

Buprenorphine has similar side effects to methadone (see fact sheet) but generally they are mild and settle down after the first week of treatment. When starting treatment patients should not drive or operate machinery until stabilised on their dose or during dose increases. It is dangerous to mix buprenorphine with other drugs such as alcohol, benzos or methadone. Injecting buprenorphine is dangerous and may cause vein damage, ulceration and infection and major health problems. Patients should carry identification that they are taking buprenorphine and advise doctors of the fact, as in hospital or in emergencies, opiate painkillers will be ineffective.

Withdrawal from buprenorphine usually causes lesser symptoms and for a shorter period than from other opioids, but should be done slowly from maintenance doses and with adequate support. Remember that once detoxed, tolerance to opiates soon returns to zero. There have been several reports of people overdosing when they use heroin following detox or ceasing maintenance treatment. Buprenorphine on its own is relatively safe in overdose but if mixed with other drugs and alcohol it can be deadly.

Call an ambulance immediately if:

- You are unable to wake someone up: A common myth is that a person is 'sleeping it off' THIS IS NOT TRUE. If they don't respond to shaking and calling their name - they are in danger
- You hear gurgling or choking sounds as they are breathing
- They have cold clammy skin or are sweating profusely
- Their eyes are open, but they're like 'doll's eyes' – staring or vacant
- They have passed out or become unable to speak or move. If they are still breathing and have a pulse - lie them on their side while waiting for the ambulance
- No pulse and is not breathing commence CPR (Cardio-Pulmonary Resuscitation) and wait for the ambulance
- A pulse but NO BREATHING, commence mouth-to-mouth resuscitation ONLY

Detox and treatment

For further information about drug treatments trials contact:
NUAA (02) 9369 3455,
NDARC (02) 9398 9333, or
Turning Point (03) 925 48061



Other pharmacotherapies

Common Names

Pharmacotherapy is the name given to several chemical detox and substitute medication maintenance methods that have been trialed in Australia in the past couple of years for people who are mainly dependent on opiates.

- Buprenorphine marketed as Subutex® and commonly referred to as 'Bupe'
- Naltrexone
- Levo-alpha-acetyl-methadol also known as LAAM
- Slow Release Oral Morphine (SROM)

Naltrexone acts to block the effects of opiates (heroin) in the body while the other medications act as an opiate substitute in the body and prevent the person from experiencing withdrawal symptoms and are trialed as an alternative treatment to methadone.

History of the drug

Prescribed and supervised heroin is available to a small number of people in the UK and some European countries and there is evidence that its use may be effective where other treatments fail. It is not available for treatment in Australia where substitution therapies only may be used. Methadone was the only available therapy for twenty years and new therapies have since been developed.

Buprenorphine is a long acting opioid medication used as a pain reliever, and has been extensively used in France as a maintenance therapy in more than 50,000 patients for over seven years. After a large trial coordinated by NDARC in Australia it has been available for use here since 2001. Overall research shows that substitution treatment with buprenorphine works as well as methadone; people will simply prefer one medication or the other and due to individual differences one may be more effective for some people than the other. Some people feel more alert on commencing and during buprenorphine use than on methadone.

LAAM is a synthetic opioid with very similar effects to methadone as an opioid substitution drug. It has been trialed in SA and Victoria but is unlikely to be marketed as there is concern that although it has been extensively used overseas, there is evidence of a very small risk of significant side effects.

SROM is an opioid analgesic. Small trials of its use have been inconclusive. There have been suggestions to use another opioid, hydromorphone, for maintenance but no trials have been conducted and neither medication can be legally prescribed as maintenance therapy.

Naltrexone has been used extensively overseas. It is an opioid antagonist and blocks the effects of opioids in the body and is used in two quite different ways. It is used for rapid detoxification and after detoxification it is used to support abstinence.

It is being trialed in NSW at NDARC and the Langton Centre and in Victoria at Turning Point. The basis for using naltrexone as a treatment is that if the user feels nothing each time they use heroin, they will stop using.

Naltrexone Rapid Detoxification

Detoxification is the management of physical withdrawal from a drug of dependence. It can occur in a wide range of settings from at home without any medication, at home with medication and as a clinic in-patient so that associated risks and discomfort are minimised.

Variations on rapid and ultra rapid detox using naltrexone and other antagonists have been used for over 10 years in various countries, but the efficacy of this type of treatment has never yet been scientifically quantified. Two clinical trials are under way in Sydney, one at Sydney Hospital, the other at Westmead Hospital, as well as similar trials in Queensland and South Australia. These comprehensive trials, when complete, will give a clearer picture of the efficacy of rapid detox, and for whom it may be most successful. As an opioid antagonist, naltrexone speeds up withdrawal from heroin or any other opiate. Methods vary but in most programs people are sedated to some degree. Anaesthesia is not recommended due to the associated risks, and fatalities while under anaesthetic have been reported overseas.

Although it has been claimed to be a 'painless withdrawal', the reality seems to be that there is some discomfort ranging from mild to distressing. Rapid detox may be a useful addition to the range of treatments for opioid dependency, particularly for people who have decided on abstinence and want to start long term naltrexone treatment. Clinical trials in Australia suggest that, like all detox procedures, rapid detox is only the beginning, and that long term outcomes are no different and no better than those associated with standard detox procedures. To quote Dr James Bell who conducted the Sydney Hospital Pilot Study "This is not the 'magic bullet'. Being drug free is a change in consciousness."

Drawbacks of Naltrexone Rapid Detoxification

It's important to be aware that with this treatment rapid or ultra rapid detox, if successful, is only the beginning. It is doubtful that naltrexone removes the physical cravings for opiates in all cases, and it certainly does not remove the psychological dependency. Counselling and/or a good support group, and support from family and friends are essential for the next few years maybe even a lifetime for some people. This treatment should only be considered if there is an absolute faith in the medical professionals supervising the treatment, and never at home. The costs and risks of the treatment should be fully evaluated and considered. Naltrexone is not registered in Australia for rapid detoxification.

Naltrexone maintenance

When taken daily, naltrexone blocks the effects of heroin and other opioids. It should only be taken under medical supervision. The use of black market naltrexone is dangerous. If someone is still dependent on opioids when they take naltrexone, they will experience severe withdrawal symptoms (as in the 'rapid detox method'). A person must have ceased heroin use 7-10 days BEFORE attempting naltrexone maintenance, and methadone use 15 days before commencing naltrexone. The usual dose is half to one tablet daily. The basis of treatment is that if a person on naltrexone uses a normal dose of heroin it will have no effect. Many programs and trials of naltrexone maintenance treatment (including Australian research) report very high drop-out rates. It seems that naltrexone is most useful for those who are very highly motivated to stop using and who have strong support and incentive to do so. It is important not to miss doses and it is good practice for a carer to supervise doses. There are no withdrawal symptoms when stopping naltrexone but this should only be done with adequate counselling to avoid the likelihood of relapse. Patients should carry identification that they are taking naltrexone and advise doctors of the fact as in hospital or emergency, opiate painkillers will be ineffective. Finally, remember that once detoxed or maintained on naltrexone, tolerance to opiates is back to zero. There have been numerous reports of people overdosing when they use heroin following naltrexone detox or ceasing maintenance treatment. If a person who is on or has been on naltrexone is unconscious suspect concurrent drug and or alcohol use and call an ambulance.

Buprenorphine

Buprenorphine is an opioid medication that is similar to heroin and methadone but different, in that as a 'partial agonist' it has milder opioid effects at high doses and that withdrawal from buprenorphine can be milder than from heroin or methadone. It is used in short term withdrawal programs to get through the discomfort of stopping or reducing heroin use and it is used as a maintenance treatment to allow people to stop the use of heroin. It may be useful for people who have come down to a low dose of methadone (30mg daily or less), to transfer to buprenorphine and withdraw faster and easier than possible from methadone. Buprenorphine is not effective when swallowed so it comes in a tablet form that dissolves under the tongue. Usual doses are up to 16mg once a day while many people get the same effect from up to 32mg every second day or three times a week. The basis of treatment is that it prevents withdrawal symptoms when heroin use is stopped and no effect of a normal dose of heroin will be felt if it is used while stabilised on the treatment. For this reason doses should not be missed.

Buprenorphine should only be taken under medical supervision. The initial dose should be small and taken at least 6 hours after the last heroin use and 24 hours after methadone doses or withdrawal symptoms will occur. It is not suitable for people to transfer from high doses of methadone and is not approved for use in pregnancy as there has not been enough experience with it to determine that it is safe.