METHADONE: THE BAREST BASICS; A GUIDE FOR PROVIDERS

Source of Origin: *Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center*

GENERAL COMMENTS

To the greatest extent permitted by local laws and regulations, methadone should be provided pursuant to the same professional and ethical standards that apply to all other health services.

Providers should encourage the availability of a broad range of treatment approaches, and sources of care, and assist in the referral and transfer of patients upon request.

The vast body of experience with the use of methadone in the treatment of opioid dependence should be utilized to the maximum. It is accessible through the professional literature, web-based resources or direct consultation with colleagues.

Methadone maintenance - even when provided over a period of decades - is not associated with adverse effects on any organ of the body.

The lives of patients at the start of treatment can be chaotic and warrant a relatively greater degree of supervision and structure. Any constraints, however (e.g., on take-home medication), should be reviewed on an on-going basis and relaxed or removed as stability is achieved.

DOSAGE

General: **Start low, go slow – but aim high**

- **Primum non nocere**: Estimates of the degree of dependence and tolerance are unreliable, and should never be the basis for starting doses of methadone that could, if the estimation is wrong, cause overdose
- There is no **moral** value associated with either “high” or “low” doses
- Methadone should not be given as “reward,” nor withheld as “punishment”

Specific:

- Initial doses should not exceed 30 mg
- Dosages should be increased and decreased gradually. Both for safety and comfort, smaller changes (e.g., 5 mg at a time) at wider intervals (e.g., every five days) should be utilized when patients are at relatively lower dosage levels (below 60 mg per day), while larger and more frequent changes (e.g., 10 mg every three days) will generally be safe at higher levels.
- In general, higher maintenance doses are associated with better therapeutic outcomes than are lower doses; the range optimally effective for most patients is 80-120mg per day.
- When addressing subjective complaints of “methadone not holding,” consider dividing – as well as increasing - the daily dose; this may be

particularly relevant for patients who are pregnant and/or receiving anti-retroviral treatment.

ANCILLARY SERVICES

- The more that can be **offered** the better, but such service should not be mandatory.
- One of the major obstacles to methadone treatment effectiveness is the widespread stigma associated with the illness, the patient and the treatment. Patients should be supported in dealing with this stigma, and providers should seek every opportunity to educate the public (including, perhaps most importantly, medical colleagues).

MAINTAINING CONTINUITY OF CARE

- To the greatest extent possible, arrangements to continue methadone should be made for patients upon entering institutions (e.g., hospital or jail), or returning from them to the community.
- Unless there is unequivocal documentation of higher doses of methadone being given in the prior setting, the dosage guidelines recommended for new patients should be applied.

URINE TOXICOLOGY, SERUM METHADONE LEVELS

- The value of these and other laboratory tests must be weighed against their costs, and the potential benefits of enhanced treatment services which the funds could otherwise support.
- Observation of the act of urination is demeaning and usually antithetical to an optimal physician-patient relationship.
- Laboratory test results, regardless of the method of specimen collection, should not be relied on if they are inconsistent with clinical observations

THERAPEUTIC OBJECTIVES

- Treatment goals might relate to heroin and other drug use, HIV risk behavior, relationships, employment, housing, etc. – but they should be determined collaboratively by the clinician and patient, and generally not imposed by the treatment provider.

INFORMED CONSENT - SPECIAL CONSIDERATIONS IN ADDICTION TREATMENT

- The patient must be informed at the start of treatment if the clinician's primary obligation is to the State or some other third party – e.g., to a Court, employer, family member, etc. Even where this is not the case, it must be recognized that in many countries patients will not believe that their confidentiality will be protected, and this view – whether justified or not - may affect the therapeutic relationship.
- Patients must be advised of the specific causes for involuntary termination and the appeal mechanism(s) available to challenge such terminations.
- Patients considering **voluntary** termination of treatment must be informed of the likelihood of subsequent relapse.