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▶ Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care.

Ford C., Halliday K., Lawson E. et al.
[UK] Royal College of General Practitioners, 2011.

Evidence-based guidance for British GPs on how to withdraw heroin and other opioid addicts from opiate-type drugs or to maintain them by long-term prescribing of legal substitutes, with a focus on the use methadone and buprenorphine, the main medications used for these purposes in the UK.

Adapted abstract This guidance is to aid primary care clinicians and others in the use of substitute medication for opioid dependence when prescribing for maintenance or detoxification. The use of substitute medication can be an important element in the treatment of opioid dependent patients and can help support patients on their own road to recovery. Medications include methadone, buprenorphine and others such as codeine, heroin and slow-release oral morphine. This guidance has been updated in line with guidance from the UK's National Institute for Health and Clinical Excellence on methadone and buprenorphine in the management of opioid dependence, and UK national clinical guidelines on the management of drug misuse and dependence. The bulk of the present guidance concentrates on the areas of methadone and buprenorphine prescribing where the evidence base is most extensive.

Effectiveness

Methadone and buprenorphine are effective evidence-based medications used in the treatment of opioid dependence.

Both are effective support agents in detoxification.

The primary function is to reduce (and eventually replace) illicit opioid use and in so doing reduce harm and improve the health and psychological well-being of the patient.

Both are more effective as part of a package of care that includes psychosocial support.

There are other drugs, such as morphine sulphate, dihydrocodeine and diamorphine,

which are also occasionally used and which have an increasing evidence base world-wide.

Maintenance or detoxification

Choosing between maintenance and detoxification regimes can and should occur at many points during treatment, starting at the first assessment and then at various points, as appropriate.

Methadone and buprenorphine can be used as maintenance interventions or as detoxification agents. Other medications, such as long-acting morphine sulphate, and dihydrocodeine, can also sometimes be used.

Maintenance

Methadone is still considered the gold standard substitute medication for long-term opioid dependence. However, buprenorphine is also effective.

Optimal daily dose for maintenance is usually between 60 and 120mg for methadone and 12 and 32mg for buprenorphine. Some people need larger doses and some smaller.

Methadone is usually prescribed in an oral liquid formulation 1mg/ml. Buprenorphine is prescribed as sublingual tablets of 0.4 mg, 2mg or 8mg, or in a buprenorphine/naloxone combination as 2mg/0.5mg and 8mg/2mg tablets.

Assessment

Before prescribing any substitute medication opioid dependence should first be confirmed by history and examination, including physical examination, and by toxicology screening using urine or oral fluid swabs.

Induction

Initiation procedures for methadone and buprenorphine are very different.

For methadone:
- Start low and titrate up slowly until optimal dose to prevent the risk of overdose.
- The starting dose of methadone should be low: between 10mg and 30mg daily, depending on the amount of heroin, the length and method of use or other opioids being used, because of the cumulative effect until steady state is reached.
- Methadone doses should then be titrated upwards to optimal levels, usually between 60 and 120mg.
- Methadone increases of between 5 and 10mg a day, with a maximum of 30mg dose increase each week for the first two weeks, are recommended. (After that the rate of increase can be slightly quicker.) In young people or patients with a short opiate dependence history or unknown tolerance, increases may be slower.

For buprenorphine:
- Need to get the timing of the first dose right following use of heroin (or methadone or other opioids) to avoid precipitated withdrawal, then can increase dose quickly.
- To avoid precipitated withdrawal, start buprenorphine at least eight to 12 hours after the last use of heroin or 24 to 36 hours after the last use of methadone and when withdrawals have begun.
- Precipitated withdrawal only occurs on the first dose; the longer this first dose can be

delayed after heroin or methadone use, the lower this risk.
• Doses above 12mg (16mg is more effective) block the effects of heroin and other opiates used 'on top'.

Doses should be supervised through induction and until stability is achieved.

Three months is advised as the length of supervision but this can be shortened if it is clinically unnecessary or a hindrance to the patient, eg, due to employment.

Both methadone and buprenorphine should be prescribed in instalments, on FP10 (MDA) in England and Wales or GP10 (3) in Scotland, initially daily.

It is the responsibility of the prescriber to ensure safe induction on to these drugs. This responsibility cannot be delegated. However, a close working relationship with pharmacists and drug workers can be helpful in facilitating titration to an adequate dose as quickly as possible.

Stabilisation

Stabilisation involves finding a suitable dose that keeps the patient engaged in treatment without the need to supplement with other drugs and/or heroin.

The process of psychosocial support is often strengthened once drug use has been stabilised.

Interactions

Both methadone and buprenorphine interact (although more so methadone) with other central nervous system depressants, including benzodiazepines, antidepressants and alcohol, increasing sedation and hence the risk of overdose; patients must be informed of this.

It is important to remember that several missed doses may mean a loss of tolerance to opioids.

Three days missed consecutively should lead to a dose review and possible reduction in dose.

Five or more days missed consecutively should lead to re-assessment and re-induction if there is likely to be significant loss of tolerance.

Effective opioid maintenance doses enable patients to remain tolerant to opioids and thereby provide important protection against overdose. Opioid users in effective treatment are far less likely to overdose than those not in treatment.

Ongoing care

Treatment is reviewed at every contact and needs to be re-examined more formally, about every three to four months, to measure improvements in health and well-being, and to monitor any use of alcohol or drugs on top of the prescribing.

A prescriber should also review the prescribing and the other elements of treatment as part of an overall package of care to support people on their road to recovery.

A toxicology screen (urine or oral fluid swab) needs to be taken frequently at the

beginning of treatment and regularly when the patient is stabilised (usually between two and four times a year) if they are continuing on maintenance, to confirm use of medication and to monitor use of additional drugs.

Screens should never be used punitively, but as an aid to treatment.

Screens positive for heroin or other drugs require a review of treatment and dose, but should not normally lead to the cessation of treatment or dose reduction.

It is important that patients are given good information on the drugs they are being prescribed, and on their actions and effects, along with advice on safe storage of take-home doses.

Special groups

It is important to remember the needs of special groups, such as black and minority ethnic communities, polydrug users, people with dual diagnosis, problematic drug users in prison or hospital, and women who are pregnant and/or have children.

Primary care-based drug treatment

Treatment of people who use drugs is multifaceted and the patient should always be at the centre.

Managing their care normally requires a multidisciplinary response; wherever possible, this should be provided in collaboration with others such as other primary care practitioners, practice nurses, dispensing pharmacists, practitioners with a special interest and addiction specialists.

Practitioners should only prescribe and treat to the level of practice at which they feel competent and confident.

Stable patients may not need as much input as those new to treatment but they must always continue to be reviewed and supported to make changes at each appointment with a major review at least every three months.

Last revised 26 April 2011

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