Initiating substitute prescriptions

Methadone

Methadone is the most commonly used substitute prescription. Methadone should only be prescribed as part of a treatment package which, except for maintenance regimens, will include a psychosocial therapy. The usual criteria for commencing substitute prescribing are:

- opiate dependence by ICD 10 criteria
- at least 6 months regular use
- usually pre-determination stage of change for changing use of the problem drug
- high risk behaviour
- failed attempts at abstinence
- requested by the patient

Before proceeding with substitute prescribing the doctor should:

- determine the most suitable methadone programme (see hierarchy of regimens)
- agree co-therapist and psychosocial therapy
- agree care plan with patient and set default conditions for stopping prescription
- agree pharmacy

There are two different objectives when initiating methadone:

To stabilise on the minimum dose

In this case the starting dose is a matter for clinical judgement based on history of past use and withdrawal symptoms. A rough guide is to substitute 1mg methadone for each £1 daily use. This can be done in the community.

Unless tolerance is known to exist e.g. patient is already receiving a prescription, the initial dose should not exceed 40mg (this is below the lethal limit for naive users).

Steady state is reached after 7 days. The dose can be reviewed after 2-3 days and increased if necessary. The maximum dose should not normally exceed 80mg. Doses in excess of 60mg can be expected to have a heroin 'blocking effect'. Once stabilised the dose should remain unchanged for at least 1 month prior to starting agreed reductions. A reduction rate of 5ml every 2 weeks down to 25-30mg is usually well tolerated.

ii **To stabilise on the maximum dose**

There are occasionally circumstances where the aim is to achieve a high dose as quickly as possible e.g. patients thought to be using very high doses or very high risk users.

The patient should be asked to attend the Addiction Unit expecting to stay for much of the day. Start methadone 40mg and then give 10mg increments every 1 hour depending upon the effect as judged by pupil size and drowsiness. Maximum dose should not exceed 100mg on the first day.

Levacetylmethadol (LAAM)

LAAM is suitable for patients who are intending to remain on a maintenance prescription indefinitely and who have already been stabilised on methadone. The advantage is that it is to be taken only 3 times weekly: Monday, Wednesday and Friday.

Transfer to or from methadone should be abrupt and use a ratio of methadone:LAAM of 1:1.2 or 1.3. The initial dose of LAAM should not exceed 120mg. If patients complain of withdrawal on Sundays, the Friday dose can be increased by up to 40%. Both gradual (10% per week) and abrupt LAAM withdrawal regimens have been successful.