Substance Misuse Medication Prescribing Guidelines (DQ398)

Summary

These guidelines are designed to be a resource for all staff within Addaction, but particularly those involved in the use of medication for the management of substance misuse. There are separate guidelines for alcohol and smoking cessation.

Prescribing in Addaction is individualised. This means that prescribing takes place within a tailor-made recovery plan that takes into consideration the findings from the clinical review and risk assessment of the particular service user.

The reader is also referred to the Orange Book, from which these guidelines have been established, as well as further reading that can be found at the end of each section.

Drug misuse and dependence (Orange Book): UK guidelines on clinical management https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

Other relevant policies and guidelines:

- Addaction Formulary (DQ 231)
- Prescribing and Treatment Review Guidelines
- Medicines Code (DQ136)
- Non-Medical Prescribing Policy (DQ101)
- Resource Library - Working with Opioid Use
- Resource Library - Harm Reduction

This document was last updated: September 2019

Issue	Page(s)	Issue Date	Additions/Alterations	Initials
1.0	All	19/9/2019	New guidance. Replaces: DQ079 – Buprenorphine Guidelines DQ094 – Methadone Guidelines DQ105 – Prescribing Policy DQ111 – Stimulant guidelines DQ114 – Buprenorphine/Naloxone Guidelines DQ138 – Benzodiazepine guidelines DQ139 – Lofexidine guidelines (remains unavailable) DQ195 – Position statement on injectable diamorphine	RB

Contents

1.0 Opioid Substitution Therapy

Prior to prescribing Opioid Substitution Therapy (OST), a comprehensive assessment must be performed, and dependence to opioids established (see DQ105 and Drug Testing Guidelines for more information)

If a comprehensive assessment cannot be performed (for example in the case of a short notice prison release), it may be appropriate to provide a short term (bridging) prescription. Refer to section 8.6 in the Prescribing and Treatment Review Guidelines for more information on prescribing following release from secure environments.

1.1 Choosing an appropriate OST

Buprenorphine and methadone are recommended for the treatment and prevention of heroin withdrawal, and for maintenance programmes. They are also recommended for managing dependence to other opioids.

Buprenorphine is considered to cause less respiratory depression than methadone and is associated with a reduced risk of fatal overdose in the first weeks, during titration.

The choice of which OST to prescribe should be based on the following clinical factors:

- ➔ Potency of opioids used (e.g. OTC, prescribed, illicit)
- ➔ Severity of dependence
- ➔ Associated risks (e.g. injecting, previous diversion)
- ➔ Comorbidities (cardiovascular, respiratory, pain)
- ➔ Patient's pre-existing preference for either drug
- ➔ Benefit (or lack of) from either drug in previous treatment episodes
- ➔ Requirement for rapid induction onto an effective maintenance dose (titration with buprenorphine may be done more rapidly and with less risk of overdose than methadone)
- ➔ Treatment goals
- ➔ Other factors e.g. pregnancy

Clients commencing OST titration should have their daily dose supervised by a local pharmacy.

For more information on supervised consumption see the Prescribing and Treatment Review Guidelines.

2.0 METHADONE

Methadone is a synthetic, full opioid agonist. In the UK the oral solution and injectable forms are licensed for the treatment of opioid dependence.

The first line formulation of methadone in Addaction is oral solution (1mg/ml with sugar or sugar-free).

2.1 Titration

Dose titration should aim for a stable dose of methadone that avoids both intoxication and withdrawal. It is difficult to give a set regime as for some titration will be associated with continued use of heroin.

Initial dose	**10-30mg** (10-20mg if tolerance is low or uncertain) A first dose can be up to 40mg in heavily dependent individuals who are tolerant. The prescriber must be experienced in using higher than usual initial doses, and the client must have access to close supervision
Subsequent doses	Dose increases should not exceed **5-10mg per day,** and the total weekly increase should not exceed 30mg over the starting dose. There should be ongoing reviews of withdrawal symptoms and illicit drug use during this period.
Therapeutic dose	Aim for lowest dose that results in **complete cessation** of heroin use. This is typically between **60-120mg per day**. The dose should both stop withdrawal symptoms, **and** stop any cravings for heroin. The dose needed to stop cravings is likely to be higher than the dose at which a client feels 'stable'. **It may take 2-4 weeks (or more) to reach the desired dose of methadone**

2.1.1 Risk of methadone overdose

There is an increased risk of opioid overdose during methadone titration, especially if the client is taking multiple CNS depressant drugs (particularly benzodiazepines) and alcohol.

Clients **must** be made aware of the risk of over-sedation and the risks of ongoing illicit use. They should be trained on the use of naloxone and issued a 'take home' kit.

During dose titration clients must be reviewed regularly, and any assessed risk should be balanced with the need to achieve a therapeutic dose. Any missed doses during the

titration phase must be notified by the pharmacist before any further doses are given (the 3-day rule does not apply during titration.)

2.1.2 Risk of QTc prolongation

Clients prescribed methadone ≥100mg/day and/or with other risks of QT prolongation (e.g. concomitant medication, cardiac disease and electrolyte abnormalities) should have a baseline ECG performed and repeated 7 days after titration, with referral to a cardiologist if abnormalities are identified.

If ECG is 'normal' but the risk of QT prolongation remains high, consider repeating at least at 12 monthly intervals.

See ECG Policy (DQ233) and Guidelines for recording an ECG (DQ233.1) for more information.

2.2 Review

Clients on methadone should be reviewed by a prescriber at least every 12 weeks (more frequently during titration and where there are additional risks)

The established dose should be reviewed for continued effectiveness (ongoing abstinence from heroin and no cravings).

The dose of methadone should not be reduced unless there are clinical reasons (e.g. interacting medication). Dose reductions should only occur as part of a planned detoxification regime with appropriate support in place to prevent relapse.

Supervision arrangements should also be reviewed, and relaxed when appropriate. Safe storage assessment should accompany the decision to relax supervision arrangements.

However, take-home doses should **not usually** be prescribed where:

- ➔ The client has not reached a stable dose, and has unstable drug/alcohol misuse, or has an unstable psychiatric illness or threatening self harm
- ➔ There are concerns about diversion
- ➔ There are concerns about possible risks to children/young people and vulnerable adults.

2.3 Detoxification

Opioid detoxification should be offered to suitable clients once preparation and provision of post-detox support has been arranged.

A full programme of psychosocial support must be in place during detoxification.

<u>Dosing</u>

The stable methadone dose can be reduced at a rate of around 5mg every 1-2 weeks.

2.4 Other formulations of methadone

The decision to prescribe concentrated liquid, methadone tablets or ampoules must be undertaken by a clinician who is competent to do so. A 'High Risk'/RED form must be completed and authorised by a senior clinician.

Concentrated Liquid (10mg/1ml) - should not be used unless prescribing is 'inherited' or there are exceptional circumstances why the 1mg/ml strength cannot be used.

Tablets (5mg) - should not normally be prescribed due to an increased potential for diversion.

However there are some circumstances where the prescribing may be justified as follows:

- ➔ To prevent vomiting in pregnant clients taking methadone
- ➔ A service user is going on holiday abroad (see DQ105 for more information)
- ➔ Proven intolerance to Methadone Oral Solution

Methadone Injection

See section on injectable medication below.

2.5 Further reading

1. Drug misuse and dependence: UK guidelines on clinical management (DHSC) https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
2. Misuse of Synthetic Opioids (NEPTUNE) https://smmgp.org.uk/media/12031/neptune-fentanyl-clinical-management-mar-18.pdf
3. Methadone and buprenorphine for the management of opioid dependence (NICE) https://www.nice.org.uk/guidance/ta114
4. Drug Misuse Prevention (NICE Pathways) https://pathways.nice.org.uk/pathways/drug-misuse-prevention
5. Summary of Product Characteristics (Physeptone Liquid) https://www.medicines.org.uk/emc/product/3704/smpc
6. Summary of Product Characteristics (Methadone 10mg/ml Injection) https://www.medicines.org.uk/emc/product/3578/smpc

3.0 BUPRENORPHINE

Buprenorphine is a semi-synthetic opioid. Its primary action is as a partial opiate agonist; consequently high doses produce a milder, less euphoric and less sedating effect than high doses of other opioids. However it exerts sufficient opiate effects to prevent or alleviate opioid withdrawal including craving.

The generic product should be used first line in clinical services. It is available in 8mg, 2mg and 0.4mg sublingual tablets as licensed products for OST, and in 0.2mg sublingual tablets (licensed for pain but may be useful in the later stages of detox).

3.1 Titration

IMPORTANT: Buprenorphine can precipitate unpleasant withdrawals on initiation, therefore it is important that clients are carefully counselled and that the first dose is given at least 12 hours after last heroin use or 24-36 hours after the last methadone dose (dose should be lowered to <30mg/day prior to switching).

Ideally, clients should be experiencing mild withdrawal symptoms prior to taking the first dose of buprenorphine (this reduces the likelihood of precipitated withdrawal)

Buprenorphine is largely metabolised in the liver, therefore baseline LFTs should be ascertained prior to initiating treatment. If clinically well, do not delay starting treatment unless there are reasons for concern (e.g. Hepatitis C positive, significant alcohol intake).

Liver function should be checked periodically once treatment with buprenorphine is established.

As a first line, generic buprenorphine sublingual tablets should be prescribed. Other formulations should only be considered if there are clinical reasons to do so, and if the client has tried generic buprenorphine. There are significant cost considerations for the non-generic forms.

Initial Dose (Day 1)	**4-8mg** Sometimes useful to split the dose and give 4mg supervised and 4mg to take away
Subsequent dose (Day 2)	Increase by 2-8mg if withdrawal symptoms present
Therapeutic dose (Day 3 and onwards)	**12-24mg/day** (may need up to 32mg/day) Doses in this range typically provide a 'blocking effect' such that any on-top use of heroin is without effect.

The duration of action is dose related as a result of the high affinity for opioid receptors:

- ➔ Low doses e.g. 2 - 4mg exert effects for up to 12 hours.
- ➔ Higher doses e.g. 16 – 32mg can exert an effect for up to 48 – 72 hours.

The high affinity at high doses can allow alternate-day dosing regimens, (for example 32mg on alternate days) however this is not common practice in the UK.

3.2 Review

Clients should be reviewed at least every 12 weeks. The effectiveness of prescribing buprenorphine should be assessed (for example on-top use of heroin/other opioids might indicate that an incomplete dose is being absorbed)

Difficulty in stabilising onto buprenorphine requires a review of treatment that may encompass dose level, dispensing regime, psychosocial interventions, transfer to alternative pharmacotherapy (e.g. methadone), withdrawal from maintenance treatment, or use of non-pharmacological therapies.

3.3 Detoxification

Detoxification regimes can be varied to suit the needs of the service users depending on dose levels, desired speed of withdrawal from buprenorphine treatment and the overall situation of the service user. It is important to clarify treatment aims with the client (e.g. expectations, concerns, and aftercare/support needs) at the outset.

Most service users do not experience significant withdrawal discomfort until they have reduced to low doses of buprenorphine, or even until after doses have stopped.

An example of a gradual dose reduction schedule is proposed as follows:

Daily buprenorphine dose	**Reduction rate**
Above 16mg	4mg every 1-2 weeks
8-16mg	2-4mg every 1-2 weeks
2-8mg	2mg every 1-2 weeks
Below 2mg	0.4-0.8mg every 1-2 weeks

3.4 Other formulations of buprenorphine

Buprenorphine/Naloxone sublingual tablets (Suboxone®□) - can be used for opioid detoxification or maintenance. They have a similar efficacy to generic buprenorphine but the addition of naloxone acts as a deterrent to intravenous administration and diversion.

Suboxone comes in 8mg/2mg and 2mg/0.5mg strengths (buprenorphine/naloxone). It does not come in the lower 0.4mg strength and therefore this should be considered when prescribing lower doses as part of a detoxification regime.

Espranor®□ - are oral lyophilisates containing buprenorphine that come in 8mg and 2mg strengths. They are designed to dissolve very quickly and may aid compliance where

standard sublingual tablets are not tolerated.

Espranor is not interchangeable with other buprenorphine sublingual formulations at the same dose ("like for like" switch) as Espranor® has a **25-30% higher bioavailability**. There is currently limited evidence for use in practice and pharmacokinetics varies between individuals. Therefore when making switches from Espranor® to generic sublingual preparations (or vice versa), clinicians should use their professional judgement regarding a new dose.

3.5 Switching from buprenorphine to methadone

If a service user is stable on buprenorphine, methadone can be commenced 24 hours after the last dose, at an initial daily dose of up to 30mg. Appropriate dosage levels vary according to the dose of buprenorphine and individual factors.

The following table gives guidance but dose levels of methadone should be titrated according to the response (being mindful of the residual blockading effect of Buprenorphine that may last for a number of days).

Current buprenorphine dose	Starting methadone dose
>8mg	30mg
4mg	20mg
2mg	10mg

3.6 Further reading

1. Summary of Product Characteristics (Buprenorphine sublingual Tablets) https://www.medicines.org.uk/emc/product/4163/smpc
2. Summary of Product Characteristics (Suboxone 8mg/2mg sublingual Tablets) https://www.medicines.org.uk/emc/product/9285/smpc

4.0 OTHER OPIOID PHARMACOTHERAPIES

4.1 Slow-release Oral Morphine

There is some evidence that slow-release oral morphine (SROM) preparations can be useful in treating patients who fail to tolerate methadone or buprenorphine, and in maintaining patients. There is also some evidence that SROM may be useful in patients who are not 'held' on methadone.

In Addaction services, SROM should only be considered where methadone and buprenorphine have been considered, been trialled at optimised doses and have been judged to be inappropriate.

The reasons for rejecting these first line treatments should be recorded in the patient's record. SROM should only be prescribed by a specialist, or suitably competent clinicians (this would normally be a consultant psychiatrist or specialist doctor).

Prior to prescribing, a Red List form (see Addaction Formulary for more information) must be completed and authorised appropriately.

Clients on SROM must be monitored by the prescribing clinician.

4.2 Injectables

Prescribing injectable medication (morphine, methadone or diamorphine) is **not** a first line treatment for substance misuse. It could only be considered as a treatment option following failure of *optimised* oral maintenance drug treatment that has been pursued for at least six months.

➔ The optimised oral maintenance drug treatment is characterised by four factors:
1. Adequate dosages of oral methadone or buprenorphine
2. Adequate level of supervision and monitoring of service users
3. Strongly encouraging involvement with psychosocial services
4. Competent staff developing positive therapeutic relationships with patients

There must be a clear plan of goals and expectations agreed with the client. This should be reviewed at every consultation. Ideally there should be observed injecting if available and there must be a commitment to embrace psychosocial interventions. The client should be encouraged to use injectables by the intramuscular (IM) route and educated regarding appropriate sites for injecting.

Returning to oral medication from injectable medication should be considered if:
1. The patient is physically deteriorating or other psychosocial factors may be hindering progress.

2. The patient attends intoxicated; convert the prescription to supervised oral treatment if appropriate to continue treatment

3. The patient continues illicit use or poly drug use.

4. There is poor injecting technique; advise the client about safer injecting. If no

improvement (especially groin or neck intravenous (IV) use) then there is a need to weigh up risks/benefits.

4.2.1 Historical prescribing

Occasionally we 'inherit' clients from services transferring to Addaction who are in receipt of a prescription for injectable diamorphine. These clients must be reviewed by a senior clinician with a Home Office licence to prescribe diamorphine, in order to develop a plan for continuation of this treatment. This review must give consideration to transferring onto a licensed OST medication or SROM.

The review must also include an assessment of injecting technique and sites of injections must also be assessed.

4.2.1.1 Monitoring

Should diamorphine prescribing be continued following this review, the client must be seen by the prescribing doctor on a regular basis.

A Red List form must be completed and authorised appropriately.

4.2.2 Heroin Assisted Treatment (HAT)

There is compelling evidence for making injectable opioid treatment (IOT), usually diamorphine (heroin), available for those who continue to be at risk despite optimised oral OST. A section of the OST treatment population, despite being given access to optimised treatment with oral opioid maintenance, can fail to make adequate progress and continue to be involved in high levels of injecting drug misuse and other risk-taking behaviour.

HAT programmes differ from how injectable opioids have been prescribed in the past in the UK. They include the absolute requirements that the patient must:

1. Attend in person for their prescribed injectable opioid maintenance treatment daily or even more frequently, according to the treatment plan
2. Inject their dose under the direct supervision of a clinician who is competent to do so.
3. Be given no take-away injectable medication.

Currently, Addaction are not commissioned to provide HAT. The decision to provide or bid for a service that involves providing HAT must be discussed with the Executive Medical Director and senior members of the Clinical Governance directorate.

Diamorphine injection may only be prescribed by a suitably qualified medical doctor with the appropriate Home Office licence.

5.0 BENZODIAZEPINES

Benzodiazepines have their own potential for misuse and dependence and are often taken in combination with opiates or stimulants. Many drug misusers misuse benzodiazepines but the majority do not require long-term replacement prescribing or high doses.

For those who are benzodiazepine dependent, sudden cessation in their use can lead to a recognised withdrawal state akin to alcohol withdrawal.

Clinicians must be aware of the proliferation of the internet benzodiazepine market. These drugs are increasingly easy to obtain. Therefore prior to a decision to prescribe, one should be aware that any prescription dose could be easily topped up. Self-directed reduction with appropriate psychosocial support is a valid alternative to prescribing and should be considered ahead of prescribing.

5.1 Prescribing benzodiazepines

There is little evidence to suggest that long-term substitute prescribing of benzodiazepines reduces the harm associated with benzodiazepine misuse and there is evidence that long-term prescribing (especially of more than 30mg diazepam equivalent per day) may cause harm.

Therefore, the decision to prescribe benzodiazepines should only be considered after careful history taking (especially the presence of co-existing mental health disorders) and confirmation of benzodiazepine dependence from careful consideration of the patient's history and clinical records and/or observed symptoms of withdrawal and with support from current and, where available, historical drug testing. The **goal** of benzodiazepine prescribing within Addaction services is to gradually reduce the dose down to zero. Maintenance prescribing of benzodiazepines is not appropriate

5.1.1 Conversion to diazepam

If a reducing prescription is considered appropriate, it is usually advised to convert the daily dose to an equivalent of diazepam.

<u>Diazepam 5mg is approximately equivalent to</u>:
Alprazolam 0.25 mg
Chlordiazepoxide 15 mg
Clobazam 10 mg
Clonazepam 0.25 mg
Loprazolam 0.5 mg to 1.0 mg
Lorazepam 0.5 mg
Lormetazepam 0.5 mg to 1.0 mg
Nitrazepam 5 mg

Switching to diazepam is best carried out gradually, usually in a stepwise fashion. Consider making the first switch in the night-time dose to avoid daytime sedation.

For information on switching for other benzodiazepines or z-drugs, (zopiclone, zolpidem,

and zaleplon) see the Ashton Manual (available online at www.benzo.org.uk).

5.1.2 Detoxification from benzodiazepines

Only very rarely should doses of more than 30mg diazepam equivalent per day be prescribed. The aim should normally be to prescribe a reducing regimen for a limited period of time.
If the patient is also receiving a long-term prescription of methadone for concomitant opioid dependence, the methadone dose should be kept stable throughout the benzodiazepine reduction period. Concurrent detoxification from both medicines is not recommended in a community setting.

Rate of withdrawal

Benzodiazepines, including diazepam, can be withdrawn in proportions of about one-eighth (between one-tenth and one-quarter) of the daily dose every fortnight.

In **dependence on therapeutic doses**, the dose can be reduced initially by 2-2.5mg and, if withdrawal symptoms occur, the dose can be maintained until symptoms improve. Smaller reductions in dose can be made if the patient is not coping and is experiencing withdrawal symptoms that are too uncomfortable for them to tolerate. It may be necessary to increase the dose to alleviate the symptoms before making a reduction again but this should be avoided where possible as there is a risk that the dose will see-saw.

While full detoxification can proceed without difficulty within weeks or within 2-3 months for some patients, withdrawal may take three months to a year, or longer in some cases. An optimal speed or duration of dose reduction is not known.

If very high dose prescribing is required and, after careful assessment, the patient is stable and free of withdrawal symptoms at, for example, 50mg diazepam-equivalent a day, the dose should be gradually reduced at a faster rate than suggested above, for example, by half over six weeks and then the planned rate of reduction should be again reviewed in line with the guidance above.

5.1.3 Monitoring and Review

Review of care should be sufficiently frequent to detect and manage problems early. While reducing the dose, structured psychosocial interventions, counselling, support groups and relaxation techniques can be helpful along with advice and support for any emerging anxiety, depression or insomnia.

It is important to note that, because of long-term effects, all patients on a benzodiazepine prescription must be regularly reviewed, at least every three months.

Those undergoing a benzodiazepine detoxification need frequent monitoring to identify progress and difficulties, and to adjust treatment accordingly, in line with an agreed care plan.

5.2 Further reading

1. Clinical Knowledge Summaries (NICE, 2018) Benzodiazepine and Z-drug withdrawal https://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal#!management
2. The 'Ashton Manual' at www.benzo.org.uk has detailed information on supporting benzodiazepine withdrawal as well as background information on the drugs.

6.0 STIMULANTS

Along with traditional stimulants, such as amphetamine and cocaine, there has been emerging use of methamphetamine and a range of new psychoactive substances with similar stimulant properties that are likely to pose similar or greater risks.

6.1 Management

Harm reduction approaches to stimulant use should be discussed with the client, particularly safer injecting practices (remember that stimulant user may inject 10-15 times a day) and the use of glass pipes, rather than cans and plastic bottles, to avoid inhaling harmful substances.

Cocaine users should be advised that the sharing of cocaine straws and injecting paraphernalia in the form of rolled-up bank notes is a factor in the transmission of hepatitis C.

6.1.1 Psychosocial Support

The mainstay of the treatment of stimulant misuse and dependence is psychological (particularly abstinence-based psychosocial treatment approach, linking counselling and social support), and non-pharmacological.

Approaches incorporating contingency management have been found to be more successful at promoting abstinence, both with regard to primary cocaine use and also for patients in opioid maintenance treatment programmes who also use cocaine.

The client's mood should be monitored closely, including assessment of the risk of suicide as withdrawal from stimulants may precipitate or exacerbate pre-existing conditions such as anxiety, agitation and depression. A focus on stress reduction techniques can help to manage this, however the use of an antidepressant (e.g. fluoxetine) for major depressive episodes can also be considered.

6.1.2 Substitute Prescribing

There is no indication for the prescription of cocaine or amphetamines in the treatment of stimulant withdrawal and it is not recommended that other stimulants, such as methylphenidate or phentermine, are prescribed.

However, there is evidence that when providing maintenance treatments (methadone or buprenorphine) to patients with opioid dependence problems who also take cocaine, cocaine use may decrease or stop with the provision of effective opioid maintenance

treatment, and when it persists, it may respond positively to further improvement of the opioid maintenance treatment.

Those with a comorbid severe cocaine or crack dependence may need specific psychosocial interventions aimed at addressing the cocaine use even despite good stabilisation and cessation of heroin use.

Dexamfetamine

There was previously thought to be a limited place for the prescription of dexamfetamine in the treatment of amphetamine misuse, and this still occurs in some parts of the UK. The evidence comes from reports that are typically small in number and weak in design, and the evidence of benefit is not convincing. Even though there may be individual patients for whom existing treatment should be continued for the time being, substitute stimulant prescribing should not ordinarily be provided.

6.2 Further reading

1. Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances (NEPTUNE) http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf
2. Harm Reduction (Addaction Resource Library)

7.0 NALTREXONE

Naltrexone is recommended as a treatment option in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence programme. Those who take it know that they cannot achieve a 'high' from using heroin and that any money spent on heroin will be wasted. It does not directly stop a person wanting to use heroin, although it may help to reduce or prevent cravings in some people.

7.1 Prescribing Naltrexone

Prior to prescribing, liver and renal function should be established as naltrexone is contraindicated in severe impairment.

Ensure that sufficient time has passed since the service user last used an opioid (negative urine screen)

- ➔ Heroin users should have been opioid free for 7 days.
- ➔ Methadone users should have been opioid free for 10 days.
- ➔ Buprenorphine users may transfer onto naltrexone within 3 days if the final dose was 2mg or less.

Service users must be warned of the risk of acute opioid toxicity occurring if they attempt to overcome the naltrexone blockade by using a large amount of opioids. Such an attempt has life-threatening consequences.

7.1.2 Dose

Day One - 25mg (Half a tablet)

This dose should be taken in the service and the client monitored for any signs of opioid withdrawal.

Day Two onwards - 50mg a day

7.1.3 Review

Duration of treatment with naltrexone is dependent on the individual and their recovery. An initial period of three months should be followed by a review to establish whether continuation of treatment is beneficial to the client.

Naltrexone is prescribed for up to six months, however it may be prescribed for longer if the service user is benefiting from the treatment and wants to continue with it. Treatment can only be continued as long as there is no evidence of liver dysfunction (liver function should be repeated annually whilst the client is still in treatment)

7.2 Psychosocial Support

Psychosocial support should continue whilst clients are taking naltrexone. The support should have an abstinence focus and include strategies for coping with cravings.

7.3 Further Reading

1. Naltrexone Summary of Product Characteristics
https://www.medicines.org.uk/emc/product/6073/smp