledge in this area do nothing to enhance the likelihood of this.

4. Assessment of the patients' pain where previous or current drug misuse is apparent

4.1 It is not appropriate to use an acute hospital admission as an opportunity to address the underlying substance misuse problem. Discussion regarding substance misuse and referral to appropriate services, i.e. GP, 'Open Road', 'Essex Stars' (formerly Changes), prior to discharge can be made.

4.2 Health care prescribers / providers need to understand and acknowledge these patients will have a greater pain intolerance (hyperalgesia is present – they will experience pain as greater), and for those patients who misuse opiates, opioid tolerance will also be present.

4.3 In addition, where the patient is taking Subutex or Suboxone (containing buprenorphine; an opioid partial agonist); giving opioids to control pain may be counterproductive. Pain management for this subset of patients require a different approach. Please contact the IPMS for help with these patients.

4.3 The principles of pain assessment can be divided into those who are current misusers, and those who have been previous misusers but are currently abstinent.

Pain assessment of patient with history of substance misuse	
Current misusers	**Previous misusers**
1. Pain assessment as per MEHT guidelines. 2. Full assessment of current drug misuse. Contact Key worker; contact number from the patient-check this is a reliable source. 3. Liaise with external agencies 'Essex Stars' (Specialist Treatment and Recovery Service) (see contact number below), or dispensing community pharmacist to ensure dose and drug correct. 4. Drug medication history to check for potential interactions (see Appendix 2). 5. Anticipate, recognise and manage opioid withdrawal. Liaise with Drug and Alcohol Service for advice (see contact numbers below). Drugs may include loperamide, mebeverine, and diazepam. (Clinical Opiate Withdrawal Scale maybe used). This can be accessed via link below. **See Appendix 1.**	1. Pain assessment as per MEHT guidelines. 2. Ascertain when and what last used. 3. Prevention of relapse. 4. Discussion of analgesics available. 5. Ascertain if they are receiving opioid substitution therapy; methadone or *buprenorphine (Subutex or Suboxone) 6. Liaise with external agencies 'Essex Stars' (see contact number below), dispensing community pharmacist to ensure dose and drug correct if they are currently on a maintenance regime.

https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf 6. Treatment of symptoms associated with withdrawal. Refer to MEHT guideline 18007 – Opioid withdrawal in adult inpatients. Liaise with Drug and Alcohol Service for advice (see contact numbers below). This may include the introduction of methadone. (Clinical Opiate Withdrawal Scale maybe used). This can be accessed via link below. **See Appendix 1.** ***https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf*** 7. Ascertain if they are receiving opioid substitution treatment; methadone or buprenorphine (Subutex or Suboxone). Where the patient is receiving buprenorphine regime (Subutex and Suboxone) see pain management section. 8. Refer to the IPMS (Integrated Pain Management Service). 9. Referral for assessment and / or treatment of co-existing psychiatric illness. 10. Provision of agreed and effective analgesia (this is to be regarded as totally separate from any maintenance opioids given to prevent withdrawal).	7. Refer to the IPMS (Integrated Pain Management Service). 8. Referral for assessment and / or treatment of co-existing psychiatric illness 9. Provision of agreed and effective analgesia (this is to be regarded as totally separate from any maintenance opioids given to prevent withdrawal).
A formal plan of the agreed analgesia needs to be written clearly in the patient's medical notes; this reduces the risk of under treatment by inexperienced staff, and of potential manipulative behaviour by the patient.	
'Essex Stars' is the local Community Drug and Alcohol Service; they will have up to date prescription doses for all patients registered to them. Their contact telephone number is 01245 348837. See their website for opening hours. John Crome, Alcohol Liaison Nurse Specialist at Broomfield Hospital, can be contacted on 01245362000 ext. 4804 Mobile – 07879423847. Working hours Monday to Friday 7am to 3pm. If not available in working hours, the dispensing community pharmacist can confirm doses and maintenance drug used.	
'Open Road' Centre: (01245 284772 Helpline: 0844 4991323) provide support, advice and information through their triage service. They also carry out psychosocial assessments and provide interventions where required. They offer information	

regarding other substances of abuse; including stimulants, benzodiazepines, cannabis, 'legal highs', and matters concerning binge drinking.

5. Patients presenting in pain, but deny drug misuse

5.1 These patients may follow a pattern in their behaviour, see table below (British Pain Society).

Features of presentation that may alert practitioner to the possibility of substance misuse
• Cutaneous signs of drug abuse - skin tracks and related scars on the neck, axilla, groin, neck, forearm, wrist, foot and ankle. Such marks are usually multiple, hyper-pigmented and linear. New lesions may be inflamed. • Shows signs of "pop" scars from subcutaneous injections. • Being assertive, aggressive or emotionally labile. • Current intoxication / withdrawal. • May show unusual knowledge of controlled substances. • Gives medical history with textbook symptoms or gives evasive or vague answers to questions regarding medical history. • Reluctant or unwilling to provide reference information. May have no general practitioner. • Will often request a specific controlled drug and is reluctant to try a different drug. • Generally has no interest in diagnosis - fails to keep appointments

5.2 These patients need to be encouraged to disclose accurate information regarding substance misuse, and it explained in no uncertain terms to them that omitting information will prevent the best chance of controlling their pain.

5.3 If the patient discloses what substances they have been using, discussion with local Drug and Alcohol Service is important at this stage. The patient may be known to them, they will be able to inform you of their treatment / maintenance plan. If unknown to them they will be able to assist in a reliable conversion from street drugs to prescribe and initiate a maintenance opioid dose which will prevent withdrawal occurring. See the contact numbers for 'Open Road' and 'Essex Stars'.

5.4 Pain assessment and management is the same as for patients in section 4.

5.5 For patients where methadone is initiated by the medical / surgical team to prevent withdrawal, be aware that respiratory depression is uncommon, but tends to occur at the time of methadone titration or rotation of opioids. Where respiratory depression occurs, respiratory support is suggested instead of naloxone as this will precipitate withdrawal. These patients will require very close monitoring.

6. Management of Acute Pain

6.1 Pain management and prescribing is as MEHT Guideline 06007 – Severe Pain Management. However, there may be variation in view of the patients' substance misuse issues, and these are highlighted below.

6.2 All patients with a history of substance misuse who have planned surgery should be seen by the IPMS regarding their pre-op needs, post-op, and pre-discharge pain management.

6.3 It is important to maintain sufficient background medication to avoid withdrawal in addition to that needed to provide analgesia. Health care providers / prescribers need to understand that opioid substitution treatment is not for pain control. The sole purpose is to prevent withdrawal.

6.4 The risk of relapse, (the rapid return to compulsive drug use even after long periods of abstinence), is a very real issue for the previous misuser, and exposure to opioids, even in oral form can provoke a very rapid reinstatement of dependence, even after prolonged periods of stable abstinence. This prolonged risk of relapse reflects persisting brain changes after dependence. **The use of opioids in previous misusers needs to be explained before introduction of opioids in their pain management plan.**
The patient may refuse opioids for the fear of return to the 'addicts' lifestyle'. If commenced, this patient group need to be monitored closely and reduction to simple analgesics is carried out at the earliest opportunity. You may like to draw up a verbal or written agreement with the patient to provide them with a plan and to optimise compliance. The inclusion of multi-modal analgesics in their regime should be considered if not already included. Complimentary techniques to pain management should also be considered.

6.5 It is advisable to maintain consistency and minimise the number of clinicians involved in analgesic prescribing. The Pain Service is an appropriate single point of contact for any changes in drug regimes.

6.6 **For patients receiving buprenorphine**

Buprenorphine is an opioid receptor partial agonist partial antagonist (it has agonist and antagonist properties), and it is used in the treatment of opiate dependency. For this effect it may have been the preferred regime chosen by the patient. When patients are admitted to hospital requiring pain management it is desirable to maintain, and minimise disruption of the patients' maintenance regime. However, there are times where the patients' pain may not be managed sufficiently, i.e. where pain is severe, and guidance to manage their pain is required. Please refer these patients to the Pain Team as soon as possible. Patients taking buprenorphine may experience opiate blockade effects because of the partial agonist partial antagonist effect.

6.6.1 Patients who can manage on non-opioids with their buprenorphine regime continue. Use multi-modal analgesia, i.e. paracetamol and NSAID if tolerated.

6.6.2 It may be possible to use buprenorphine (Temgesic) for PRN analgesia and no other full opioid agonist. If the patient is receiving additional CNS depressant drugs, e.g. pregabalin, benzodiazepines, opioids, etc., the risk of respiratory depression is increased.

6.6.2 Where the patient is receiving up to 16mgs/24hours of Buprenorphine the patient is more likely to experience opioid blocking effects, e.g. the introduction of full opioid agonist will have little effect. Dividing the daily dose of buprenorphine to reduce the blockade effect is generally beneficial (i.e. 16mg OD given as 4mg QDS) and titrate opiate analgesia.

6.6.3 Where pain is severe and pain cannot be managed as above and / or the patient is receiving over 16mgs/24hours of Buprenorphine, it may be worthwhile persevering with dividing the doses throughout the 24 hour period. If pain is still not being managed effectively the patient may require cessation of their buprenorphine regime, bridging this with methadone, and giving additional full opioid agonists until the pain is managed. PLEASE CONSULT WITH THE DRUGS AND ALCOHOL LIASON NURSE FOR THE STARTING DOSE OF METHADONE. Once pain is managed, the patient ceases to use methadone, and the buprenorphine regime is re-introduced. Please seek advice from the Pain Team.

6.6.4 Adjunct alternatives may also be considered, e.g. Central / peripheral nerve blocks, neuropathic analgesics, etc.

6.6.5 Buprenorphine and tramadol (partial μ agonists) can be used. However, they have a ceiling effect when treating severe pain.

6.6.6 Consider the patients renal and hepatic function prior to prescribing.

6.7 **For patients already receiving methadone as their maintenance drug or when there is a need to switch to Methadone from buprenorphine maintenance as pain is not managed by using the above advice**

6.7.1 Initiating methadone in hospitalised patients, or continuing methadone in patients whose medication has not been supervised, should be done by titrating the dose with regular small doses and observing the response. Introducing methadone is complex due to variable pharmacokinetics. In patients who metabolise the drug slowly, methadone accumulates over several days, and a dose which might have been safe on day 1 can be toxic on day 2 or 3. Patients need to be monitored for signs of toxicity during the first week of methadone therapy. PLEASE CONSULT / LIAISE WITH THE DRUGS AND ALCOHOL LIASON NURSE FOR THE STARTING DOSE OF METHADONE.

6.7.2 Avoid partial agonist/antagonist drugs for patients receiving methadone as withdrawal may be precipitated.

6.7.3 If IV route is considered, PCA may be an option. If a PCA is used, the bolus dose tends to be higher than usual in these patients and the inclusion of a background infusion is sometimes required. Careful patient observation is required and these patients should be cared for in HDU or ITU areas. Dose titration is needed when

setting up the PCA to ensure both safety and adequacy of pain relief. PLEASE REFER TO THE PAIN TEAM.

6.7.4 Consider the patients renal and hepatic function prior to prescribing.

6.8 Neonatal opioid withdrawal syndrome (NOWS) is an expected and treatable outcome of prolonged use of opioids during pregnancy. Please contact the Pain Team for advice.

6.9 Patients on naltrexone do not benefit from opioid analgesics. Naltrexone should be ceased 72 hours prior to elective surgery if opioid analgesia is needed.

7. Considerations on Discharge

7.1 It is important to remember that continuing management of the patient's medication on discharge will need support from the local drug dependency team and advice from the team needs to be sought when weaning to oral analgesia so that this can be planned in parallel with establishing / maintaining an appropriate opioid maintenance regimen.

7.2 Recognise potential problems with alcohol / drug intoxication including carelessness whilst self-medicating. Try to involve a responsible partner, carer, etc., in safe administration of analgesics on discharge. Opioids may be given as a supervised daily prescription at the patients' local dispensing pharmacy.

7.3 Where patients are to be discharged with an opioid prescription, consider giving a limited supply in view of misuse or overdose potential. On the patient's discharge letter, the doctor should ask the GP to review this as soon as possible. Analgesics post discharge should be time limited and weaned as quickly and as safely as possible.

8. Staff and Training

1.1 Medical and nursing staff are expected to understand the need to assess pain, and the clinical importance of treating pain promptly and safely in patients with substance misuse issues.

8.2 Training and education is provided by the IPMS (Integrated Pain Management Service), both formally and informally for all clinical staff. The IPMS is available for advice and consultation via the pager system, and through the Lorenzo referral system.

8.3 All link nurses will be informed of updated guidelines at regular meetings for them to disseminate to their areas / wards.

8.4 Medical staff will be informed of revised guidelines via senior medical staff within the IPMS at audit meetings and twice yearly teaching sessions for all FY1 and FY2 doctors.

8.5 Corporate services will ensure that the guideline is uploaded to the intranet and the website and notified to staff via Focus.

9. Non-compliance with this Guideline

9.1 Failure to provide thorough assessment and effective pain management is a breach of patient rights, and has clinical and non-clinical repercussions:

- Patient satisfaction and well-being is compromised
- Accountability and professional responsibility is breached
- Clinical risk is increased, due to multi-systemic influence of pain
- Delayed discharge from hospital decreases Trust efficiency and increases risk of hospital-inquired infection.

9.2 A datix should be completed and submitted to the Risk Management Department for non-compliance with this guideline.

10. Audit and Monitoring

10.1 Yearly audit of compliance to regular pain assessments on wards and emergency areas are carried out by the IPMS. The population group are rare, and we ask that all patients with substance misuse issues be referred to us so we can advise and oversee their care.

10.2 Incidence of clinical risk or patient complaints resulting from non-compliance of this guideline is recorded via the central risk events database and PALS if involved.

10.3 The IPMS manager and lead consultant will liaise at corporate level to put strategies in place to address issues.

11. References

1. http://www.actiononaddiction.org.uk/Documents/The-Management-of-Pain-in-People-with-a-Past-or-Cu.aspx

2. The British Pain Society, Royal College of Psychiatrists, Royal College of General Practitioners, Advisory Council on the Misuse of Drugs (2007)
Pain and substance misuse; improving the patient experience

3. http://www.asam.org/research-treatment/pain-and-addiction

4. 'Drug misuse: opioid detoxification' NICE clinical guideline 52 (2007)

5. Drug Misuse and Dependence, UK Guidelines on Clinical Management. (2007)

6. Australian and New Zealand College of Anaesthetics (ANZCA) (2010)
Acute pain management: scientific evidence Systematic review and recommendations:
- Acute pain management in heroin users (11.7)
- Acute pain management in opioid-tolerant patients (and OST patients) (11.8)

12. Glossary

Hyperalgesia	Refers to an increased sensitivity to the experience of pain.
Opioid Substitution Treatment	(OST) is the structured prescribing of an opioid as a treatment of dependence. Most commonly, this involves the prescribing of methadone, or buprenorphine.
Withdrawal syndrome	Withdrawal symptoms occur when the body and the brain react adversely to the lack of a particular drug in the system. The body becomes habituated to these drugs, so when it is no longer present, adverse reactions (the withdrawal symptoms) occur. Withdrawal symptoms occur during the following conditions: cocaine addiction, heroin addiction, crystal meth addiction, Cannabis addiction, opiate addiction and other substances of misuse. Symptoms vary depending on the substance used. Opioid withdrawal is characterised by intense dysphoria, craving for opioids, signs and symptoms of autonomic over activity (anxiety, restlessness, sweating), gastrointestinal disturbances (abdominal cramps, nausea, vomiting, diarrhoea), diffuse muscle and joint pains, yawning, stuffy nose, goose flesh, and pupil dilation. Alcohol withdrawal symptoms range from mild nervousness, anxiety, fatigue, headaches, sweating, palpitations, hand tremors, to the more severe symptoms of ‘delirium tremens’ (confusion, hallucinations, instability of the autonomic nervous system), agitation, fever, and convulsions. Cocaine withdrawal includes agitation and restless behavior, depressed mood, fatigue, general malaise, increased appetite, vivid and unpleasant dreams, slowing of activity, agitation or extreme suspicion or paranoia. Crystal Meth is not known to be physically addictive. In most cases it takes between twenty four and forty eight hours for the drug to process through a person's system after the last dose is taken. While Crystal Meth withdrawal symptoms can be very intense, they are generally psychological in nature. The addict going through the withdrawal process will experience symptoms of anxiety, agitation, sleeplessness, and intense cravings for the drug. Cannabis withdrawal symptoms includes craving, decreased appetite, insomnia, weight loss, aggression, anger, irritability, anxiety, restlessness, headaches, fatigue, hot/cold flushes,

	aching muscles. These symptoms of withdrawal produce about the same amount of discomfort as withdrawing from tobacco.
Relapse	The rapid return to compulsive drug use even after long periods of abstinence.
Tolerance	The phenomenon whereby with repeated exposure a progressive increase in the amount, of drug administered is required to achieve the same effect.
Addiction	**I**s a state that is characterized by compulsive drug use or compulsive engagement in rewarding behavior, despite adverse consequences.
Dependence (physical)	A state of adaptation manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug or administration of an antagonist.
Pseudoaddiction	A pattern of drug-seeking behaviour among pain patients', because of inadequate management of their pain problem which can be mistaken for addiction.

Appendix 1

(Use Clinical Opiate Withdrawal Scale Cows). This can be accessed via link below.
https://www.drugabuse.gov/sites/default/ files/files/ClinicalOpiateWithdrawalScale.pdf

APPENDIX 1
Clinical Opiate Withdrawal Scale

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

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

Reason for this assessment:_____

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

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

This version may be copied and used clinically.

Journal of Psychoactive Drugs Volume 35 (2), April - June 2003

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

Appendix 2

Analgesics and drug interactions with substances that may be misused

Pain Medication	Substance of misuse	Effects
Carbamazepine	Methadone or buprenorphine	Accelerates methadone or buprenorphine metabolism. May cause withdrawal and require a dose increase.
NSAIDs or aspirin	Alcohol	May increase gastrointestinal bleeding.
Opioids	Alcohol	Additive CNS depressant actions.
	Benzodiazepines	Additive CNS depressant actions.
	Cannabis	Use with care. One study suggests cannabis can potentiate CNS depressant effects of opioids.
	Opioids	Prescribed opioids will have additive CNS depressant actions with street-derived opioids. Avoid buprenorphine in patients dependent on illicit opioids as they might precipitate withdrawal symptoms.
Paracetamol	Alcohol	Possible association with increased hepatotoxicity in alcoholics. Use reduced dose
Phenytoin	Alcohol	Chronic heavy intake of alcohol may accelerate phenytoin clearance so that bigger doses are needed.
	Benzodiazepines	Unpredictable. Phenytoin levels may potentially be increased or decreased. Benzodiazepine levels tend to decrease.
	Methadone or buprenorphine	Accelerates methadone or buprenorphine metabolism. May cause withdrawal and require a dose increase.
SSRIs	Ecstasy and amphetamines	Unpredictable. Possibility of additive serotonin effects especially with ecstasy giving “serotonin syndrome”. Fluoxetine can also inhibit

		the metabolism of amphetamines causing toxicity. SSRIs may blunt ecstasy's pleasurable effects. However, SSRIs are often used with MDMA to prolong the effects, reduce the severity of the "mid-week blues" and may also be neuroprotective.
	LSD	May exacerbate "flashbacks" in some individuals. Pleasurable effects of LSD may be reduced.
Gabapentin / pregabalin (note pregabalin is to be initiated by the pain team ONLY)	Methadone (plus see opioids below)	May increase side effects such as dizziness, drowsiness, confusion, and difficulty concentrating
	Alcohol	May increase the nervous system side effects of gabapentin such as dizziness, drowsiness, and difficulty concentrating. Some people may also experience impairment in thinking and judgment.
	Benzodiazepines	Additive CNS depressant actions.
	Cannabis	Additive CNS depressant actions.
	Opioids	Additive CNS depressant actions. Gabapentin has been reported to enhance the analgesic effects of morphine and the euphoric effects of buprenorphine. The impairment of cognitive and gross motor function caused by oxycodone appears to be additive with pregabalin
Valproate	Benzodiazepines	Valproate may increase benzodiazepine plasma levels giving rise to CNS depression.
5HT1 agonists ("triptans")	Ecstasy and other amphetamine derivatives	Possibility of additive serotonin effects giving "serotonin syndrome".

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