

Treatment options for heroin users

TREATMENT OPTIONS FOR HEROIN USERS TREATMENT

treatment options for heroin users

RELEASE HEROIN HELPLINE

020 7749 4053

MONDAY TO FRIDAY 10.30am–5.30pm

A service for heroin users and people
who work with them



Release, 388 Old Street, London EC1V 9LT
Release Legal Emergency Drug Service Ltd.
Registered Charity no. 801118
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Substitute Prescribing Therapies

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Treatment Options for Heroin Users – by Gary Sutton

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Treatment Options for Heroin Users (Substitute Prescribing Therapies)

Introduction

This booklet has been produced as a result of many, many hours of talking to users, their friends and families and professionals about what help exists for heroin users in the UK. In writing it I have tried to briefly explain how various different kinds of treatment drugs work, how they differ and why one option may be better suited to one individual than another. Formulations and descriptions are included to assist anyone in deciding if what they feel they are offered, or need, is available as a syrup, tablet or ampoule and to recognise anything they may be offered on the street. Most of these drugs have the capacity to cause death by overdose in what may seem modest quantities, or in the case of the partial antagonists, and antagonists, induce severe withdrawal in an opiate dependent person.

Try to decide what it is you want from treatment, if you can, although many people get in touch with services just because they instinctively feel they need a change in direction and find out what the agency or doctor offers.

If you feel the treatment isn't working go back and explain what you feel is wrong. It may help to keep a diary/notebook through the early weeks. If you still feel you are getting nowhere some services have user groups and advocates. These are people who are trained in resolving difficulties between clinics or doctors and individuals. The Methadone Alliance (020 7374 4395) can tell you if there is one in your area, as can the National Drug Users Development Agency, (020 7739 6633) who can advise you on setting up your own group or tie you in with an existing one.

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Substitute Prescribing

The emphasis on getting people into treatment, commissioning research and providing an evidence-based care plan for users is a recent development that implies that service providers are investing money in people whose opiate use has become a problem, while central government demands results in return for the new expenditure.

Many services are consequently experiencing a shake up, with realistic doses of medication starting to appear more widely across the country and waiting times finally beginning to drop. However, a disagreement between professionals has also begun to appear. Some believe that the Government's new policy is driven not by health or care imperatives but by reducing drug related crime. The question for many is how to balance the two without further 'demonising' drug users and discouraging them from coming forward for help if they need it.

At present, doctors have to apply for a Home Office license to prescribe diamorphine, cocaine or dipipanone. It has been suggested that this system should be expanded to include all drugs listed in this booklet, with the exception of oral methadone. The most likely outcome is that a license will be needed for all injectable drugs, but it is still possible that the licensing system will take in a wider range of drugs. This may mean that some of the choices now available will not be open to all practitioners in the future.

Some GP's already have agreements with local specialist agencies that they will not prescribe for users, or if they do, it will be in conjunction with specialist drug services. Consequently, the range of treatment options may be reduced in some areas to specific medications.

If you are already in treatment and think that you may be able to improve your stability, reduce your dependence on illegal drugs or move towards coming off, by being treated with a different medication or dose, ask your drug worker or clinician/prescriber to discuss your case. Perhaps an advocate might help if you have trouble expressing your feelings or get nervous in front of prescribers!

Coming into treatment these days is arguably more regimented and less flexible than it used to be. However, unless you are on a court order, it is still your choice. Here are some of the factors that might influence you in making the right choice.

Pluses

On the positive side you can get a degree of control over your heroin use, provided you are adequately medicated. You will not need to use gear – you may choose to for the emotional and mental relief but you don't have

to chase(!) gear around, wait hours, spend a fortune on keeping your habit (and your mobile phone) topped up and you are not breaking the law. The money you can save could make a real difference to your quality of life as even a small heroin habit is going to cost you at least c.£75 a week just for the drugs.

If you are an injector, you may find that putting down the needle is a difficult but crucial step in the right direction. HIV and Hepatitis can affect all injectors, the older you get the harder it gets to hit a vein (your doctor may discuss a transition period to oral or an injectable maintenance option, if you can show an awareness of good injecting practise).

It is really important that policy makers accept that services are competing with relatively cheap and potent street drugs which are widely available throughout the UK. (doorstep delivery accounted for 25% of deals in the Release Heroin Survey 2002). Many people are uncomfortable with the supervised consumption of opiate substitute medication in their local pharmacy (although some others say it suits their needs) or handing tubs of urine over to a succession of drug workers who often seem to change post every few months, or are placements gaining work experience. There are a wide range of reasons why people approach services, to insist that drug treatment as we understand it will survive as a model over the next ten or twenty years is naive. One of the problems of putting this document together, is that some of the drugs listed here are not usually considered as appropriate for treating opiate addiction. They have been included firstly to inform and allow users and professionals to recognise them and how they work and reject any option that won't assist or is contra-indicated and also for pain control issues for patients already on mainstream treatment options such as methadone.

Minuses

The negative side brings up issues that you have to balance against the pluses, not least whether to decide if you want it on your medical record that you have had a drug problem. This may go against you if you try to get work in certain professions, life insurance or a mortgage. Coming into treatment can be difficult. You may need to present for 'titration', and to present in withdrawal. Many users find this very hard and consequently have a little 'straightner' before attending. This obviously affects your tolerance for the day and you might find yourself sub medicated as a result. You may be titrated up to a maximum of 40mgs of methadone on day one – more users are now finding they are able to get proper therapeutic doses 80–120mgs (where indicated).

Daily pick-up for at least the first three months is a Department of Health Working Group recommendation that, while designed to guard against diversion and overdose, has no real evidence base to support its inclusion

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and has probably discouraged more people from coming into treatment than any other factor. However, if you work, have pressing childcare issues, live a long way from the dispensary or can illustrate stability, you can often get the time period reduced and go onto three times or twice weekly collections. Try to explain to your keyworker or practitioner why it is difficult to attend at least six days out of seven, don't just assume you can't go into treatment because of this problem, which occurs time and again on our help-line, if you have a good case you may be able to display why you should get a reduced probationary 'pick up' period! Many users are also unhappy about taking their medication ('supervised consumption', under scrutiny of the person who dispenses it) in front of people who may be their neighbours. The Department of Health guidelines themselves acknowledge that there may be good reasons in particular cases for shortening or omitting the period of supervised consumption.

A rural Police authority once proposed to prosecute all 'druggies' who turned up for their methadone at chemists by car. After taking advice from the local drug squad and treatment advisors, it was decided that the proposal would have dire consequences for both patients and society in general and was shelved. However, if you get stopped and found 'unfit to drive under the influence of drink or drugs' you will probably lose your licence for some time and find insurance very hard to get in future. It is possible to keep your driving licence if you are on an oral methadone maintenance script but you will need to report that you are in treatment and comply with the instructions the licensing section issue.

There is an insulting stereotype that all heroin users are thieves, which is nonsense, but you will find yourself stereotyped, even by association with other users. If you have kids you may be aware of the problems that being on the child protection register can cause. Using drugs will not automatically get your children on the register but Release has worked with clients whose kids would not have been noticed by social services without a malicious rumour or maybe a dated previous conviction around drugs coming to their attention. It is only fair to point out that not everyone has negative experiences of social services.

Know your Rights

The Alliance (formally known as The Methadone Alliance) and Lifeline produce an excellent booklet to explain your rights and what you can expect from services. It covers areas like urine testing, supervised consumption and treatment contracts. It is available from the Alliance (020 8374 4395) and Lifeline (0161 834 7160). It will prove very useful to you and comes from a different perspective to this little work, which is designed to explain the drugs, how they work and why they might be part of the answer for you. You may also find The Methadone Handbook and The Detox Handbook well worth a look, they are available free at many drug

services, or to buy online from www.exchangesupplies.org or HIT (0870 9909702). Exchange also produce leaflets that cover the main treatment drugs discussed in this publication individually.

Range of Prescribing Options

If you are using heroin or another opiate or opioid (synthetic opiate) there are a range of treatment options based around prescribing interventions. This booklet is not an exhaustive list, indeed some of the drugs and formulations are very rarely used, but it does also represent the most frequently used medications. Some of the treatments are licensed for the treatment of addiction in the UK and prescribers generally feel safer prescribing with an 'evidence base' to support their actions. Consequently, you are much more likely to be offered one of these medications (oral methadone, buprenorphine, lofexidine) rather than some of the other drugs included in this booklet such as morphine, dextromoramide or even codeine. Not that this evidence base is foolproof. LAAM, a methadone based substitute medication (see page 13) that allows for forty eight hour dosing intervals passed muster in rigorous tests by the Food and Drug Administration Authority (USA) but was withdrawn when occasional heart problems occurred perhaps due to dose accumulation or overdose in patients after use in the community. Although not now used in the UK, LAAM is included as it may be re-introduced here in future (see below).

Treatment options that utilise non-pharmacological interventions are not included in this booklet, although many projects offer counselling services and 'social interventions' (benefit and housing advice), and clients may benefit from these and complementary therapies. The benefits of widening the practical assistance available to users are clear, although in many cases the clinical efficacy of some therapies may be less obvious.

Dose Levels

All dose levels should be individual and properly titrated (measured against symptoms and tolerance). Attention should be given to drug using history, particularly injecting history, venous access and body weight. HIV and Hepatitis status is also important as many medications interact and a malfunctioning liver will not metabolise (breakdown) opiates effectively. There is an active debate about dose for dose equivalence of street drugs and pharmaceuticals which needs to be resolved. The table in the 'Orange Guidelines', Drug Misuse and Dependence, Guidelines on Clinical Management' (1999 HMSO) is very poor. The original theory of 'Blockade Dosing', soaking the receptor sites to reduce the efficacy of using on top is once again being accepted as the most effective maintenance option. As this requires higher doses many services will consider the risk of overdose or selling some of your methadone on to be a justification for supervised consumption until you can display a degree of stability they feel warrants 'take home privileges'.

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Safer Injecting Equipment

From a health perspective, it seems illogical to offer clean syringes and sterile paraphernalia such as water and swabs yet continue to frustrate access to proper pharmaceutical preparations. Street drugs are far more suited to 'sharing' scenarios than offering users appropriate supplies of their drug of choice. People cook up in the same spoons to divide small quantities of liquefied powders more evenly. Filters are a major problem in the transmission of blood borne viruses and microbial infection risk which could be avoided by the use of fully soluble pharmaceuticals.

The National Treatment Agency and Injectable Prescribing

The NTA is an organisation that has inherited the role of coordinating drug treatment in England. After much deliberation it published the results of its own invited expert groups conclusions on ('the potential roles' of) 'Injectable Heroin and Methadone' in June 2003.

This effectively laid down new guidance to treatment providers around the age-old issue of prescribing injectables. It concluded that injectable prescribing may be beneficial to a minority of users. For people seeking this type of treatment a clear pathway through failure with oral high dose buprenorphine or methadone is identified. It is made clear that priority should be given to improving the patient's chances of achieving a desirable outcome without resorting to injectables.

The document stresses eight principles for consideration in assessing suitability for heroin or methadone injectable prescribing.

We need not list all eight here verbatim but the major considerations, where not already covered in this booklet, are that the main treatment pathway to an injectable prescription could be best summed up by the phrase 'where all else has failed'. Furthermore, greater levels of supervision will be required for patients on injectables. This may lead to massive cost and restructuring implications if the provision of injectables is to be increased. Where patients are already in receipt of an injectable prescription, a degree of stability has usually been considered a prerequisite, consequently the undertaking to offer an improved service aimed at maintaining stability is presumably directed at a relatively small percentage of patients.

It is accepted that starting people on an injectable prescription may be a long term commitment, this will be a major relief to many people who may previously have felt vulnerable about their 'privileged' status. It may concern both patients (the term selected to describe service users throughout the document) and providers that cost may prove a

disincentive to initiate people. New programmes, it seems, will be ‘pilots’, implying a review period some time in the future before the treatment becomes widely available. Presumably these formulations will be licensed for the treatment of drug dependence. In terms of individual practitioner licences to prescribe mention is made of specialists working in an ‘appropriately supported treatment setting’. It will also be interesting to see how people who have ‘failed’ with other therapies remain in treatment in order to fulfill one criterion for a heroin script assessment.

Considering Maintenance

Many users find that opiate maintenance provides an emotional ballast to their lives that are otherwise unstable, fraught and depressive. Others have serious, chronic pain control issues in combination with emotional or psychological trauma. That these clients may enjoy their medication is a side issue. If the pursuit of happiness (or even equilibrium) is chemically aided then, some would argue, so be it. Why opiates are seen as less valid anti depressant medication than serotonin reuptake inhibitors is political and historical as much as medical. Many older users have no intention of detoxing. These clients could be seen occasionally (six monthly) and provided with maintenance repeat prescriptions in order to free up time for waitlisted users who want to engage with services. Legal opiate/opioids are drugs that allow people to parent, find and hold down work and, if taken appropriately, do no organic damage. Blocking access to pharmaceutical quality drugs has not reduced the demand for drugs, it has helped beat a path to poor quality drugs delivered by socially excluded users desperate to support their own habits or by career criminals.

Considering Detox

For non maintenance therapies the argument is different but the case equally valid.

The number of ways people choose to detox themselves is based on finance, circumstance and experience. For example, many people would prefer to detox on methadone up to a point then transfer to dihydrocodeine on a reducing dose. Many would choose a route from buprenorphine(Subutex) to lofexidine (Britlofex) and onto Naltrexone to help prevent relapse. The Release Heroin help-line fields dozens of calls every month asking about rapid opiate detoxification (ROD) or Rapid Antagonist Induction (RAI), its more contemporary title, with Naloxone, a service very few health authorities will fund as it is purchased from private sector providers, despite some strong evidence around its cost effectiveness.

The reality is that today or on any given day, thousands of users are trying to reduce or detox themselves at home rather than in a conventional treatment setting. The reasons for this are practical, and personal. Access

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to detox is far too slow in much of the UK and some experienced users feel they can do it themselves 'at home'.

On the subject of home alone detox we publish a 'home detox' booklet, with some useful tips that is available through Release Publications (020 7749 4044) or the Help-line (020 7749 4053). 'Safer Heroin', our booklet for people who use street heroin also contains a short chapter on cutting down and managing your dose. Again available on the above numbers, price £2 to professionals, free to users.

The helpline will be pleased to talk to detoxing callers on a daily basis to offer advice and support, confidentiality is guaranteed.

Methadone

Methadone is the mainstay of drug treatment in the UK. Less than five years ago, prescribing, particularly maintenance therapy, which is an area where methadone has a high profile, was still regarded as highly controversial. Happily, this is now changing despite some prominent practitioners stating that maintaining anyone on opiates/opioids rather than trying to detoxify them is merely trading one addiction for another. Consequently, these people tend to focus most of their frustrations on methadone.

There are plenty of research papers from all across the world supporting methadone, and it is undeniably effective for a very large number of people who are able to rebuild their lives while on long-term maintenance 'scripts. It can also be used as a short term community based reducing dose detox therapy (in which context it is rather less successful). Methadone is less sedating than heroin and offers less of a 'high'. It has a very long half-life (usually over 24 hours) and consequently can be used once daily (although some users will split their daily dose into two). Anecdotally, there is some evidence that heroin users disappointed with the effect of methadone may gravitate towards 'potentiators' (other substances that increase the 'buzz', such as alcohol, cyclizine, or a benzodiazepine like temazepam). This dynamic is hardly unique to methadone, but again, its prominence ensures that these issues are not ignored. There are a number of health considerations that often occur when methadone is discussed – tooth decay (a sugar free version is available), libido (most opioids and opiates reduce the sex drive in the medium/long term) and somatic (bone) pain or calcium deficiency (no evidence to support this).

Methadone is one of the most researched medicines available, and if used correctly is safe. Always keep methadone out of the reach of children, they seem to find the green syrup visually attractive. This is another area where methadone receives unwanted attention as thoughtless storage has caused infant fatalities leading to a call for stricter controls.



A user injecting methadone ampoules into the 'upper outer quadrant' of the buttock (I/M)

Methadone is available in a bewildering variety of formulations. Some of these are;

Mist. Methadone or Methadone mixture DTF 1mg/1mL

Other formulations – variety of trade names plus concentrate 'Methadose' (Rosemont) 10mg/mL (blue) 20mg/mL (brown). Sugar-free preparations are available.

Physeptone linctus 2mg/5ml – 'Linctus' originally a cough suppressant is now very rare, many people still use the word 'linctus' to refer to methadone mixture.

Physeptone is a tradename for methadone.

Physeptone tablets-scored 5mg Wellcome L4A marked on tab.

Injection – Physeptone ampoules 10mg/mL

Methadone ampoules 10mg/mL 20mg/mL 35mg/3.5mL 50mg/5mL

Methadone ampoules (concentrate) 50mg/1mL 50mg/2mL 35mg/1mL

Methadone by injection, unsurprisingly considering the issues discussed above is not considered appropriate therapy by all prescribers and drug workers. About 12% of methadone clients receive injectables (see section above). The particular adaptability of methadone to oral ingestion is one major reason that injectable methadone is not greatly favoured. In other words, if nearly 90% of an oral methadone dose can be absorbed in the gastro-intestinal tract, there is no pharmacological justification for prescribing injectables. Injecting is seen by many as deviant and fetishistic behaviour which should not be indulged. Furthermore the patient instructions on methadone ampoules indicate sub-cutaneous or intramuscular injection whereas most users will attempt to inject intravenously.

Although they offer some cost advantages, there is some concern over the acidity of methadone concentrate ampoules. Certain clients seem to suffer tissue damage at injection sites. This may be due to particularly sensitive skin as it would appear not all are affected. A degree of dilution with water for injection seems to offer a remedy. The amount of water needed is largely trial and error, try doubling the volume from a sterile water amp. Clients on significant daily doses may find liquid volume from non concentrates a problem. *Injecting oral methadone in any of its formulations should not be attempted.*

Dosing levels are, of course, critical to the success of any treatment intervention. It used to be accepted wisdom that anything over 60mgs per day was high dose methadone prescribing. The goalposts have now moved and evidence shows that doses between 80–120mg of methadone daily are most effective at reducing heroin use and improving health and social functioning. Many services are not yet up to speed on this, but the situation is slowly improving in most areas. Release's survey of 2002 found that of 1689 Heroin users questioned, 728 were on methadone scripts and on top of these another 116 (16%) of people regularly increased their intake by buying extra 'grey' market supplies, this strongly suggests many are on inadequate doses.

Methadone (getting the dose right)

The client is given a starting dose and this is increased until no withdrawal symptoms can be observed. This may take three days returning to the unit, or in reviews, disputes or unusually high dose cases a period as an inpatient. At a GP surgery, due to lack of resources, this may take weeks. Before commencing, a positive urine (for opiates) will be required and a drug history taken. If you are already on a 'script', and moving area, you should be able to keep your dose, but will need to be assessed. Your papers should follow you, but the Heroin help-line's experience is that the transition can often be problematic. A good advocate should be able to assist if you run into problems.

Methadone 'failures' are, in reality, often less a fault of the drug itself than either the way it is delivered (inappropriate dose, inconvenient collection regimes) or an unrealistic expectation on the part of the prescriber/clinic or client. Being a long acting agonist it accumulates in the body and offers an alternative to the sedation/withdrawal cycle evident with street heroin or morphine. This is why stability is often mentioned in connection with methadone maintenance therapy. While methadone can offer help with depression and anxiety it does not realistically substitute for heroin in this regard. Clients who expect it to will be disappointed and perhaps look to augment their medication with opiates, benzodiazepines, alcohol or cocaine. Which may cause problems if you are required to produce urine tests. The benefits of methadone treatment can be compromised by punitive treatment regimes. Instructions provided by the National Treatment Agency in June 2003 said, *'compulsory detox and reduction regimes have poor outcomes and are not recommended'*.

PLUSES

- less intoxicating than heroin
- long duration of action
- effective orally
- reduces heroin craving
- generally available
- much cheaper than heroin

MINUSES

- less euphoric than heroin
- protracted withdrawal
- product image problem (stigma)
- many clients hit a 'brick wall' with out-patient detox often c.30mgs and again 8/12mgs

LAAM (Levo-alpha-acetylmethadol)

An opioid related to methadone that is far more extensively used in the USA. Much of the interest in LAAM stems from its long half life which means patients can be dosed every two to three days rather than every day. This would mean less problems with daily pick up and presumably, diversion. It follows that if less clients are seen daily then the capacity to reduce waiting lists exists.

Well absorbed through the gut, like methadone LAAM can be given as a 'syrup'.

PLUSES

- good oral absorption
- daily pick up unnecessary
- cost effective

MINUSES

- dose accumulation/OD risk factor
- difficult initiation period common
- some side effects reported in 'trial' groups

Buprenorphine

Buprenorphine was licensed for the treatment of opioid addiction in the UK in 1999. It is available in sub-lingual tablets, these are small white rhomboids, 400 microgrammes, 2 milligrammes or 8 milligrammes (mgs.)

The trade name is Subutex.

The usual dose is around 12 mg, usually once daily. Dose can vary between 2–32mg a day.

Buprenorphine is also available as Temgesic, small, white round tablets of 0.2 or 0.4 mgs, again they are designed to dissolve under the tongue, but not licensed for use in drug dependence.

How Buprenorphine works

Buprenorphine has both opiate agonist and antagonist properties. Opiates latch onto receptors on nerve cells. In doing this they displace and over time replace the indigenous endorphins. Some opioids stimulate the receptors (agonists), Some occupy and block action at the receptor site (antagonists), while a third group can do either, depending on what is happening at the receptor on contact. We call this third group partial agonists or agonist/antagonists and buprenorphine falls into this category.

While clinical tests have yielded excellent results for buprenorphine, there are some key questions to consider. Firstly, can clients used to injecting or swallowing pills be convinced that a tablet that melts under the tongue is going to be effective? If induction is difficult due to the partial antagonist effect will clients stick it out? If clients on more than 30mgs daily of methadone should not be transferred to Subutex doesn't this exclude the majority of treatment clients? Good guidance is included in the latest paper published by The Royal College of General Practitioners on Buprenorphine and it seems both from this source and anecdotally that patients on higher doses of heroin can transfer straight from street gear more effectively than might be supposed given the caution on dosing with methadone change overs. The delay before initiating should be at least 12 hours both with heroin and 36 hours on methadone, however if the person is *clearly* in withdrawal it should be assumed that starting buprenorphine will not exacerbate the condition and make matters worse.

The main advantages with Subutex as a treatment drug are its relative lack of euphoric action and its greatly reduced overdose potential. Withdrawal is also said to be less severe. Buprenorphine is proving effective as both a maintenance and a detox option for people considering giving up heroin, there is mounting evidence that it may be at least as effective as methadone in community based detoxification programmes. It also seems to be less implicated than pure opiate agonists in the use of other drugs (such as heroin and cocaine) while in treatment. Furthermore, post detox people can be started on the opiate blocker, Naltrexone (see p. 22) within a couple of days, offering extra protection against relapse.

GP's are becoming increasingly comfortable with the idea of prescribing Subutex, mainly for the reasons mentioned above.

A quick mention of injectables, buprenorphine is available as an ampoule (300microgrammes/mL), but this is very rarely seen. More of a concern is the crushing and injecting of Temgesic. This has historically been a regional issue, relevant in Scotland and Northeast England, very rare in London or the south of England, where heroin or more popular opioids are widely available.

PLUSES

- reduced OD risk
- limited euphoric effect
- oral route of administration
- high dose block on other opiates
- easier detox for smaller habits?

MINUSES

- may be difficult to transfer from pure agonists
- limited euphoric effect
- unsuitable for high dose methadone transfers
- some users uncomfortable with sublinguals

Diamorphine Hydrochloride (Pharmaceutical Heroin)

(see section above on injectables)

Only available through Home Office licensed practitioners, Diamorphine is pure pharmaceutical heroin. This formulation is usually only offered to people who have 'failed' on methadone or other therapies. Some clinics offer 'reefers' (heroin in cigarettes), but many find providing smokeable formulations irreconcilable with their role as health agencies, (the NTA paper does not consider non injectables). Tablets are available, but because of the way heroin is metabolised in the body it is dubious whether they are any more effective than morphine tablets (see below). Much the same could be said for diamorphine linctus.

The most popular formulation is ampoules for injection (intravenous, subcutaneous or intramuscular). Dose is an issue as diamorphine must be taken eight hourly. There is much discussion about its equivalence with methadone. As a rough like for like guide to find a daily equivalent dose for injectable methadone with diamorphine ampoules, you would need to multiply by between a factor of three and three and a half. i.e. 100mgs methadone = 300–350mgs diamorphine. There is often expressed concern that prescribing diamorphine to users will leak onto the 'grey market'. There is no evidence to suggest that this happens, or is likely to happen. Common sense would surely dictate that addicts are less likely to sell their drug of first choice than any substitute medication.

PLUSES

- drug of choice for many users
- very soluble.
- arguably easier to withdraw from than methadone.
- removes need for black market heroin

MINUSES

- limited availability.
- doses often unrealistic.
- short acting.
- peaks/troughs across 24hr period
- unit cost very high (in the UK!)

Footnote on heroin – Some users of street heroin have found that they find pharmaceutical diamorphine 'disappointing', in that it does not seem to produce the same 'hit' that they expect from pure heroin. There are a number of theories about this from psychological to pharmacological. The idea that tolerance builds continuously with heroin is untrue. Tolerance will build slowly but not infinitely and most long term maintenance people tend to stabilise between 350–700mgs daily.

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Morphine

Morphine is an alkaloid of opium, in fact it is the 'daddy' of the family which also includes codeine (see below), papaverine, thebaine etc. The half life of morphine is short and morphine usually needs to be taken four hourly. There are slow release formulations available which address this problem but as ever with short acting opiate agonists dose levels are problematic. Many prescribers are nervous about exceeding the dose levels cited in the British National Formulary which refer, for drugs under the 'Analgesic' heading, to pain relief. Although many patients are seeking relief from chronic pain they are unlikely to have the same expectations of their medication as users with a background of heroin dependence whose histories, motivations and needs can be extremely complex. The DH guidelines produced for GP's (and all doctors) say methadone and morphine are dose equivalent at 1mg:1mg, but this ignores the fact that the half-life of morphine is about 1/8th of that of methadone. This means to reach a meaningful dose equivalent you would need to multiply morphine dose by about 8. (The Handbook of Clinical Drug Data suggests 1mg of methadone = 10mg of morphine over 24hrs). Which means that a client on 100mg of methadone will require something like 800–1000mgs of morphine a day. A figure that frightens prescribers as it seems like a colossal amount of a drug with 'clear abuse potential'.

It is not a cheap drug for health authorities to provide or patients to buy. Many heroin users do not get on with morphine because they find it too short acting, too harsh and too 'prickly.' One study found that patients on methadone stabilised far better than a similar group given morphine. The morphine patients complained that the dose was insufficient and spent much of the study clock watching waiting for the next dose. Which is much as you would expect if the dose was insufficient, but the point that repeat dosing is necessary is important. This can be time consuming and damaging to confidentiality, particularly if people are on morphine mixture which is bulky and difficult to conceal or ampoules.

In conclusion, morphine doesn't offer an answer for most users, however this is not sufficient justification for ignoring its potential as a therapy. Its wide variety of formulations offer considerable scope for a tailored individual treatment for clients who are able to overcome the drawbacks and benefit from its particular properties.

Morphine Oral Solutions

As directed by prescriber – Morphine Hydrochloride, over 13mgs per 5mL becomes sufficiently strong to be a Controlled Drug (CD), as opposed to a Prescription Only Medicine (POM). This has legal ramifications for the prescriber and dispenser rather than the individual for whom it is prescribed.

Oramorph

Morphine Sulphate.

Probably the most common liquid formulation for people in treatment comes in;

Oramorph 10mg/5mL or the concentrate 100mg/5mL (sugar free).

Tablets

Sevredol – Morphine Sulphate – oblong tablets, scored 10mg (blue), 20mg (pink) and 50mg (green).

The rest of the oral morphine range are controlled release. This means that they are designed to be absorbed at a steady rate modifying the euphoric effect and reducing the daily dosing regime to twice daily, except Morcap SR and MXL (both capsules) which can be taken once or twice daily.

MST Continus and Oramorph SR are morphine sulphate tablets, round, film coated and identified with strength numbered, MST are also marked NAPP; 5mg (white)*, 10mg (light brown/buff), 15mg (green)*, 30mg (purple), 60mg (orange), 100mg (grey), 200mg (light green)*.

(*Denotes available in MST Continus only). 10mg MST are a darker shade of brown than the Oramorph version.

The modified release capsules are Morcap SR, marked with a K and strength numbered with banded, MXL marked MS OD with strength, Zomorph in various strengths (marked) from 10mg to 200mg.

MST Continus is also available as a suspension, granules of morphine sulphate to mix with water.

Note: *none of the above are suitable for injection.*

Suppositories

Morphine hydrochloride or sulphate. 10mg, 15mg, 20mg and 30mg. These should be kept in the fridge and inserted up the rectum. Not widely available and despite the famous scene in 'Trainspotting', almost impossible to reinsert.

N.B. The practice of melting suppositories down for injection is extremely dangerous and can lead to a variety of life threatening conditions.

In a fairly recent Swiss trial, long term opiate dependent people were offered a choice of heroin, methadone or morphine by oral or injectable routes of administration.

The uptake for places on the morphine cohort was very low. This may have been different if the choice had been morphine or methadone but it does seem that morphine is less popular with opiate users than it used to be. One major exception to this is Cyclimorph – (Wellcome morphine tartrate 10/15mg and cyclizine 50mg).

Cyclizine has a significant potentiating effect on opiates. Valoid (Marezine USA) Tablets white, scored WELLCOME T4A, ampoules 50mg/1mL are often mixed with a range of opioids for this reason. These can cause paranoia/ psychological disturbance if used in high doses (+ 200mg daily) over a medium to long term period. Although the morphine content is low cyclimorph are often mixed with methadone to increase the duration of the hit. People can get very greedy and disorientated and overdose can become a risk.

Morphine Sulphate ampoules 10,15,20,30mg 1mL/2mL. Traditionally used in pain control, palliative care and post operatively. Morphine is the pain killer by which all others are measured. The side effects when used in maintenance treatment at high dose probably explain its relative lack of desirability among injecting opiate users.

PLUSES

- 'similar' effect to heroin (cyclimorph)
- wide range of formulations
- excellent painkiller

MINUSES

- large doses usually required
- short acting
- very 'prickly' with high dose I/V
- **overdose risk**
- cyclimorph can cause mental health issues

Codeine and dihydrocodeine

Codeine is closely related to morphine being an alkaloid of opium but possessing around 1:5th–6th of the strength. It is a much-underused drug in treatment. The usual formulation is codeine phosphate.

Dihydrocodeine seems to have been supplanted by Subutex as a relatively non euphoric dependence reducing agent. Buprenorphine has the advantage of a much longer half life. The reason it never really achieved the prominence its properties warranted was not least because of a largely inaccurate perception at the Home Office that the tablet form is frequently crushed and injected. The usual formulation is dihydrocodeine tartrate.

Codeine and dihydrocodeine come as tablets, modified release tablets, syrup/linctus and ampoules.

Many mild analgesics contain small quantities of the above drugs. These formulations are too weak to be of use in the treatment of dependence and often contain other drugs such as paracetamol, aspirin etc. that may be injurious if taken in sufficient quantity to feel the opiate effect of codeine. The main difficulty with codeine is that it is painfully constipating.

It can be used as a maintenance drug for users with fairly small tolerances,

but it may be more useful for tailing off at the end of a detox. That is to say reaching 30mgs of methadone or a quarter gramme of heroin and converting.

At this point dose equivalence becomes a matter for titration but as a rough guide over a day's duration, somewhere in the region of 15 x 30mg of dihydrocodeine (split into three or four doses) should offer cover.

From a purely physical perspective, reduction is a fairly painless procedure, but as with all opiate detoxes a 'brick wall' will appear, at which point further reductions become increasingly uncomfortable.

Codeine Phosphate

(POM) Tabs 15mg, 30mg, 60mg

Syrup codeine phosphate 25mg/5mL

Codeine Linctus 15mg/5mL (available as sugar free)

Can be sold to public if max. single dose does not exceed 5mL (not prescription)

Injection (CD) Codeine phosphate ampoules 60mg/1mL

Dihydrocodeine Tartrate

(POM) Tabs: 30mg, DF118 Forte 40mg (POM)

DHC Continus (Modified Release) 60mg, 90mg, 120mg

Injection (CD) Dihydrocodeine tartrate ampoules 50mg/1mL (very rare)

PLUSES

- good for detox/reduction
- minor euphoric action

MINUSES

- very constipating
- minimum euphoria compared with other options
- dose conversion difficult
- urine tests as morphine

Dipipanone

Doctors treating patients for addiction cannot prescribe Dipipanone to people without a licence provided by the Home Office. This drug was accorded special status, (putting it on a par with Heroin and Cocaine) in 1984. The drug in its standard formulation 'Diconal', retains a type of cult status among older users, who speak nostalgically of its euphoric properties. As mentioned above this is in part at least caused by the mix of a powerful opioid, dipipanone with cyclizine, the anti emetic.

The real problem with Diconal comes when they are prepared for injection. The use of diconal in this fashion is most inadvisable, particularly if they are not filtered through another syringe packed with folded uncoloured toilet paper, which removes some of the insoluble contents. Firstly, the tablets have a silicon base which accumulates in the veins and causes

thrombosis. A build up of tablet excipient can collect with bacteria on the valves of the heart leading to endocarditis.

Missing the vein with Diconal can and probably will, lead to painful abscessing, which may require hospital treatment. Fingers and limb amputation are not uncommon among people who inject Diconal. Diconal have also been implicated in a number of fatal overdoses. The cyclizine is likely to cause paranoia and, if used continuously, may result in psychiatric disturbance/hallucinations.

Although Diconal is an effective painkiller in the management of *severe pain* and if used orally in therapeutic doses can be an very effective medication, it is a high risk option and needs very careful assessment. It is not appropriate for people who are still injecting. However Diconal tablets are rarely encountered, even on the black (grey) market these days, although chemist break-ins and sales from patients suffering organic pain occasionally result in localised short term availability.

Diconal – Dipipanone hydrochloride 10mg/cyclizine hydrochloride 30mg. tablets pink, marked WELLCOME F3A. Occasionally available as dipipanone linctus 1mg/1mL (without cyclizine).

PLUSES

- very euphoric
- oral formulation

MINUSES

- very euphoric/disorientating/ can lead to irritability
- only available from licence holders
- **overdose risk**
- **major health dangers from injecting**

Dextramoramide

Dextramoramide tartrate (Palfium) tablets are well known among users of opiate drugs for their connection with injection related overdose. The line between 'stoned' and respiratory shut down is very fine indeed. Much in the fashion described above for Diconal, but with perhaps even more drastic consequences, Palfium are not a tablet that opiate naive people should 'dabble' with. They do not have the near hallucinatory effects of Diconal but, it is worth noting, that there was an attempt to include them with Diconal in the 1984 legislation relating to 'licensing only status.' This did not succeed.

Not really a major maintenance choice (since the early 1980's) except in occasional circumstances usually involving chronic pain management issues for non injecting individuals. Short acting. The 10mg tablets are far more sought after than the equivalent dose in 5mg tabs. Dextromoramide Tartrate 5mg (white) and 10mg (peach) tablets. 10mg suppositories available but very rare.

PLUSES

- euphoric
- oral formulation
- excellent analgesic
- short acting

MINUSES

- euphoric
- very frequently injected
- **major overdose risk**

All the drugs we have discussed so far are either opiate agonists (heroin, methadone, etc). or a partial antagonist, Buprenorphine. The next section will look at full opiate antagonists, Naltrexone and Naloxone; Lofexidine, a centrally acting antihypertensive drug that reduces blood pressure less than clonidine (a close relative and a drug used in in-patient detoxes for years); and some benzodiazepines and how they might be included in a treatment plan.

Lofexidine

Lofexidine is a drug which is designed to alleviate some of the symptoms of opiate withdrawal. It will not stop you from experiencing withdrawal symptoms altogether but should, by reducing the production of noradrenaline prevent you from experiencing some of the nervous energy (the derivation of the phrase 'kicking' comes from the involuntary leg movements that result) and anxiety that accompany opiate cessation. As it can lower your blood pressure and make you feel light-headed and unwell you should absolutely comply with the treatment regime and see your prescriber regularly.

The course will last about ten to fifteen days, and your blood pressure should be taken on initiation and regularly thereafter.

A typical regime might start with around six to eight tablets daily working up in conjunction with symptoms to a maximum of twelve on day five/six and gradually tail off at a rate that you feel comfortable with (given the circumstances!).

Sleeping tablets are sometimes used in conjunction with a lofexidine (trade name Britlofex) detox usually a benzodiazepine, such as Valium.

People attempting this detox will need support and should only attempt it in a comfortable and supportive environment.

It is not an easy detox, (what is?), and will require plenty of willpower to complete.

That having been said it is an option you may wish to discuss if you don't want any opioids involved in your detox. It does take the edge off the traditional 'home cluck', that users fear, but it will not be for you if you still have a 'decent' sized dependence on opioids.

substituted
therapies

Naltrexone/Naloxone

As these antagonists have the ability to evacuate and occupy the relevant receptor sites in the brain, they reverse the effects of opioids among dependent individuals. Naltrexone Hydrochloride is a non addictive substance with a variety of applications.

Rapid Antagonist Induction (RAI) or Ultra Rapid Opiate Detoxification (UROD) is an inpatient procedure usually unavailable on the NHS, that offers the most painless method for coming off opiates yet devised. In short, you are sedated with intravenous or oral anaesthesia and withdrawal is induced by an opiate antagonist (naloxone or naltrexone). Some premedication is taken 12 hours before admission. A range of further medications such as clonidine (a relative of lofexidine) and octreotide (an anti diarrhoea medication) are administered. Although patients are often disorientated on regaining consciousness, most can be discharged within 48 hours of admission, although some units retain patients for five days, only commencing Naltrexone on around day three.

It is usual for a range of take home medications to be distributed to a responsible carer.

Sleep disturbance may endure for anything from 3 days to over a month (albeit reducing). For this reason, a course of benzodiazepines may be indicated. Anti nausea medication and non opiate based painkillers such as Voltarol (diclofenac), deal with residual minor aches and pains (expect these as your heroin use will have masked minor ailments for your time on gear).

Cost here is the issue for most users and their families, despite the good results that this abstinence based treatment delivers.

Naloxone, available as short acting Narcan (trade name) is used to bring people out of an opiate induced overdose.

PLUSES

- least painful detox yet
- symptoms abate very quickly in most cases when medicated

MINUSES

- cost
- NHS reluctant to endorse

Naltrexone is also used as a relapse prevention tool, it is not a maintenance treatment and should not be mistaken for one. It is an opiate antagonist that prevents access to the relevant receptor sites of heroin, morphine, methadone etc.

The treatment is available in two basic forms as a tablet and as an implant. The implant is a minor surgical intervention, requiring a little local anaesthetic and the insertion of a capsule sized device beneath the skin.

Two strengths exist: one will last around 6–8 weeks, the other 5–6 months. The best way to imagine the way Naltrexone works is to picture trying to open a door with a Chubb key that has a key in the locked position on the other side. You can't get it in. This crudely is how opiates find the receptor site that is occupied by Naltrexone.

How long should you take it? It really depends on how confident you are that you can stay off on will power and support. If in doubt you should probably stay on the medication. If you do come off for a while and then go back. Be very aware that your tolerance has now dropped and if the Naltrexone is out of your system you are at great risk of overdose. If you fancy trying to see if your new implant works by buying a bag, don't bother, it does.

The tablet is Naltrexone hydrochloride, Nalorex 50mgs peach, film coated. People with chronic liver disease should seek specialist advice, but generally it causes few problems in this respect.

PLUSES

- relapse proof (with compliance)
- will get you through a very vulnerable time
- minimal side effects
- available as implant or tablets

MINUSES

- be wary of swapping addictions (cocaine, alcohol etc.)
- possibly toxic for people with hepatitis?
- **reduced tolerance can lead to OD in lapse**
- initial cost for implant

Benzodiazepines

A very complex addition to an already difficult equation, benzo's such as Valium (diazepam) Temazepam, Mogadon (nitrazepam), Rohypnol (flunitrazepam) etc. can assist or hinder depending on your programme, your expectations, your search for a 'buzz' or just your need for some sleep and relief while detoxing.

Undermedicating clients in treatment has been one of the major reasons for the rise in demand for benzo's. People used to a certain effect from street drugs found themselves in many cases, given risible quantities of substitute medications without proper induction or even an idea what to expect. In many cases their response was to 'potentiate' with benzo's, creating in a short period of time another dependency. Benzodiazepine withdrawals should not be attempted rapidly. Their place in the treatment of opiate dependence is a matter for debate that goes beyond the scale of this little booklet. That they are almost imperative in all kinds of detox and many reduction regimes is certain, as sleep deprivation is the most commonly cited reason for failure to complete detox.

prescribing
therapies

In Release's 2002 Heroin study we found out of 728 people prescribed Methadone, 344 were also prescribed some type of benzo, of this group another 163 bought benzo's on top of the amount they were prescribed.

PLUSES

- good relaxant properties
- cheap, legal to possess

- good for home detox

MINUSES

- habit forming
- **risk of OD used with other 'down' drugs**
- difficult to get off. Possible fitting episodes

Summary

Treatment services often forget that for most users the choice is between their drug of preference or a medication that allows them to get their lives, finances and health together without feeling that their chemical crutch has been removed before they can get around without one. For some people it is not possible to put an accurate estimate on when and if this might occur. Our understanding of addiction may allow us to alter the symptoms but although there are common factors that occur when looking at opiate dependent peoples lives we have no panacea. We take no dogmatic or philosophical line on this issue, preferring to work to educate, inform and support to help realise our client's wishes within a legal framework from a harm reduction perspective.

Release's Heroin help-line is available We are open 10.30am–5.30pm Monday to Friday. on 020 7749 4053 to answer any questions that reading this booklet has brought up.

substitute
prescribing
therapies

