Opioid Pharmacotherapy for Young People.

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OPIOID PHARMACOTHERAPY FOR YOUNG PEOPLE

If you work in the youth services sector, you may come across young people (aged 12-25) who use opioids and may be dependent – and you might be wondering what treatment looks like for them.

Treatment can include pharmacotherapy.

As opioid dependency and treatment is more common in older age groups[1], those working in the youth services space may be less familiar with pharmacotherapy as a treatment option.

This guide provides an overview of opioid pharmacotherapy, including:

- how it works
- pathways to accessing it
- barriers to treatment.

This guide is designed to inform anyone working in the youth sector, and it will also be useful to community members interested in understanding opioid pharmacotherapy.

What is pharmacotherapy?

Pharmacotherapy is the treatment of health conditions by using pharmaceutical products (drugs) as medication.[2]

When the health condition is a drug dependency, pharmacotherapy involves replacing the drug of dependence with a legally prescribed substitute.

The use of prescribed pharmaceuticals can help as part of a comprehensive treatment plan. Medications are used to help reduce the intensity of withdrawal symptoms, drug cravings and the likelihood of use.[3]

Opioid pharmacotherapy is the use of medications, combined with counselling and behavioural therapies, to treat opioid dependence.

Other names used for opioid pharmacotherapy include:

- Medication Assisted Treatment for Opioid Dependence (MATOD)
- Opioid Substitution Treatment (OST)
- Opioid Maintenance Program (OMT)
- Opioid Replacement Therapy (ORT)
- Opioid Agonist Medication (OAM)
- Opioid Agonist Treatment (OAT).

Opioids in Australia

Opioids include any natural or synthetic drugs that are derived from, or related to, the opium poppy.

Opioids include certain types of painkillers known as 'opioid pain medications', and illegal drugs, such as heroin.

Some of the most common opioids are:

- codeine (Nurofen Plus®, Panadeine Forte®, Mersyndol®)
- fentanyl (Sublimaze®, Actiq®, Durogesic®)
- heroin
- morphine (MS Contin®)
- opium
- oxycodone (Oxynorm®, OxyContin®, Endone®).

Most harms associated with opioids are usually from the use of illegal opioids (such as heroin) or pharmaceutical opioids (such as oxycodone) used in ways other than prescribed. This is known as 'extra-medical' use.[4]

KEY STATISTICS

- Every day in Australia, nearly 150 hospitalisations and 14 emergency department (ED) presentations involve opioid harm.[5]
- In 2019, opioids were present in 3 in 5 drug-induced deaths (60.5% or 1,129 deaths).[6]
- In 2019, 53% of opioid deaths were attributed exclusively to pharmaceutical opioids, 32% to illicit opioids and 11% to both illicit and pharmaceutical opioids.[7]
- On a snapshot day in 2020, over 53,300 clients received pharmacotherapy treatment for their opioid dependence at 3,084 dosing points across Australia.[1]

Medications used in opioid pharmacotherapy

Methadone and buprenorphine are the two main medications used to treat opioid dependence.

According to research and clinical experience, methadone and buprenorphine are safe and effective in the treatment of opioid dependence.[8] Both are listed as World Health Organization essential medicines.[9]

Whether somebody will begin their pharmacotherapy treatment on methadone or buprenorphine is a joint decision made by themselves and their prescribing doctor.

A third medication that can be used is Naltrexone, which blocks the effects of opioids completely – rather than acting as a substitute. It can only be prescribed to prevent relapse for someone who has become free of opioids.

Naltrexone is a less common treatment option, as remaining opioid-free can be difficult for people who have experienced long-term use.[10] It is a medication that is more commonly prescribed to treat alcohol dependence.

Due to its infrequent use as an opioid treatment option in Australia, this mini bulletin does not include a discussion of naltrexone.

METHADONE

Methadone is the oldest treatment approach for opioid pharmacotherapy.

It is a full agonist opioid, which means that higher doses will provide stronger effects. Like any other opioid medication, it can cause overdose if more than the prescribed dose is taken. This is more likely if the person has a low opioid tolerance, or if it is taken with other drugs.[10]

Methadone is available in liquid form to reduce the potential for diversion ('extra-medical' use). Two preparations are registered for the treatment of opioid dependence in Australia – Methadone Syrup and Biodone Forte.[11]

Generally, there are two types of methadone programs that people might engage with:

- **Withdrawal (short-term detoxification programs)**
  Runs for approximately 5-14 days and is usually carried out in a residential withdrawal (detox) unit or home-based withdrawal. Aims to ease the discomfort of stopping the use of opioids.
- **Maintenance (long-term programs)**
  Can last for months or several years. Aims to reduce the harms associated with opioid use and improve a person's quality of life.[12]

In long-term methadone programs, the person attends a daily dosing point at a private or public clinic, or a community pharmacy. The pharmacist will dilute the methadone liquid in some water, and then the person will take their dose under the supervision of the pharmacist. The person is charged a dispensing fee.

It is possible for some people to obtain takeaway or unsupervised doses of methadone if considered appropriate and beneficial following assessment with the prescribing doctor.

This will be based on factors such as:

- whether they have a safe place to store the medication at home
- whether there is any risk of the medication being diverted
- following a period of pharmacotherapy to determine a stable and suitable dose for treatment.[10]

A person's prescribing doctor or nurse practitioner can be contacted to discuss approval for takeaway doses.[10]

BUPRENORPHINE

Buprenorphine is a newer pharmacotherapy treatment and acts as a partial agonist. This means it still produces opioid effects but it is not as strong as a full agonist like methadone.

Buprenorphine has a ceiling effect, where its effects reach a maximum level and cannot be increased further even if more doses are taken.[10] Many people who start on methadone treatment may transition to buprenorphine at some point (and sometimes vice versa).

The first two formulations of buprenorphine in Australia are sublingual (taken under the tongue), and include:

- **Suboxone Sublingual Film®** – a combination of buprenorphine and naloxone (also known as Narcan®) on a film strip that is dissolved under the tongue or inside the cheek. This is the most widely used form.[13]
- **Subutex Sublingual Tablets®** – tablets contain buprenorphine only and must be dissolved under the tongue.[14]

Like methadone, the person undergoing treatment is required to attend a daily dosing clinic to receive their medication and is charged a dispensing fee. Again, takeaway doses will depend on:

- whether they have a safe place to store the medication
- whether there is any risk of the medication being diverted[10]
- following a period of pharmacotherapy to determine a stable and suitable dose for treatment.

LONG-ACTING INJECTABLE BUPRENORPHINE (LAIB)

In 2019, two forms of Long-Acting Injectable Buprenorphine (Buvidal® and Sublocade®) were also made available in Australia. Restrictions were further eased in 2020 to allow prescribers who do not work at specialist AOD clinics to also prescribe.

LAIB is provided as weekly or monthly injections under the skin, which slowly release the buprenorphine into the body. This keeps the person stable for an extended period of time.[4]

This new form of buprenorphine overcomes some of the challenges people experience from the daily dosing requirements associated with methadone or sublingual buprenorphine.

These challenges include:

- inability of client to attend daily dosing schedules due to location or lifestyle burdens
- the stigma patients experience attending clinics or pharmacies daily
- the costs associated with daily dispensing fees
- potential diversion and inappropriate use of the medication
- accidental exposure of takeaway doses to others (e.g. young children in the house).[15]

With LAIB treatment, the person only needs to present at their dosing point weekly or monthly for their injection, and no takeaway doses are required. This helps to reduce the potential limitations listed above. Although LAIB is relatively new in Australia, there is a growing body of evidence to show it is a safe and effective treatment for opioid dependence.[15, 16]

How does opioid pharmacotherapy help people?

When a person begins pharmacotherapy treatment, the aim is to replace the opioids they have been using with buprenorphine or methadone.

Both medications:

- reduce the euphoric effects of opioid use
- reduce opioid withdrawal symptoms
- control or eliminate cravings
- make the person generally feel more 'normal'.

This allows people to stabilise and live more productive lives through improved:

- physical and mental health
- social functioning and relationship maintenance
- ability to gain and maintain employment.[10]

For some people, the long-term goal may be to stop using opioids completely.

For others, pharmacotherapy may not be about stopping completely, but rather, addressing health concerns and risk behaviours associated with opioid use. For example, reducing:

- the risk of HIV and other blood borne virus infections associated with injecting drug use
- the likelihood of overdose
- criminal behaviour associated with acquiring illegal opioids.[10, 17]

Some people will require lifelong treatment for their opioid use, and pharmacotherapy should be provided in addition to psychosocial supports such as mental health, financial, housing, food stability and relationships.[10]

People should also be actively offered counselling services in combination with their pharmacotherapy treatment, which can have a significant impact on improving outcomes.[10]

Naloxone

Naloxone is a drug that can temporarily reverse an opioid overdose. Opioids affect the part of the brain which regulates breathing. When a person overdoses, they risk going into severe respiratory depression, which can lead to death.[18] Symptoms of an opioid overdose include:

- cold, clammy skin
- small pupils
- decreased awareness or responsiveness
- slow or irregular heartbeat
- slowed breathing
- falling asleep 'going on the 'nod'[19, 20]

Although it is not a pharmacotherapy treatment, as a precaution naloxone should be made available to anyone who is accessing pharmacotherapy for opioid use, including friends and family members.

Naloxone can be injected intramuscularly (into a muscle) or delivered by an intranasal spray (into the nose). It can be administered by medical professionals, such as paramedics or nurses, as well as family, friends, or bystanders in an emergency when someone has overdosed.

WHO CAN ACCESS NALOXONE?

In 2019, the Australian Government introduced the take home naloxone pilot. Under this program, naloxone has been made available free of charge and without a prescription in New South Wales, South Australia and Western Australia. This includes in locations such as:

community and hospital-based pharmacies

- alcohol and other drug treatment centres
- needle and syringe programs
- custodial release programs
- GP clinics.[21]

Elsewhere, naloxone is available in all states and territories with a prescription, or over the counter from a pharmacy, for a fee. However, Victoria and Tasmania have recently introduced free naloxone access through needle and syringe (NSP) programs.

Victoria: https://www.cohealth.org.au/health-services/drugs-and-alcohol/naloxone/

Tasmania: http://www.premier.tas.gov.au/releases/free_take-home_naloxone_trial_will_save_lives

Anyone can administer naloxone. It is easy to use, and instructions are included with each product.

You can speak to prescribing pharmacists or alcohol and other drug (AOD) service providers for information and training on how to use it.

ARE THERE ANY SIDE EFFECTS?

Most side effects from naloxone are mild. Naloxone cannot be used to get high, so it has no potential for non-prescribed use. There is no evidence that extended use of naloxone can cause harmful physical effects or dependence.[22]

While there is no risk of poisoning from naloxone, administering a high dose to someone who has taken an overdose can lead to sudden withdrawal symptoms due to the opioid effects being blocked.

This can be highly unpleasant and disorientating for a person when they regain consciousness[22], sometimes leading to confusion and aggression.[23] Anyone administering naloxone should be aware of this possible reaction, and treat the person calmly and with care.

The person may also feel the urge to rapidly take opioids again to counteract withdrawal symptoms, which can increase the chance of a second overdose.[22]

The effects of naloxone only last for a short period of time. If you administer naloxone to someone experiencing an opioid overdose – you should also call the ambulance so the paramedics can assess whether another dose might be required.

More information

- https://www.health.gov.au/initiatives-and-programs/take-home-naloxone-pilot
- https://www.penington.org.au/report-naloxone-access/
- https://overdoselifesavers.org/
- https://addictionconcepts.files.wordpress.com/2021/01/thn_report_digital_final.pdf

Barriers to access

There are identified barriers to accessing opioid pharmacotherapy in Australia, particularly relevant in rural and remote regions.

Some of these barriers can be addressed using LAIB instead of methadone or sublingual buprenorphine.

Barrier	Why?	Addressed by LAIB?
Geographical /lifestyle	People experiencing opioid dependency may have living situations which make it difficult to visit a pharmacy daily. This might include: • lack of service providers in their area • travel costs, and time spent getting to and from dispensing point • restrictiveness or lack of freedom with regular dose collection • inflexible work conditions that cannot accommodate time away.[17]	Yes – because LAIB doses only require weekly or monthly injections. The client does not have to attend a clinic or pharmacy daily.
Costs	Like most medications, methadone and buprenorphine are subsided under the Pharmaceutical Benefits Scheme (PBS). However, private dispensing charges are allowed by state and territory governments through pharmacists and doctors. This can cost a patient around $35-$50 a week if they are receiving daily doses. This cost compares with approximately $6.00 per monthly script for someone with a healthcare card who requires ongoing treatment and medication for any other chronic condition. Dispensing fees are a major barrier to people remaining on pharmacotherapy treatment. They present a significant financial burden for clients on fixed income, disability benefits or welfare support.[17, 24]	Yes – patients will still be charged dispensing fees, however, it would be on a weekly or monthly basis, as opposed to daily. This results in a significant cost reduction.
Stigma	Many people accessing pharmacotherapy experience stigma in a number of different ways, which can turn them away from treatment. This includes stigma from: • family and friends • employees in pharmacies or clinics where methadone or buprenorphine is dispensed, as well pharmacotherapy prescribers and GPs • the community – this can be intensified if the person is living in a small town where anonymity is limited.[17]	Yes – only having to attend a dosing point on a weekly or monthly basis can remove daily interactions at a pharmacy, clinic or with a doctor – where a person may feel stigmatised. This reduces opportunities of 'being seen' in the community.
Lack of additional support	People who are opioid dependent may have multiple and complex issues, for example: housing, legal, employment and mental health.[10] It is important that people receiving pharmacotherapy treatment are provided wrap around support services if they present with complex issues - the lack of such support can result in a barrier to remaining on treatment.[10, 17]	Some people may benefit from the daily interaction associated with attending a pharmacy. The reduction in health care interaction needs to be considered when prescribing monthly LAIB.

Accessing opioid pharmacotherapy for young people

Although opioid use is less common in younger age groups, there are still young people who will present to community counselling and outreach services, detox clinics, residential rehabilitation and other youth services with opioid use and dependency issues. In most cases, the young person is likely to be using other drugs in combination with opioids.

If a young person wishes to access pharmacotherapy, they will need to be put in contact with a prescribing doctor. Some organisations will have an overdose prevention team, or equivalent, who specialise in being able to locate opioid pharmacotherapy prescribers. Alternatively, individual workers may have to locate prescribers themselves. Workers can call doctors on behalf of the young person and schedule appointments.

There are a number of specific barriers youth AOD workers and their young person might face when trying to access opioid pharmacotherapy, such as:

- Difficulty locating a prescriber: This includes being able to find a close prescriber and also finding one suitable to the young person's current situation (e.g. one that is close enough to where they live, as a young person may not have transport options).
- Unwillingness to prescribe: Even if a suitable prescriber is located, some doctors may be hesitant to prescribe methadone or buprenorphine to a young person because of their age, and the stigma attached to people who suffer from opioid dependency.
- Dosing: If a prescription is approved, correct dosing can still be a challenge. Again, a doctor may be wary of the young person's age and unwilling to approve a larger dose – even if it's required to better stabilise the young person.

Internal stigma can also impact a young person's personal decision to go on opioid pharmacotherapy, as opioids are largely considered by society as an 'adult drug'. Therefore, the need for pharmacotherapy can be difficult for a young person to accept.

This section was informed by expert insight from Uniting Vic & Tas and Odyssey House Victoria.

Help and support

If you're unsure whether a client is suitable for opioid pharmacotherapy, seek secondary consult from the AOD clinical leads within your organisation, or from an AOD service provider. Alternatively, speak directly to an accredited doctor.

For further help, information and advice, see the table below. These numbers are available to all members of the community.

State	Pharmacotherapy advice mediation support	Alcohol and Drug Information Service (ADIS)
ACT	N/A	02 5124 9977
NSW	Opioid Treatment Line: 1800 642 428	1800 422 599
NT	N/A	1800 131 350
QLD	QPAMS: 1800 175 889	1800 177 833
SA	N/A	1300 131 340
TAS	N/A	1800 250 015
VIC	PAMS: 1800 443 844	(Directline) 1800 888 236
WA	Community Pharmacotherapy Program: (08) 9219 1907	1800 198 024

Additional Information

For people thinking about going on pharmacotherapy, Harm Reduction Victoria has made a series of four videos to assist with this decision-making process.

- Changing Lanes (HRV):
  https://www.hrvic.org.au/changing-lanes-video
  https://www.hrvic.org.au/pharmacotherapy-video-project

The Association of Participating Service Users (APSU), a service of the Self-Help Addiction Resource Centre (SHARC), has also created two podcasts on the impact of COVID-19 on pharmacotherapy, combining the real-life experiences of people with the perspectives of professionals.

- Straight From the Source:
  https://apsupodcast.libsyn.com/

Penington Institute's Community Overdose Prevention Education (COPE) program works with any organisation whose clients include people who use opioids and/or people who may witness an overdose.

Community Overdose Prevention Education (COPE) program:
https://www.penington.org.au/cope-overdose-first-aid/

The Drug Overdose Prevention/Peer Education (DOPE) program has delivered peer-based overdose education to illicit drug users since 1999. Overdose training sessions are available for staff and clients.

Drug Overdose Peer Education (D.O.P.E):

https://www.hrvic.org.au/d-o-p-e

https://apsupodcast.libsyn.com/

Clinical guidelines

Australia has national guidelines outlining the broad policy context and framework for opioid pharmacotherapy. The guidelines aim to promote a national standard for opioid pharmacotherapy treatment, while also recognising the different jurisdictional approaches.

Most states and territories also have their own publicly available clinical guidelines, as well as a separate guidelines document for LAIB (due to its recent introduction as a treatment option).

These documents are useful for health and medical professionals seeking clinical advice – but can also be useful to the broader community. Links are provided to each document below.

National:

- National Guidelines for Medication-Assisted Treatment of Opioid Dependence - https://www.health.gov.au/sites/default/files/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence.pdf

Australian Capital Territory:

- Opioid Maintenance Treatment in the ACT: Local Policies and Procedures - https://www.health.act.gov.au/sites/default/files/2018-09/Opioid%20Maintenance%20Treatment%20in%20the%20ACT%20-%20Local%20Policies%20and%20Procedures%202018.pdf
- Buprenorphine depot products: Information for pharmacists and prescribers - https://www.health.act.gov.au/sites/default/files/2020-02/Depot%20buprenorphine.pdf

New South Wales:

- NSW Clinical Guidelines: Treatment of Opioid Dependence 2018 - https://www.coordinare.org.au/assets/Main-Site/Uploads/Resources/resources/a90aefbdc2/NSW-Clinical-Guidelines-Opioid-Dependence.pdf
- Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence - https://www.health.nsw.gov.au/aod/Publications/full-depot-bupe-interim-gl.pdf

Northern Territory:

- Northern Territory Department of Health: Medicines and Poisons https://health.nt.gov.au/professionals/medicines-and-poisons-control2/medical-practitioners-schedule-8-medicines

Queensland:

- Queensland Medication-Assisted Treatment of Opioid Dependence: Clinical Guidelines 2018 - https://www.health.qld.gov.au/__data/assets/pdf_file/0032/718952/qld-matod-clin-gdln-2018.pdf
- Long-Acting Injection Buprenorphine in the Treatment of Opioid Dependence Queensland Clinical Guidelines: 2019 - https://www.health.qld.gov.au/__data/assets/pdf_file/0032/932684/lai-bpn-clinical-guidelines.pdf

South Australia:

- Medication assisted treatment for opioid dependence (MATOD) – Prescribing resources https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+programs+and+practice+guidelines/substance+misuse+and+dependence/drug+and+alcohol+programs/medication+assisted+treatment+for+opioid+dependence+%28matod%29+prescribing+resources
- Interim Brief Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence for South Australian Community MATOD prescribers - https://www.sahealth.sa.gov.au/wps/wcm/connect/20f2a107-51b6-4006-a7cc-fd07b11ffc90/brief-depot-bupe-interim-guidelines+for+South+Australia+Community+prescribers+2020+11+24.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-20f2a107-51b6-4006-a7cc-fd07b11ffc90-nwKLcLT

Tasmania:

- Tasmania Opioid Pharmacotherapy Program – Policy and Clinical Practice Standards - https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0018/112527/2012_TOPP_Document.pdf

Victoria:

- Pharmacotherapy policy in Victoria - https://www2.health.vic.gov.au/public-health/drugs-and-poisons/pharmacotherapy/pharmacotherapy-policy-in-victoria

Western Australia:

- Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence - https://www.mhc.wa.gov.au/media/1614/wa-clinical-policies-and-procedures-for-the-use-of-methadone.pdf
- Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence for Western Australian CPOP prescribers - https://www.mhc.wa.gov.au/media/3616/clinical-guidelines-for-use-of-depot-buprenorphine-in-wa.pdf

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