METHADONE:
THE BAREST BASICS – A GUIDE FOR PROVIDERS

Source: Newman, R. (2003). Methadone: the barest basics a guide for providers. SEEA Addictions 4:1-2.

Slightly modified and adapted by the authors and members of the editorial board: Kastelic, A., Pont, J., Stover, H. Opioid Substitution Treatment in Custodial Settings. A Practical Guide, Oldenburg, 2008

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 referring and transferring drug users upon request.

The vast body of experience with the use of methadone in the treatment of opioid dependence should be utilised 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.

People's lives can be chaotic at the start of treatment, which warrants a relatively greater degree of supervision and structure. Any constraints, however (such as on take-home medication), should be reviewed on an ongoing basis and relaxed or removed as stability is achieved.

DOSAGE

General: start low, go slow – but aim high

- First, do no harm: 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" or withheld as "punishment".

This document as well as the harmreduction.eu website, was created within the joint action '677085 / HA-REACT,' which has received funding from the European Union's Health Programme (2014-2020).

Specific

- Dosages should be increased and decreased gradually. Both for safety and comfort, smaller changes (such as 5 mg at a time) at wider intervals (such as every five days) should be utilised when people are at relatively lower dosage levels (less than 60 mg per day), whereas larger and more frequent changes (such as 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 people is 60–120 mg per day.
- When there are subjective complaints of "methadone not holding", consider dividing – as well as increasing – the daily dose; this may be particularly relevant for people who are pregnant and/or receiving antiretroviral therapy

ANCILLARY SERVICES

- The more that can be offered the better, but such service should not be mandatory.
- One of the major obstacles to the effectiveness of methadone treatment is the widespread stigma associated with the condition of dependence, the person being treated and the treatment. Drug users should be supported in dealing with this stigma, and providers should seek every opportunity to educate the public (including, perhaps most importantly, health care colleagues).

MAINTAINING CONTINUITY OF CARE

- To the greatest extent possible, arrangements to continue methadone should be made for people upon entering institutions (such as police detention, arrest house, hospital or prison) or returning from them to the community.
- Unless there is unequivocal documentation that higher doses of methadone were given in the previous setting, the dosage guidelines recommended for new drug users should be applied.

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HA·REACT
JOINT ACTION ON HIV AND CO-INFECTION PREVENTION AND HARM REDUCTION

URINE TOXICOLOGY AND 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 the funds could otherwise support. Clinical guidelines in many countries insist on a drug testing prior to the commencement of substitution treatment.
- Observing the act of urination is demeaning and usually antithetical to an optimal physician-patient relationship.

THERAPEUTIC OBJECTIVES

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

INFORMED CONSENT – SPECIAL CONSIDERATIONS IN ADDICTION TREATMENT

- The drug user must be informed at the start of treatment if the clinician's primary obligation is to the state or some other third party – such as to a court, employer, family member, etc. Even if this is not the case, in many countries drug users will not believe that their confidentiality will be protected, and this view – whether justified or not – may affect the therapeutic relationship.
- The drug users must be advised of the specific causes for involuntary termination and the appeal mechanism(s) available to challenge such terminations. Drug users considering voluntary termination of treatment must be informed of the possibility of subsequent relapse. Users who have chosen voluntary termination should be encouraged to reduce dosages at their own pace rather than accept forced dose reduction intervals.

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