Methadone to buprenorphine transfers

Tom English

Psychiatrist
St Vincent’s Hospital, Melbourne

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What we'll cover

- Opioid use disorder and opioid agonist therapy
- Australian OAT
- Methods of transfer from methadone to buprenorphine

Heroin – phenomenology of the first experience

- “The first time I had it, it was like a kindly grandmother putting a warm shawl around my shoulders, bringing me in from the cold for the first time”

- “It feels like warmth and silence, like being held, like nothing matters, and there’s no more care in the world - no harm can be done”

- “It feels like the gates of heaven opening up, like a warm hug from your mother when you were two years old and afraid”

- “Once you feel that feeling, if even one time, it cuts so fucking deep that there is no turning back. It’d be like giving a blind man sight, just for a moment, and then telling him to walk around for the rest of his life knowing what he lacks”

Is opioid agonist therapy (OAT) effective?

- OUD with behavioural interventions alone - 80% relapse within 2 years of intensive residential treatment (Bart 2012)

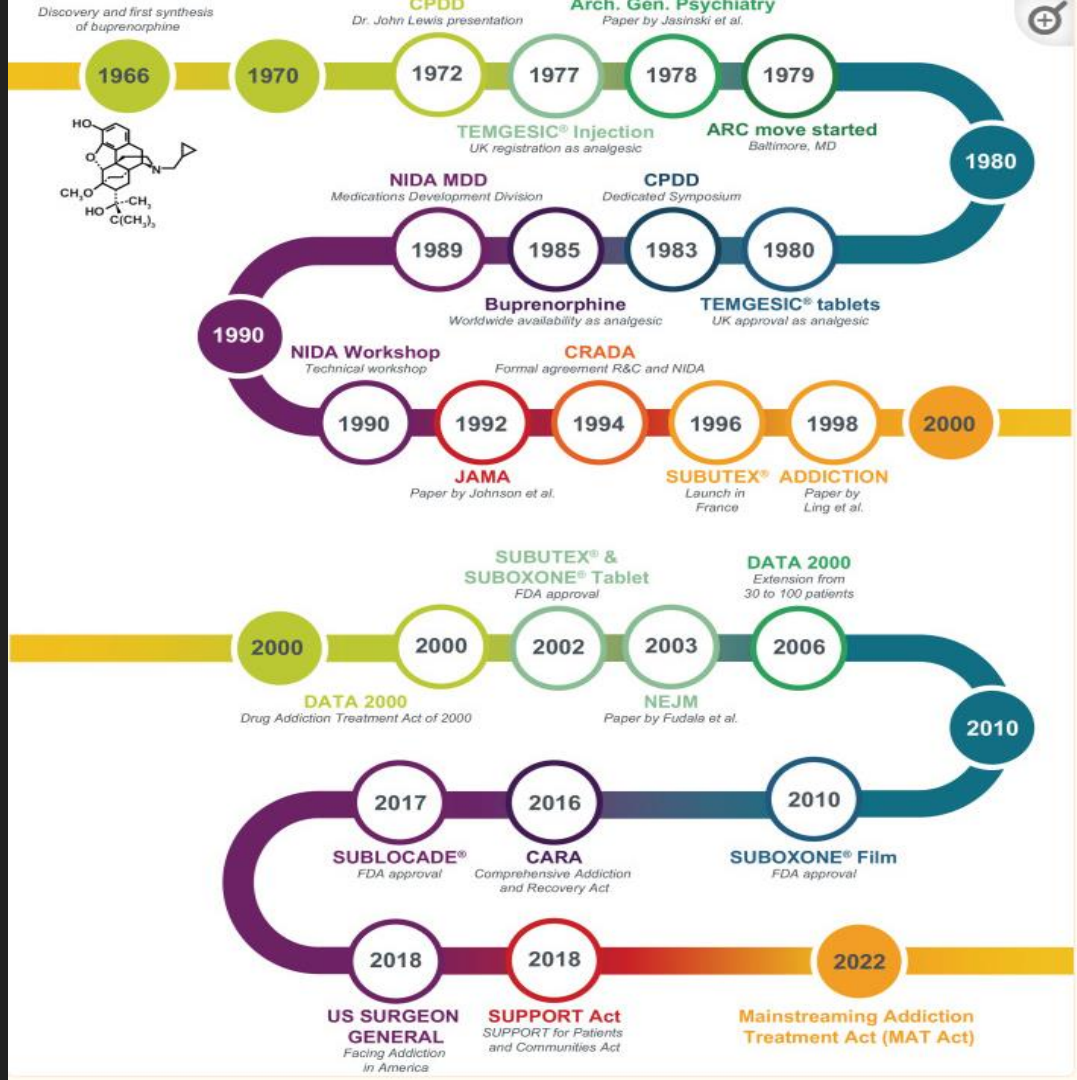
Is opioid agonist therapy (OAT) effective?

- Methadone and buprenorphine both reduce other opioid use
- Both reduce all cause mortality (by ~55%, Santo et al 2021)
- Both reduce overdose deaths (buprenorphine > methadone)
- Both retain patients in treatment (60-80% during studies, 15% continuing to use illicit opioids during treatment)
    - Methadone has better retention than buprenorphine comparing both at LOW doses
    - Equal retention in higher doses (Mattick et al 2014, Cochrane Review)
- Treatment outcomes improve with duration
- Risk
    - Of mortality during first 4 weeks: OD risk 5x higher for methadone than buprenorphine (Kimber et al 2015, Lancet)
    - Of mortality post treatment: 6x higher in first 4 weeks after ceasing OAT vs during OAT, 2x thereafter

Methadone and buprenorphine

- Methadone
  - ~1949: began to be used to facilitate opioid withdrawal (USA's "Narcotic Farm", Lexington, Kentucky; attended by William Burroughs author of "Junkie", 1953)
  - First study on methadone as long term treatment for OUD: 1965 (Dole and Nyswander)
    - *"Disappearance of narcotic hunger, freeing the patient for other interests"*

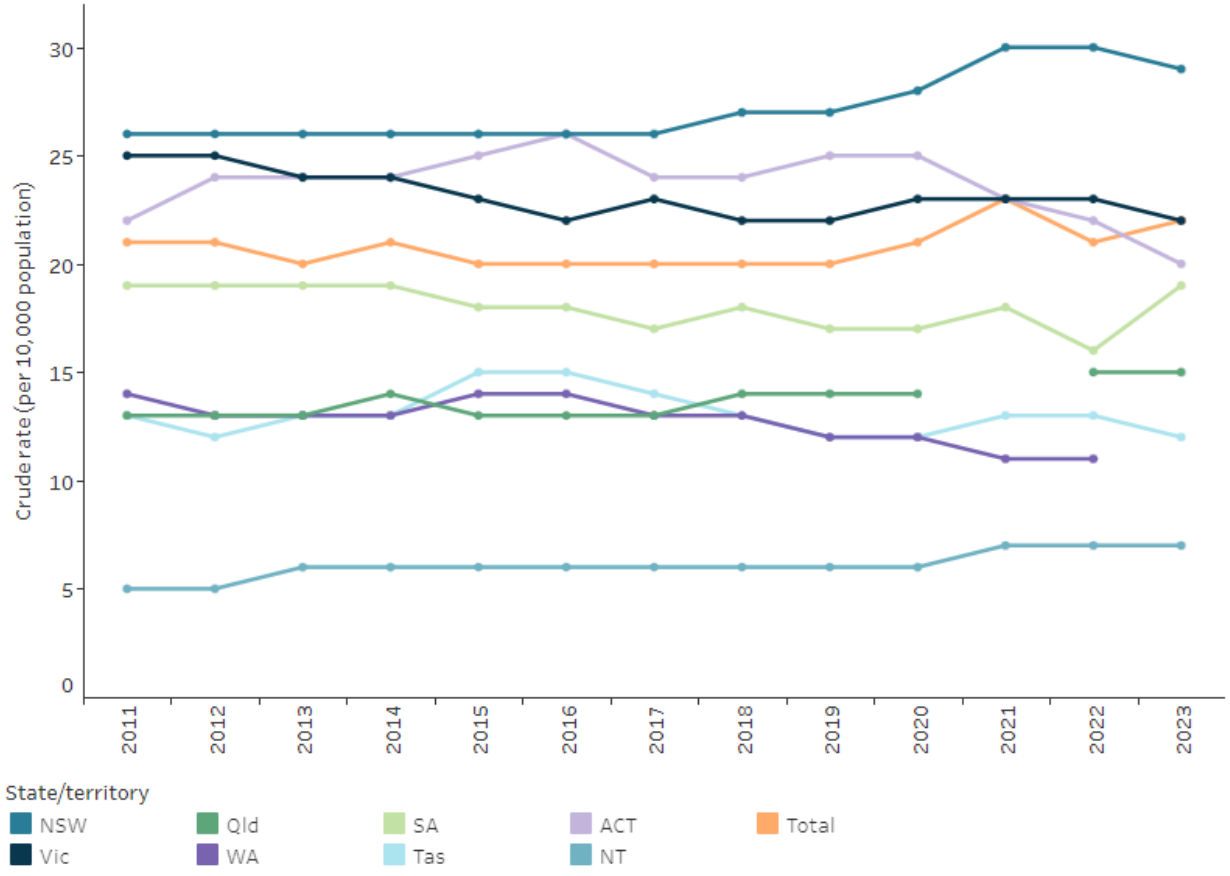
- Buprenorphine (Heidbreder et al 2023)
  - Discovered in 1966 (England, attempt to find an "improved codeine")
  - Approved for OUD in France in 1995, 2002 in USA
  - USA: approved for OUD in 2002
  - **Australia**
    - Subutex approved by TGA in 2000
    - Suboxone approved by TGA in 2005
    - Buvidal and Sublocade approved by TGA in April 2020


Discovery and first synthesis of buprenorphine
1966
1970
CPDD
Dr. John Lewis presentation
1972
Arch. Gen. Psychiatry
Paper by Jasinski et al.
1977
1978
1979
TEMGESIC® Injection
UK registration as analgesic
ARC move started
Baltimore, MD
1980
NIDA MDD
Medications Development Division
CPDD
Dedicated Symposium
1989
1985
1983
1980
Buprenorphine
Worldwide availability as analgesic
TEMGESIC® tablets
UK approval as analgesic
1990
NIDA Workshop
Technical workshop
CRADA
Formal agreement R&C and NIDA
1990
1992
1994
1996
1998
2000
JAMA
Paper by Johnson et al.
SUBUTEX®
Launch in France
ADDICTION
Paper by Ling et al.
SUBUTEX® & SUBOXONE® Tablet
FDA approval
DATA 2000
Extension from 30 to 100 patients
2000
2000
2002
2003
2006
DATA 2000
Drug Addiction Treatment Act of 2000
NEJM
Paper by Fudala et al.
2010
2017
2016
2010
SUBLOCADE®
FDA approval
CARA
Comprehensive Addiction and Recovery Act
SUBOXONE® Film
FDA approval
2018
2018
2022
US SURGEON GENERAL
Facing Addiction in America
SUPPORT Act
SUPPORT for Patients and Communities Act
Mainstreaming Addiction Treatment Act (MAT Act)

National Opioid Pharmacotherapy Statistics Annual Data collection

Web report | Last updated: **30 May 2024** | Topic: Alcohol & other drug treatment services |

- Australia: a snapshot in 2023 (excluding W.A)
  - 53,000 people on OAT
    - 24000 in NSW, 15000 in Victoria, 8400 QLD, 3500 SA, 900 ACT, 670 Tasmania, 190 NT
  - 3100 opioid prescribers (80% private including GPs, 15% public, 4% correctional facilities)
  - OAT choice
    - More people on buprenorphine than methadone (for the first time)
    - Younger: buprenorphine > methadone
    - Older cohorts: methadone > buprenorphine



Source: AIHW National Opioid Pharmacotherapy Statistics Annual Data collection. Table S2.

Transfer from methadone to long-acting injectable buprenorphine

Why

- Patient reasons (Winstock et al 2009, Lintzeris et al 2018, Naren 2024)
    - To prevent heroin use
    - Methadone side effects (sedation, cognitive impairment, stigma)
    - Increased convenience, flexibility (eg no need for daily pick ups, can travel)
    - Perceived as much easier to taper off

- Our reasons
    - Lower risk of overdose
    - Lower risk of non-adherence
    - Lower risk of diversion
    - Lower risk of side effects (eg does not prolong QTc interval)
    - Methadone complicates other treatment (Eg sedating antipsychotics, benzodiazepines)
    - ?impact on psychosis (kappa opioid receptor antagonism, Clark and Abi-Dargham 2019)

Transfer from methadone to long-acting injectable buprenorphine

Why not? Risks

- Precipitated withdrawal (higher affinity, lower intrinsic activity)
- Acute deterioration of a fragile mental state
- Failed transfer, destabilized, use of heroin to compensate, increased overdose risk
- Post transfer mental state deterioration
- Some patients simply do better on methadone

Methods of transfer from methadone - buprenorphine

1) Methadone washout
2) Naltrexone induced withdrawal with BPN rescue
3) Microdosing method/modified Bernese method (using sublingual or transdermal BPN)
4) Microdosing method (using IV BPN)

1) **Methadone washout (suitable for those on low dose methadone)**

a) Downtitrate methadone to 30-60mg daily,
b) Allow “washout” for 48 hours; await opioid withdrawal (eg COWS 12+)
   - Methadone blood concentration can vary up to 1700% for a given dose (individual variability of CYP enzymes)
   - Methadone half life ~24 hours (5-130h)
c) Then introduce buprenorphine
   - Eg 2mg, assess for PW, then 6mg 1 hour later, 4mg PRN symptom triggered)
   - If not causing PW, increase rapidly (too slow = assoc with increased dropout)

1) Methadone washout

a) Some patients: bridge with oxycodone (half life 3 hours) between methadone and buprenorphine
   - Oxycodone preferred as
     - Oxycodone can be differentiated from heroin on UDS
     - Oxycontin is tamper proof, difficult to inject

Day	Oxycodone formulation and dose calculation
1	Oxycodone MR (OxyContin®) 3:1 conversion e.g. for 50mg methadone, give total daily dose of 150mg OxyContin® as divided dose i.e. 75mg OxyContin® BD
2	Oxycodone MR (OxyContin®) 3-4:1 conversion (depending on clinical presentation, COWS/SOWS/local drug and alcohol review form) E.g. for 50mg methadone, give total daily dose of between 150mg-200mg OxyContin® as divided dose i.e. between 75mg-100mg OxyContin® BD
3	Oxycodone immediate release (Endone®) 4:1 conversion and give one-third of that dose as a single supervised dose immediately prior to Buvidal® administration E.g. for 50mg methadone, give 200mg/3 = ~65mg oxycodone immediate release

1) Methadone washout

- Problem: mandatory withdrawal; anticipatory anxiety.
- Commonly done opportunistically in E.D
  - Patient ceases heroin, attends in withdrawal, buprenorphine commenced (oral or LAIB)

Australian Guidelines (2014) on transferring from methadone to buprenorphine

Overview of Clinical Guidelines for Transferring From Methadone to Buprenorphine
Assessment, treatment planning, and patient education—examine patient expectancies, reasons for transfer, and discuss transfer procedures. Identify, and where possible stabilize, any risks for patient safety during the transfer, including unstable substance use, physical, mental health, or social conditions
Unless urgent transfer required (eg, severe side effects to methadone), gradually reduce methadone dose until patient starts to experience mild to moderate opioid withdrawal between doses
Consider treatment setting: inpatient settings recommended for patients transferring from high methadone doses or significant health comorbidities or unstable social conditions
Cease methadone and monitor the patient regularly (at least daily) for evidence of opioid withdrawal symptoms. Initiate buprenorphine treatment when patient experiencing moderate opioid withdrawal severity (Clinical Opioid Withdrawal Scale [COWS] >12), at least 24 h after last methadone dose
Initiate low-dose buprenorphine treatment (2 mg), and monitor hourly for evidence of precipitated withdrawal, preferably using a withdrawal scale (eg, COWS). Administer further 6 mg after 1 h. Further doses (4 or 8 mg at a time) are symptom-triggered, and continue regular monitoring and dosing until patient comfortable
On subsequent days, buprenorphine dose = previous days dose + additional dose based upon withdrawal severity (symptom triggered)

J Addict Med. 2018 May-Jun; 12(3): 234–240. Published online 2018 May 24. doi: 10.1097/ADM.0000000000000396

PMCID: PMC5976217 | PMID: 29509558

Transferring Patients From Methadone to Buprenorphine: The Feasibility and Evaluation of Practice Guidelines

Nicholas Lintzeris, PhD, Lauren A. Monds, PhD, Consuelo Rivas, RN, Stefanie Leung, PhD, Adrian Dunlop, PhD, David Newcombe, PhD, Carina Walters, MSc, Susanna Galea, PhD, Nancy White, PhD, Mark Montebello, MBBS, Apo Demirkol, PhD, Nicola Swanson, RN, and Robert Ali, PhD

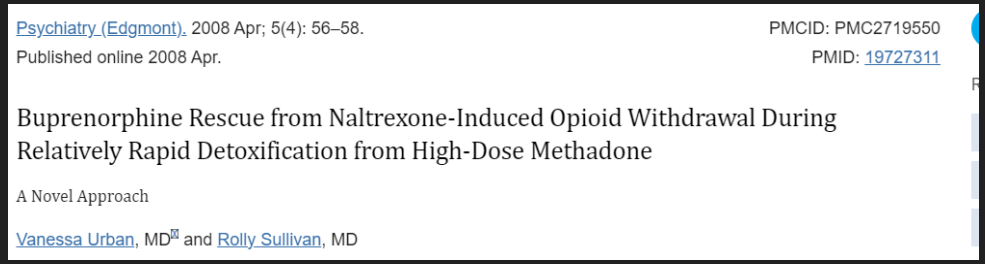
Feasibility of Australian guidelines - Lintzeris et al 2018

- Prospective cohort study (n=33) across 4 sites (Aus/NZ) testing feasibility of Australian Guidelines (Gowing et al 2014) for transfer from methadone - buprenorphine
  - Low dose: methadone <50mg (n=18)
  - High dose: >50mg (n=15)

- Results
  - Successful transfer 26/33 (79%)
  - Unsuccessful mostly (5/7) from high dose methadone group
  - BPN dose on day 1: 42% on 16mg (much higher than prev guidelines)

- Conclusions
  - Feasible to follow guidelines in low doses and some higher doses
  - Alternative methods may be useful for higher doses

2) Naltrexone induced withdrawal with buprenorphine rescue



Psychiatry (Edgmont). 2008 Apr; 5(4): 56–58.
Published online 2008 Apr.
PMCID: PMC2719550
PMID: 19727311

Buprenorphine Rescue from Naltrexone-Induced Opioid Withdrawal During Relatively Rapid Detoxification from High-Dose Methadone

A Novel Approach

Vanessa Urban, MD and Rolly Sullivan, MD

- Case series - 5x patients, 70-130mg methadone per day.
  - Withhold methadone day of transfer
  - Give 25mg naltrexone, withdrawal induced within 45 minutes
  - COWS>10 - give buprenorphine, repeated doses PRN
  - Benefits: rapid transfer (<24 hours)
  - Risk: severe withdrawal

3) Microdosing method (“Bernese Method”)

a) First described in 2010 and 2016 case studies (Hammig et al 2016, Bern, Switzerland)
b) Successfully transferred patients without precipitating withdrawal
c) Modified in studies since, also known as the “Microdosing”/”Modified Bernese” method

“Microdosing” method

The Bernese method

The Bernese method has been the basis of many unique methods of starting buprenorphine. The authors of this method determined the following[24]:

(1) Repetitive administration of very small buprenorphine doses with sufficient dosing intervals (e.g., 12 hours) should not precipitate opioid withdrawal.
(2) Because of the long receptor binding time due to higher affinity, buprenorphine will accumulate at the receptor.
(3) Over time, a greater percentage of the full μ-agonist will be replaced by buprenorphine at the opioid receptor as the dominant opioid.

Advantage

- Minimises severity and duration of withdrawal
- Improved patient comfort

Bernese method - 2016

Subst Abuse Rehabil. 2016; 7: 99–105.
Published online 2016 Jul 20. doi: 10.2147/SAR.S109919
PMCID: PMC4959756
PMID: 27499655

Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method

Robert Hämmig,[1] Antje Kemter,[2] Johannes Strasser,[2] Ulrich von Bardeleben,[1] Barbara Gugger,[1] Marc Walter,[2] Kenneth M Dürsteler,[2] and Marc Vogel[2]

Table 1

Buprenorphine dosing and use of street heroin in case 1

Day	Buprenorphine (sl)	Street heroin (sniffed)
1	0.2 mg	2.5 g
2	0.2 mg	2 g
3	0.8+2 mg	0.5 g
4	2+2.5 mg	1.5 g
5	2.5+2.5 mg	0.5 g
6	2.5+4 mg	0
7	4+4 mg	0
8	4+4 mg	0
9	8+4 mg	0

Evidence for microdosing method

Slowly increasing

- Evidence thus far is based on case series; no RCT's
  - First: Hammig et al 2016 ("Bernese method")
  - Lu and Cho 2018 (oral BPN case series)
  - Terasaki et al 2019 (oral BPN case series)
  - Teck et al 2021 (oral BPN case series)
  - Moe et al 2021 (SR on effectiveness)
  - Menard and Jhawar 2022 (transdermal BPN case series)
  - Lintzeris et al 2022 (SR on transfer strategies, outcomes)
  - Naren et al 2024 (coHealth)
  - Praeger et al 2024 (Turning Point)

Using Microdosing to Induct Patients Into a Long-Acting Injectable Buprenorphine Depot Medication in Low Threshold Community Settings: A Case Study

Joseph Tay Wee Teck[1,2]*, Alexander Baldacchino[1,2], Lauren Gibson[3] and Con Lafferty[3]

Frontiers in Pharmacology | www.frontiersin.org

March 2021 | Volume 12 | Article 631784

TABLE 1 | Examples of various buprenorphine microdosing schedules.

	Day	1	2	3	4	5	6	7	8	9	10	11
1. Bernese method (20)	Dose (mg)	0.2	0.2	0.8 + 2	2 + 2.5	2.5 bd	2.5 + 4	4 bd	4 bd	8 + 4	Titrate PRN	
2. Terasaki et al. (2019) (20)	Dose (mg)	0.5	0.5 bd	1 bd	4 bd	8	8 + 4	12		Titrate PRN		
3. VCH (22)	Dose (mg)	0.25	0.25 bd	0.5 bd	1 bd	2 bd	4 bd	12		Titrate PRN		
4. Lu & Cho (2018) (22)	Dose (mg)	0.5 bd	1 bd	2 bd	3 bd	4 bd	12	16		Titrate PRN		
5. Used in this study	Dose (mg)	0.4	0.4	0.8	1.2	1.6	1.6	2	4	6	8–12	16

VCH, Vancouver Coastal Health bd twice a day. PRN as required.

In microdosing method 1 and 5, the patient tapers down on their full agonist on day 7 to a full stop by day 11. In methods 2,3 & 4, cessation of the full agonist should happen on day 7.

TABLE 3 | Summary of patient characteristics and case histories.

Case Number	Gender	Age (years)	Primary opioid/s daily use	Reason for patient selection	Microdosing regime start to first depot (Days)	Depot buprenorphine dose and frequency
1	M	36	Methadone 75 mg Prescribed	Treatment failure with sublingual buprenorphine, methadone and naltrexone implant	14	96 mg monthly
2	M	45	Heroin 0.5–1 g inhaled	Treatment failure on both sublingual buprenorphine and methadone. Required to shield due to severe COPD.	19	96 mg monthly
3	F	51	Heroin 0.5–1 g snorted	Treatment failure on both sublingual buprenorphine and methadone. Frequent disengagement from services due to employment. Required to shield due to severe COPD.	8	96 mg monthly
4	M	42	Heroin IV 1 g and methadone 80 mg prescribed	Treatment failure with methadone and with residential rehabilitation. Multiple deliberate and accidental overdoses. Due to polysubstance use and pandemic restrictions, struggled with regular pharmacy attendance. HIV positive with ongoing IVDU.	13	128 mg monthly
5	M	46	Heroin IV 1 g, and methadone 40 mg prescribed	Treatment failure with methadone. Frequent episodes of acute renal colic resulting in a need for A/E admission and analgesia, disrupting dose collection at pharmacy. Difficulty in ceasing IVDU. HIV positive	13	128 mg monthly

M- Male F- Female. COPD- Chronic Obstructive Pulmonary disease. HIV- Human Immunodeficiency Virus. mg-milligram. g-grams. IVDU- intravenous drug use.

Australian Guidelines on microdosing method

Australian National Guidelines (Gowing et al 2014)

- Precede microdosing method

State guidelines

- Victoria (last update July 23): no specific Victorian guidelines on the microdosing method

- NSW (Interim Clinical Guideline, April 2023)
  - Expert consensus
  - Higher dose (>40mg) = use microdosing method
  - Lower dose (<30mg) = use washout method

NSW GOVERNMENT | Health

Interim Clinical Guidance:

Outpatient Transfer from Methadone to Buprenorphine Using the Micro-dosing or Bridging Methods

Day	Methadone dose	Buprenorphine dose	Throughout
0	X mg	0 mg	COWS Symptomatic relief* Support + encouragement
1	X mg	0.2 mg BD or 0.4 mg mane	
2	X mg	0.4 mg BD	
3	X mg	2 mg	
4	X mg	4 mg	
5	X mg	8 mg	
6	½X mg	16 mg	
7	¼X mg	16-32 mg Clients may commence depot buprenorphine weekly at this point (optional). See *Brief Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence*	

X = client's current methadone dose

*For example:

- Clonidine 50mcg up to QID PRN - clients should take while seated, and avoid if dizzy/light-headed
- Ondansetron 8mg up to BD PRN

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DOI: 10.1111/dar.13826

CASE SERIES

Drug and Alcohol Review | ADSAD | WILEY

Buprenorphine microdosing regimen using transdermal buprenorphine patches to transition from methadone to buprenorphine

Thileepan Naren[1,2,3] | Jon Cook[1] | Paul MacCartney[1,2] | Dean Membrey[1,2]

- coHealth Innerspace; Jan 2020- June 2023.
- All patients (n=32) transitioning from methadone to BPN using transdermal BPN patches (off-label)
- Detailed 28 day protocol (next page)
- Pharmacy daily, given takeaways for 2nd dose when indicated.

TABLE 1 Methadone to buprenorphine transition plan.

Day	Transdermal buprenorphine patch (mcg/h) site 1	Transdermal buprenorphine patch (mcg/h) site 2	Methadone	Sublingual buprenorphine
1–3	10		Usual dose	
4	10	10	Usual dose	
5–7	10	10	Usual dose	
8	20	10	Usual dose	
9–10	20	10	Usual dose	
11	20	20	Usual dose	
12–14	20	20	Usual dose	
15	40	20	Usual dose	
16–17	40	20	Usual dose	
18	40	40	Usual dose	
19–20	40	40	Usual dose	
21	40—Remove in the evening	40—Remove in the evening	Usual dose	
22	0	0	Usual dose	2 mg BD
23	0	0	Usual dose	2 mg TDS
24	0	0	Usual dose	2 mg QID
25	0	0	Usual dose	4 mg TDS
26	0	0	May attempt to cease	8 mg BD
27	0	0	May attempt to cease	16 mg mane, 8 mg nocte
28	0	0	Cease	24–32 mg daily

Note: Commence long-acting injectable depot buprenorphine once dose stabilised if indicated.
Abbreviations: BD, twice a day; mane, morning; nocte, night time; QID, four times a day; TDS, three times a day.

-Methadone not reduced until *day 26* (when BPN dose 16mg daily)

TABLE 2 Patient characteristics utilising transdermal buprenorphine patch microdose regimen.

Case no.	Sex	Opioid use	Opioid withdrawal symptoms	Sublingual and LAIB transition	Successful transition	Retention in treatment[a]
1	F	MTD 30 mg	Nil	Buvidal monthly 64 mg	Yes	Yes
2	M	MTD 50 mg	Mild (emotional lability, myalgia)	Buvidal monthly 96 mg	Yes	Yes
3	M	MTD 40 mg	Nil (aborted initial attempt due to concurrent illness)	Buvidal monthly 96 mg	Yes	Yes
4	F	MTD 75 mg + heroin	Nil	Buvidal monthly 128 mg	Yes	Yes
5	M	MTD 40 mg + heroin	First attempt aborted due to stress, second attempt no withdrawal symptoms	Buvidal monthly 96 mg	Yes	Yes
6	M	MTD 70 mg + heroin	Tolerated patches, dosed sublingual doses, felt withdrawal symptoms with LAIB	Buvidal monthly 64 mg	Yes	Yes (continued on MTD)
7	M	MTD 25 mg + heroin	Nil	Buvidal monthly 96 mg	Yes	Yes
8	M	MTD 40 mg	Nil	Buvidal monthly 64 mg	Yes	Yes
9	M	MTD 60 mg	Tolerated process until self-ceased		No	Yes (continued on MTD)
10	F	MTD 80 mg	Lowered mood—self ceased		No	Yes (continued on MTD)
11	M	MTD 70 mg	Described sudden onset WD symptoms on placement of second 40 mcg/h		No	Yes (continued on MTD)

- Results
  - 23/32 (70%) patients successfully transferred
  - Of the 9 unsuccessful: 3 were due to withdrawal, all 9 retained in methadone treatment
  - No medication for symptomatic treatment used (eg benzos, clonidine)

- Important features
  - Patch = more *gradual* increases in BPN vs when using sublingual BPN.
  - Methadone ceased much later than in other protocols

- Conclusion
  - Largest case series on transdermal BPN
  - Gradual onset of patch decreases risk of precipitated withdrawal
  - Outpatient = more scalable
  - Late methadone cessation (day 26) = safety net against treatment cessation
  - My thought; too long for certain patients (some benefit from rapid switch)

BRIEF REPORT

Drug and Alcohol REVIEW APSAD WILEY

Rotation from methadone to buprenorphine using a micro-dosing regime in patients with opioid use disorder and serious mental illness: A case series

Vivian C. Praeger[1] | Matthew Y. Frei[1] | Dan Pham[1] | Adrian J. Praeger[2,3] | Dan I. Lubman[1,4] | Shalini Arunogiri[1,4]

- Retrospective case series (n=16) Jan 2021-July 2022
- Methadone (avg dose 82mg) transfer to BPN *in patients with "serious mental illness"* ("serious functional impairment)
- Dosing regime not in paper
- Results
  - Withdrawal: 12 had mild withdrawal (COWS <12); 2 moderate (12-24) prior to first BPN dose, improved after dose.
  - 88% successful, median transfer time 6.5 days for inpatients, 10 days for outpatients. All patients ended up on LAIB.
  - 93% reported experience as "manageable". 1 patient precipitated withdrawal
  - **Conclusion: negligible risk, likely to be tolerated by patients with SMI, unlikely to exacerbate mental illness**

TABLE 1 Characteristics of study participants ($n = 16$).

Demographics	
Sex: female/male (%)	8/8 (50%/50%)
Age, years—mean (SD)	41 (6.1)
Daily methadone, mg—mean (SD), range	82 (29), 35–130
Mental health characteristics	
Mental health diagnosis	16 (100%)
Psychotic disorders[a]	5 (31%)
Schizophrenia[b]	2 (13%)
Drug-induced psychosis[b]	2 (13%)
Bipolar-I-disorder[b]	1 (6%)
Major depressive disorder[a]	7 (44%)
Generalised anxiety disorder[a,d]	5 (31%)
Post-traumatic stress disorder[a]	10 (63%
Borderline personality disorder[a]	5 (31%)
Substance use disorder characteristics	
Nicotine use disorder	14 (88%)
Regular illicit opioid (heroin) use	9 (56%)
Substance use disorder (other than opioids and nicotine)	11 (68%)
Methamphetamine[b]	7 (44%)
Cannabis[b]	6 (38%)
Alcohol[b]	2 (13%)

4) Microdosing via IV

Micro-dosing Intravenous Buprenorphine to Rapidly Transition From Full Opioid Agonists

Ashish P. Thakrar, MD, Lindsay Jablonski, PharmD, BCPS, Jessica Ratner, MD, and Darius A. Rastegar, MD

(*J Addict Med* 2022;16: 122–124)

- Why IV? No other formulation available in their hospital
- 2 patients
  - First: 65mg methadone, 5 days, discharged on suboxone 24mg
  - Second: hydromorphone + endone, 4 days, discharged on suboxone 16mg

Risks of a transfer

- Precipitated withdrawal (higher affinity, lower intrinsic activity)
- Destabilize otherwise opiate stable patient
- Acute deterioration of a fragile mental state
- Discharge during transfer, use of heroin to compensate, increased overdose risk
- Post transfer mental state deterioration
- Some patients simply do better on methadone

Microdosing method

Risk mitigation

Treatment planning
- Full biopsychosocial assessment
- Assess motivation, distress tolerance, personality
- Their expectations and understanding of the process
- Reassure them that it is *not irreversible*

Setting of transfer: consider inpatient admission for patients
- On high doses of methadone
- With significant physical or psychiatric comorbidities
- Intense anxiety, impaired distress tolerance, impulsivity, polysubstance use
- Unstable social conditions

Stabilize risks
- Unstable substance use
- Physical and mental health
- Social conditions

Case - transfer regime

Day	Buprenorphine	Methadone
1	0.8mg	120mg
2	2mg	120mg
3	4mg	120mg
4-8 (Thurs-Sun)	6mg (split: 4+2)	120mg
9	8mg (split: 4+4)	120mg
10	16mg (split: 8+8)	60mg
11	24mg (split: 16+4+4)	30mg
12	32mg (split: 24+4+4)	0
13	160mg SC (monthly)	0

Footnote to go here

Summary

1) Methadone washout
- Good for low doses, less complex patients

2) Microdosing method:
- Relatively new; reduces and sometimes completely eliminates withdrawal
- Particularly useful for high dose transfers, unstable patients
- Likely to become more common given advantages of buprenorphine
- Need to pick patients and setting carefully

3) Future trials required to optimise protocols

Questions and comments

Jill

- 70F, mother of 2, extremely isolated. Prolonged childhood neglect and protracted sexual trauma. No psychiatric diagnoses or care. Heroin for 55 years, heroin dealer. Methadone 40-50mg for many years. Fearful of losing capacity to inject heroin as she ages.
- First experience with heroin at 15 - “like a kind grandmother putting a warm blanket around me for the first time”.

    - Attempted Buvidal transfer as an outpatient (cessation, 24mg weekly LAIB x2)
    - Flooded with repressed traumatic memories, affects (shame, despair, profound loneliness)
    - “I’m so alone…how could my mother do that to me…make it go away”
    - Returned to heroin use, but opted not to recommence methadone

Case #1 - Jill

- Wants to try again
- Is this a good idea?

- Better plan
  - Inpatient
  - More psychological support before and after

- Questions
  - ?intensive dynamic work
  - ?medication to blunt her affect
  - ?how to replace the warm blanket
  - ?stay on methadone for the rest of her life

Questions and comments