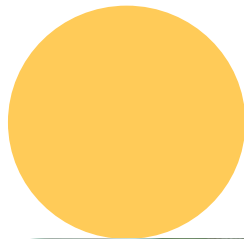


# Opioid Pharmacotherapy.

Published: July 2025



If you work in the health and community sectors, you may come across people who use opioids and are dependent on them – and you might be wondering what the different treatment options look like.

One of the more common and successful treatments in Australia is pharmacotherapy.

This guide provides an overview of opioid pharmacotherapy, including:

- how pharmacotherapy works
- barriers to treatment
- considerations for young people
- considerations for pregnant people
- pathways to access pharmacotherapy.

It's designed to inform anyone working with people who are dependent on opioids and is also useful for anyone interested in learning more about opioid pharmacotherapy.

After reading this, you'll know more about the various pharmacotherapy options and how to support people who are dependent on opioids to access pharmacotherapy, if they choose to.

## What is opioid pharmacotherapy?

Pharmacotherapy is the use of medications to treat health conditions.<sup>1</sup>

For people experiencing drug dependence (addiction), pharmacotherapy - as part of a comprehensive treatment plan - helps to reduce withdrawal symptoms, drug cravings and likelihood of use.<sup>2</sup>

Pharmacotherapy for opioid dependence involves prescribing long-acting opioids (buprenorphine, methadone) to replace shorter-acting opioids (heroin, oxycodone, fentanyl), that lead to serious harms for some people.<sup>3</sup>

So, while a person who enters a pharmacotherapy program for opioid dependence remains dependent on opioids, the program helps them stop or reduce their use of shorter-acting opioids and, as a result, reduce their risk of related harms.

Outcomes from opioid pharmacotherapy are best when combined with tailored psychosocial supports that meet a person's wants and needs. These supports can include housing, food, financial, employment, support groups, counselling and behavioural therapies.<sup>3</sup>

Pharmacotherapy programs can continue for many years and should not be terminated unless requested by the patient.<sup>3</sup>

Other names used for opioid pharmacotherapy include:

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

*There is no national agreement on which terminology should be used. For this resource, we will use the term opioid pharmacotherapy program.*



In Australia, there are two main types of opioid pharmacotherapy programs:

- **Medication-assisted withdrawal (short-term detoxification programs)**

Usually runs for 10 days or less, at an in-patient treatment service. It should always be followed by ongoing treatment and support.<sup>3</sup> Aims can include transitioning onto or switching opioid pharmacotherapies, having a break from heroin or other opioid use, or stopping opioid use completely (abstinence). Programs sometimes require the person to start an opioid pharmacotherapy program before they can attend the detox.

- **Maintenance (long-term programs)**

Can last for several months or years. This is the most common pharmacotherapy program, with strong evidence that longer-term treatment can reduce harms and improve health and wellbeing. Many people transition to a maintenance program after completing a medication-assisted withdrawal.<sup>3</sup>

People may choose to transfer to a maintenance program after completing withdrawal (and vice versa), in consultation with their doctor.

### KEY STATISTICS - OPIOID PHARMACOTHERAPY

- On a snapshot day, 55,741 people receive opioid pharmacotherapy, a rate of 21 clients per 10,000 people.<sup>4</sup> This rate has stayed stable since 2011.<sup>4</sup>
- Approximately 86% of all clients were in New South Wales, Victoria or Queensland.<sup>5</sup>
- 2 in 3 identify as male.<sup>6</sup>
- The median age is 45 years, up from 28 years in 2011.<sup>6</sup>
- 1 in 10 (12%) identify as Aboriginal and Torres Strait Islander.<sup>6</sup>

## Opioids in Australia

Opioids are any drug that acts on the opioid receptors in the brain and body, and any natural or synthetic drug that is derived from, or related to, the opium poppy.<sup>7</sup>

They include certain types of painkillers, known as opioid pain medications, as well as illegal drugs.

Some examples of opioids are:

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

### KEY STATISTICS - OPIOID HARMS

- 1 in 10 (11%) drug-related hospitalisations are attributable to opioid use.<sup>8</sup>
- Opioids are consistently the drug most commonly involved in overdose deaths, attributable to 62% of overdose deaths.<sup>8</sup>
- 4 in 5 (82%) drug overdose deaths involving opioids are considered unintentional.<sup>8</sup>
- 34% of opioid deaths are attributed to heroin only, 56% to other opioids, and 8.9% to a combination of both.<sup>8</sup>
- The proportion of opioid deaths involving heroin has been increasing in recent years, compared to other opioids.<sup>8</sup>



## How does opioid pharmacotherapy help people?

When a person begins pharmacotherapy treatment, the aim is to replace the short-acting opioids they are using with a prescribed longer-acting and less risky alternative at an appropriate dose.<sup>3</sup>

Opioid pharmacotherapies can:

- reduce opioid withdrawal symptoms
- control, eliminate or help a person manage their cravings
- reduce suicide risk
- increase patient satisfaction and engagement in treatment
- reduce the risk of HIV and other blood-borne virus infections associated with injecting drug use
- reduce the likelihood of opioid-related overdose
- reduce engagement with the criminal justice system associated with acquiring illegal opioids.<sup>3, 9, 10</sup>

These benefits can help people to stabilise and experience long term benefits, including improvements in:

- physical and mental health
- social functioning and relationships
- ability to gain and maintain employment
- managing their financial situation
- securing and maintaining adequate housing
- overall health.<sup>3, 11</sup>

For some, the goal is to stop using opioids completely.<sup>3</sup>

But for a lot of people who are opioid dependent, stopping their use of opioids completely is very challenging, so long-term pharmacotherapy may provide the best outcomes.<sup>3</sup>

## What opioid pharmacotherapy treatment is available in Australia?

Increasing awareness of the available pharmacotherapy options in Australia, for both healthcare workers and people who are dependent on opioids, can improve access to, and engagement with, treatment.

Which medication is best for a person is a joint decision made by the individual and their pharmacotherapy prescriber, informed by their preferences and treatment goals.<sup>3</sup>

Once they have a prescription from their doctor, the person receiving pharmacotherapy regularly attends a dosing point to receive their medication. Dosing points can include pharmacies and specialised clinics.

Which pharmacotherapy the person is on will affect how often the person attends for dosing. While oral pharmacotherapy will often require daily or near-daily attendance at dosing points, long-acting injectable formulations may be administered weekly or monthly.

**Methadone** and **buprenorphine** (also known as bupe) formulations are the main long-acting opioid medications prescribed for opioid dependence in Australia.<sup>6</sup>

According to research and clinical experience, they are both safe and effective in the treatment of opioid dependence and listed as essential medicines by the World Health Organization.<sup>13</sup>

People who start on methadone treatment may transition to buprenorphine at some point (and vice versa).<sup>3</sup> Once again, this is informed by their treatment goals and individual preferences.<sup>3</sup>

*“Methadone and bupe aren’t right for every opioid user. It’s just another choice. There are lots of ways to use and not use, and many roads to treatment. I have travelled a lot of them without finding what I needed before I eventually got onto methadone. For me, it’s been useful. I think if I don’t need it anymore, I’ll get off it. But that day isn’t today.” - Lori<sup>14</sup>*

In Australia, the following medicines can be prescribed for opioid pharmacotherapy treatment:<sup>3</sup>

Drug name	Brand names	How it's used	Dosing frequency
Methadone	Methadone Syrup® Biodone Forte Solution®	Mouth (liquid)	Daily
Buprenorphine	Subutex®	Mouth (tablet under the tongue)	Usually daily, or every 2 or 3 days in some cases
Buprenorphine-naloxone	Suboxone®	Mouth (film under the tongue)	Usually daily, or every 2 or 3 days in some cases
Long-Acting Injectable Buprenorphine (LAIB)	Buvidal® Sublocade®	Injection (under the skin)	Weekly or monthly

**Naltrexone** is an opioid antagonist that blocks the effects of opioids.<sup>3</sup> Because of this, it's used for relapse prevention rather than maintenance or withdrawal.<sup>3</sup>

If a person is dependent on opioids, naltrexone can cause severe opioid withdrawals.<sup>3</sup> It also reduces the person's tolerance, increasing the risk of overdose.<sup>3</sup> Because of this, it's only prescribed for people who have already successfully stopped taking opioids.<sup>3</sup>

Naltrexone is mainly used as pharmacotherapy for people experiencing alcohol dependence who want to remain abstinent. It's proven to reduce cravings and make drinking less pleasurable.<sup>15</sup>

Due to its infrequent use and lack of access on the PBS as an opioid pharmacotherapy, this publication does not discuss naltrexone in-depth.<sup>3</sup>

## Methadone

Methadone has been used in Australia to treat opioid dependence since 1969.<sup>3</sup> There are two formulations registered for the treatment of opioid dependence, which come in liquid form:<sup>3</sup>

- Methadone Syrup®
- Biodone Forte®.

*“Going on methadone helped me get my life back in order. Stresses about money, work and bills became manageable. I felt like a black cloud had been lifted off me.” - John<sup>16</sup>*

The effects of methadone usually last for about 20 – 36 hours, depending on how long and how stable someone is in treatment and their individual metabolism.<sup>3</sup>

Methadone is a full opioid agonist, which means the more you take, the greater the opioid effect. Given this, it's possible to overdose on methadone alone or in combination with other drugs (e.g. benzodiazepines). For this reason, the dose is usually increased slowly and carefully when treatment starts.<sup>3</sup>

Importantly, the overall risk of opioid-related overdose is significantly lower for those engaged in a methadone treatment program compared with those who are not.

Once on the correct daily dose of methadone, a person's tolerance to the medication usually stabilises, meaning the same daily dose can be effective for many years.<sup>17</sup>

Similar to other opioids, when someone who regularly takes methadone stops using it, they will experience opioid withdrawals.<sup>3</sup>

Methadone withdrawals can last longer and can potentially be more unpleasant than withdrawals from heroin, depending on the dose.<sup>3</sup>

If a person engaged in a long-term methadone program wishes to exit treatment, planning is essential.

Withdrawal from methadone should be done with the supervision and guidance of the prescribing doctor. Transitioning to a different type of pharmacotherapy (e.g. transferring from methadone to buprenorphine/buprenorphine-naloxone) can be of significant benefit for those planning to exit treatment.<sup>3</sup>



## Buprenorphine

Buprenorphine has been used as an opioid pharmacotherapy in Australia since 2000.<sup>3</sup> There are two buprenorphine medications available that can be taken by mouth, under the tongue:

- Suboxone Film® – a combination of buprenorphine and naloxone on a film strip that is dissolved under the tongue or inside the cheek. This is the most widely used form.<sup>18</sup>
- Subutex Sublingual Tablets® – tablets containing buprenorphine only that must be dissolved under the tongue.<sup>19</sup>

*“When I am on Suboxone, I don’t use. When I am off it, I do. It’s that simple for me. I’m not on a high dose and I know that eventually I’ll be off it for good without needing to use any opioids at all. For me, that will be freedom. In the meantime, I use the help I’m offered.”*  
- Jim<sup>16</sup>

The effects of buprenorphine last for 8-72 hours, depending on the dose.<sup>3</sup> Despite this, most people who are prescribed buprenorphine/buprenorphine-naloxone find they need to take it daily.

Buprenorphine is a partial opioid agonist, so it produces opioid effects which are not as strong as a full agonist like methadone.<sup>3</sup>

Buprenorphine has a higher affinity for opioid receptors compared to full opioid agonists, (e.g. methadone or heroin). This means that once buprenorphine has occupied the opioid receptors, other full opioid agonists, like heroin, have little to no effect until the buprenorphine has left the receptors, which can take anywhere from 24 – 60 hours.<sup>3</sup>

Buprenorphine also has a ‘ceiling effect’.<sup>3</sup> As the dose is increased, there’s an increased opioid effect up to a certain point. After the ‘ceiling’ has been reached, there is no increase in felt effects, only an increase in the amount of time the effects are felt for.

The ceiling effect and higher affinity make buprenorphine appear safer than methadone for overdose risk. However, even low doses of buprenorphine can still be dangerous if combined with other depressant drugs or sedatives, such as benzodiazepines and alcohol.<sup>3</sup>

The maximum daily dose of buprenorphine/buprenorphine-naloxone in Australia without oversight from an addiction medicine specialist (AMS) is 32mg.<sup>3</sup>

Compared to methadone, buprenorphine has less of a sedative effect.<sup>3</sup> Because of this, some people prefer buprenorphine, while others prefer the sedative and anxiety reducing effects of methadone, for example, those experiencing post-traumatic stress disorder (PTSD).

*“I didn’t realise how stoned I was on methadone until I moved onto bupe. On bupe, my head seemed a lot clearer and I had a lot more energy. It was a lot more like being straight. I liked being able to think and I ended up doing more – getting out and participating in life more.”* - Jane<sup>16</sup>

*“I found it really hard to sleep on Suboxone, and it made me get really sweaty and hyperactive which is why I wanted to switch back to methadone.”* - Lorenzo<sup>16</sup>

## LONG-ACTING INJECTABLE BUPRENORPHINE (LAIB)

Long-Acting Injectable Buprenorphine has been available in Australia since 2020.<sup>20</sup> There are two LAIB medications available:

- Buvidal®
- Sublocade®.

LAIB is provided as weekly or monthly injections under the skin, which slowly release the buprenorphine into the body.<sup>21</sup> LAIB should never be injected into the muscles or veins and should always be administered by a qualified health professional.<sup>21</sup>

The benefit of LAIB is that it keeps a person stable for an extended time without the need for daily/alternate day dosing.<sup>4</sup>

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.<sup>22, 23</sup>

*“Buvidal is convenient, I never think about it except when I’m getting the injection. It bloody hurts though. That’s the worst thing about it – it’s like a bee sting or a green ant bite! Thankfully though it only lasts a couple of minutes.”* - Jess<sup>24</sup>

**Naloxone** is an opioid antagonist that is used to temporarily reverse an opioid overdose. It's safe, effective and is listed as an essential medicine by the World Health Organization.<sup>13</sup>

Some formulations of opioid pharmacotherapy (Suboxone®) also include naloxone. This reduces the risk of the medication being diverted for nonprescribed use by removing any psychoactive effects someone may get from injecting it.<sup>3</sup>

On its own, naloxone is not an opioid pharmacotherapy, but it should be carried by anyone who is currently taking any opioids (including those using pharmacotherapy), their friends and family.

Naloxone is available for free over the counter from most local pharmacies and can be administered by anyone, including family and friends, or bystanders.<sup>25</sup> It can be injected into a muscle or delivered by a nasal spray.

It's important to always call triple zero (000) when giving naloxone, as it only lasts 30 to 90 minutes. After that a person can overdose again on long-acting opioids, even without taking any more of them.<sup>26</sup>

Triple zero (000) can also provide you with advice and support to administer the naloxone.

For more information or to find naloxone near you, visit: [health.gov.au/our-work/take-home-naloxone-program](https://health.gov.au/our-work/take-home-naloxone-program)

*"I wouldn't be able to be the man I am now and have the life I do at home, you know? Stable, and to hold down a job - I wasn't, without that program I wouldn't be able to function properly because I'd be still probably using, I would be. There's no doubt about it." – Anonymous<sup>12</sup>*



## Barriers to receiving pharmacotherapy in Australia

Opioid pharmacotherapy has been available in Australia for over 50 years and over this time there have been many improvements, including additional medications and cost reductions.

But there are still significant barriers preventing people from accessing the treatment, some of these include:

Barrier	What this looks like	How to reduce
Access	<p>Especially in rural and remote regions, access can be impacted by:</p> <ul style="list-style-type: none"> <li>• travel costs and time spent travelling due to lack of prescribers and dosing points</li> <li>• different prescribing regulations across jurisdictions, making interstate and international movements challenging</li> <li>• limited opening hours at dosing points</li> <li>• inflexible work conditions that cannot accommodate time away</li> <li>• fewer health professionals prescribing pharmacotherapy, resulting in limited access to treatment</li> <li>• access to pharmacotherapy varies considerably in custodial settings (e.g. prison, police cells, residential treatment).<sup>5,9</sup></li> </ul>	<p>LAIB removes the need for daily dosing and can make short-term travel (4 weeks at most) easier.<sup>5</sup></p> <p>Increasing the availability of LAIB administration through community pharmacy nationally could help substantially.</p>
Stigma	<p>Experiences of stigma can prevent/delay people from seeking help, these can be from:</p> <ul style="list-style-type: none"> <li>• themselves (internalised stigma)</li> <li>• family and friends</li> <li>• health professionals</li> <li>• the community – especially if the person is in a small town with limited anonymity.<sup>5,9,11</sup></li> </ul>	<p>Where appropriate, takeaway doses can serve as a sign of trust and an opportunity to avoid dosing-point stigma.<sup>5</sup></p> <p>LAIB can reduce the number of visits to the pharmacy, clinic or doctor.<sup>5</sup></p>
Knowledge and awareness	<p>Most people who use opioids are aware opioid pharmacotherapy is available, but some:</p> <ul style="list-style-type: none"> <li>• don't know how or where to access</li> <li>• have stereotypes and misconceptions</li> <li>• don't receive information from healthcare workers, as some workers hold the same misconceptions and lack of knowledge.<sup>5</sup></li> </ul>	<p>Increase knowledge of pathways to access opioid pharmacotherapy among people who use opioids and healthcare workers.</p> <p>Increase awareness that opioid pharmacotherapy is an effective treatment for opioid dependence.</p>
Additional support	<p>A lack of support for a person's multiple and complex concerns, including:</p> <ul style="list-style-type: none"> <li>• housing</li> <li>• legal</li> <li>• employment</li> <li>• mental health.<sup>3,9</sup></li> </ul>	<p>Connect people receiving pharmacotherapy treatment with wrap around support services.</p>

*"It's hard as I spend so much time on the bus getting my doses, working out how to get to the pharmacy, how to get to Melbourne."*  
- Anonymous<sup>12</sup>

*"I have more than one friend who stopped their bupe because of shame and later overdosed – good people who would likely be alive today if they didn't feel compelled to stop taking their life-saving medication. Stigma kills"* – Josh<sup>16</sup>

## REDUCING BARRIERS - COST REFORMS

Like most medications in Australia, methadone and buprenorphine are subsidised under the Pharmaceutical Benefits Scheme (PBS).<sup>27</sup>

Doses received at a public clinic are free.<sup>28</sup> For more information on public clinics, call the [National AOD Hotline](#) or one of the helplines listed on [AIVL's website](#).

Historically, doses from pharmacies had private dispensing charges of around \$40-50 a week.<sup>29</sup> Since July 1, 2023, opioid pharmacotherapy medications are treated the same as other S100 Prescription Medications, making pharmacotherapy more affordable.<sup>27</sup>

This means the costs are now capped in line with the [PBS co-payment amounts](#) and count towards the person's [PBS Safety Net threshold](#).<sup>27</sup>

For further information and examples of how this works in practice, [see Harm Reduction Australia's fact sheet](#).

## Young people and opioid pharmacotherapy

As opioid dependence and treatment is more common in older age groups, those working in youth services may be less familiar with pharmacotherapy as a treatment option.

### KEY STATISTICS - YOUNG PEOPLE AND OPIOIDS IN AUSTRALIA

- 1% of secondary school students used opioids in the past month, 5.8% in their lifetime.<sup>30</sup>
- Young people mostly used pharmaceutical opioids.<sup>30</sup>
- The number of pharmacotherapy clients under the age of 30 has been decreasing, from 11,011 in 2006 to 3,968 in 2022.<sup>31</sup>

There are many barriers that youth alcohol and other drug (AOD) workers and young people may face when accessing opioid pharmacotherapy, including:

- **unwillingness to prescribe** to a young person because of their age, and the stigma related to opioid dependence
- **dosing** can be a challenge. A doctor may be unwilling to approve a larger dose for a young person – even if it's required to better stabilise them
- **internal stigma**, which can impact a young person's decision to go on opioid pharmacotherapy. As opioids are largely considered an 'adult drug' by society, the need for pharmacotherapy can be difficult for a young person to accept
- **access varies by state/territory** - pharmacotherapy for people who are under 18 years old is only available in some states/territories in Australia.<sup>3</sup>

For young people who are opioid dependent, the evidence shows that treatment focussed on stopping opioids entirely (abstinence) is associated with lower rates of continuing treatment and lower rates of reducing opioid use, compared to pharmacotherapy.<sup>3</sup>

Pharmacotherapy should be used only after careful assessment of the risks and benefits and in the context of a comprehensive treatment plan.<sup>3</sup>

This section was informed by expert insight from [Uniting Vic & Tas](#) and [Odyssey House Victoria](#).



## Pregnancy and opioid pharmacotherapy

Those working in pregnancy and childbirth services may be less familiar with pharmacotherapy as a treatment option.

There are unique barriers faced by pregnant and breastfeeding individuals and the workers supporting them when it comes to accessing opioid pharmacotherapy, including:

- **prescribers are hesitant to prescribe** to a pregnant individual out of concern for the baby, a lack of knowledge on pharmacotherapy and the stigma related to it
- **fear of losing custody of children** if they disclose their opioid dependence. This causes pregnant individuals to not want to tell their health professionals they are opioid dependent
- **lack of stable childcare** which makes it harder to attend appointments for regular dosing and psychotherapy.<sup>32</sup>

If someone is pregnant or breastfeeding and opioid dependent, pharmacotherapy is the preferred treatment approach.

The evidence shows that treatment with methadone or buprenorphine is associated with improved outcomes for both the parent and the baby, including fewer early births and babies more likely to be a healthy weight when born.<sup>3</sup>

Some states and territories have **specialist services for people who are pregnant and opioid dependent**. These services can help them and their support worker to access treatment, including pharmacotherapy.

**This section was informed by expert insight from The Women's Alcohol and Drug Service.**

*“Going on methadone meant I got to keep my baby. Nothing beats that. But I also found life was so much easier. Not waking up sick or having to chase money or run around sorting drugs meant I could focus on more important things – being a mum and eventually doing a course and getting a job. It could have gone really differently for me if I hadn't gone on a program.” - Janis<sup>16</sup>*

## Accessing Opioid Pharmacotherapy

By supporting people who are opioid-dependent to access a pharmacotherapy program that meets their needs, if and/or when they want it, we can prevent and reduce opioid-related harms in Australia.

If a person wants to access opioid pharmacotherapy, they will need to:

1. Learn more about it by talking to people who have tried it or who are engaged in treatment, and access information and resources available via the internet or from the **state/territory-based Drug User Organisations**.
2. Write down any questions they have and which treatment they believe is right for them and why, to bring to their appointment. This should be informed by the resources they have gathered.
3. Make an appointment to see a pharmacotherapy prescriber.
  - If they want to start/re-start on methadone or Suboxone Film, they will need to identify a dosing point near them that is willing and able to service them before seeing the prescriber.
  - If they want to start/re-start on LAIB, they will need to know the prescriber's system for administering (e.g. can the prescriber provide the injection on-site or do they need to attend a different location to receive the injection). It can be helpful to ask this when making the appointment with the prescriber.

Most Australian jurisdictions have services specifically funded to help people access pharmacotherapy prescribers and dosing points. Call the **National AOD Hotline** or visit **AIVL's website** for a table of services and their contact details. Alternatively, some healthcare workers may be able to help with accessing opioid pharmacotherapy.

People on LAIB require either weekly or monthly dosing, administered by the prescriber, a trained pharmacist or a nurse (often located at the prescriber's medical clinic).

People on oral methadone or buprenorphine programs will most likely need to attend a dosing point daily until their prescriber is satisfied that their treatment is stable. At this point, they may be able to access takeaway doses or reduce dosing frequency (for some people, reaching this stage can involve substantial change and may take some time).

## Treatment stability

Treatment stability is when someone:

- is on the correct dose - the dose has not needed to be changed for several weeks to months, depending on the treatment type
- is not missing doses of methadone or buprenorphine/buprenorphine-naloxone or injections of LAIB
- is not missing appointments with the opioid pharmacotherapy prescriber
- feels like the treatment is 'working' for them - usually indicated by a substantial reduction or cessation in the use of shorter-acting opioids
- feels more in control of their life, for example paying rent or addressing housing needs, maintaining positive relationships with friends and family, managing their financial situation, eating regularly and addressing any other health conditions.<sup>3</sup>

## Takeaway doses of methadone, buprenorphine/buprenorphine-naloxone:

Depending on individual circumstance and stability in treatment, people may become eligible for takeaway doses of methadone or buprenorphine, also sometimes called unsupervised dosing. Each jurisdiction has guidelines around patient eligibility for takeaway doses, which most prescribers tend to follow.

Importantly, only the opioid pharmacotherapy prescriber can authorise takeaway doses.<sup>3</sup> But the dispensing pharmacist can refuse to dispense them if they don't believe someone is able to manage unsupervised doses.<sup>3</sup>

In most Australian jurisdictions, to be eligible for takeaway doses, you must:

- have a safe, secure (lockable) place to store your doses where they are out of reach of children, pets and/or others
- provide a urine drug sample on request, (note: not every prescriber uses urine samples to assess eligibility for take home doses, however some do)
- dose regularly (no missed doses) and attend all appointments with your prescriber
- not present in an intoxicated state when dosing or attending an appointment with your prescriber
- ideally, have no recent hospital admissions, incarcerations or criminal sanctions.<sup>3</sup>

## Additional information for people considering pharmacotherapy

For further information, help or advice, contact the [National AOD Hotline](#) at 1800 250 015.

Most states and territories also have services that can support you to access opioid pharmacotherapy. Visit [AIVL's website](#) for a table of services and their contact details.

### Additional resources:

**Consumers' Guide to the OTP:** From the NSW Users and Aids Association (NUAA), written by and for people who use drugs, that tells you what to expect on the OTP and what is expected of you.

**Changing Lanes:** A series of four videos by Harm Reduction Victoria to assist with the decision-making process.

**Lives of Substance:** Experiences of people who use or have previously used heroin, including their experiences accessing pharmacotherapy and other treatments.

**Drug Overdose Peer Education (D.O.P.E):** Delivers peer-based overdose education to people who use illicit drugs. Overdose training sessions are available for staff and clients.



## Clinical guidelines

Australia has national guidelines outlining the broad policy context and framework for opioid pharmacotherapy. Most states and territories also have their own publicly available clinical guidelines and resources.

These guidelines aim to promote a national standard for opioid pharmacotherapy treatment, while recognising different jurisdictional approaches.

Australia	<a href="#">Guidelines for Medication-Assisted Treatment of Opioid Dependence</a>
Australian Capital Territory	<a href="#">Opioid maintenance treatment</a>
New South Wales	<a href="#">Opioid dependence treatment: Clinical guidance and tools for clinicians</a>
Northern Territory	<a href="#">Medical practitioners and schedule 8 medicines</a>
Queensland	<a href="#">Queensland opioid treatment program</a>
South Australia	<a href="#">Medically Assisted Treatment for Opioid Dependence (MATOD) – Regulatory information and resources</a>
Tasmania	<a href="#">Opioid pharmacotherapy program information for health professionals</a>
Victoria	<a href="#">Pharmacotherapy policy in Victoria</a>
Western Australia	<a href="#">Community Program for Opioid Pharmacotherapy</a>



[Read more evidence articles on this topic in the ADF Library](#)

[Read more books and eBooks on this topic in the ADF Library](#)

## References

1. Basile M, Carson-Dewitt R. Pharmacotherapy. The Gale Encyclopedia of Neurological Disorders. Farmington Hills, MI: Gale; 2023 [19.02.2025]. Available from: <https://adf.on.worldcat.org/oclc/1363829817>.
2. Turning Point. Pharmacotherapy. 2021 [19.02.2025]. Available from: <https://www.turningpoint.org.au/treatment/about-addiction/treating-addiction/pharmacotherapy>.
3. Gowing L, Ali R, Dunlop A, Farrell M, Lintzeris N. National Guidelines for Medication-Assisted Treatment of Opioid Dependence. [Internet]. 2014 [26.02.2025];[225 p.]. Available from: <https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence>.
4. Australian Institute of Health and Welfare. National Opioid Pharmacotherapy Statistics Annual Data collection 2022. Canberra: AIHW; 2023 [18.02.2025]. Available from: <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/archived-content>.
5. Penington Institute. Opioid pharmacotherapy at the crossroads: enduring barriers and new opportunities. [Internet]. 2023 [21.02.2025]; p.]. Available from: [https://www.penington.org.au/wp-content/uploads/2023/08/PEN\\_Pharmacotherapy-at-Crossroads\\_FINAL.pdf](https://www.penington.org.au/wp-content/uploads/2023/08/PEN_Pharmacotherapy-at-Crossroads_FINAL.pdf).
6. Australian Institute of Health and Welfare. National Opioid Pharmacotherapy Statistics Annual Data collection 2023. Canberra: AIHW; 2024 [18.02.2025]. Available from: <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/about>.
7. John Hopkins Medical. What are opioids? 2024 [18.02.2025]. Available from: <https://www.hopkinsmedicine.org/opioids/what-are-opioids.html>.
8. Chrzanowska A, Man N, Sutherland R, Degenhardt L, Peacock A. Trends in Overdose and Other Drug-induced Deaths in Australia, 2003-2022. UNSW Sydney: National Drug and Alcohol Research Centre (NDARC). 2024 [26.02.2025]. Available from: <https://www.unsw.edu.au/research/ndarc/resources/trends-drug-induced-deaths-australia-2003-2022>.
9. Wood P, Opie C, Tucci J, Franklin R, Anderson K. “A lot of people call it liquid handcuffs” – barriers and enablers to opioid replacement therapy in a rural area. Journal of Substance Use [Internet]. 2019 [26.02.2025]; 24(2):[150-5 p.]. Available from: <https://adf.on.worldcat.org/oclc/10308240569>.
10. Santo TJ, Chaillon A, Martin N, Hickman M, Jones N, Farrell M, et al. Quantifying the impact of a large-scale opioid agonist treatment program on suicide prevention in New South Wales, Australia: A data-modeling study. Addiction (Abingdon, England) [Internet]. 2025 [06.06.2025];[1-9 p.]. Available from: <https://adf.on.worldcat.org/oclc/10620385281>.
11. Lowry N, Najia C, Kelleher M, Mitcheson L, Marsden J. Patient experience of opioid use disorder treatment medications: a systematic review of contemporary qualitative research. BMJ open [Internet]. 2024 [16.04.2025]; 14(12):[e088617 p.]. Available from: <https://adf.on.worldcat.org/oclc/10460168385>.
12. Patil Vishwanath T, Cash P, Cant R, Mummary J, Penney W. The lived experience of Australian opioid replacement therapy recipients in a community-based program in regional Victoria. Drug and Alcohol Review [Internet]. 2019 [06.06.2025]; 38(6):[656-63 p.]. Available from: <https://adf.on.worldcat.org/oclc/8270692864>.
13. World Health Organization. World Health Organization Model List of Essential Medicines, 23rd list. Geneva: WHO; 2023 [21.02.2025]. Available from: <https://list.essentialmeds.org/>.

14. NSW Users and Aids Association (NUAA). Consumers' Guide to the Opioid Treatment Program: Maintenance on the OTP. [Internet]. 2019 [06.06.2025]:[80 p.]. Available from: <https://static1.squarespace.com/static/61bc083a85af43143a2eb69a/t/62172b548f05d30af5609880/1645685624553/02%2BMaintenance%2BStandalone%2B%2BFinal%2B061219.pdf>.
15. SA Health. Medication assisted treatment for alcohol dependence. Government of South Australia; 2025 [06.03.2025]. Available from: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/alcohol/medication+assisted+treatment+for+alcohol+dependence>.
16. NSW Users and Aids Association (NUAA). Consumers' Guide to the Opioid Treatment Program: Introduction to the OTP. [Internet]. 2019 [06.06.2025]:[64 p.]. Available from: <https://static1.squarespace.com/static/61bc083a85af43143a2eb69a/t/62172aca8563bd7e704762f9/1645685483803/01%2BIntroduction%2BStandalone%2B%2BFinal%2B061219.pdf>.
17. Bart G. Maintenance Medication for Opiate Addiction: The Foundation of Recovery. Journal of Addictive Diseases [Internet]. 2012 [26.02.2025]; 31(3):[207-25 p.]. Available from: <https://adf.on.worldcat.org/oclc/10309324961>.
18. NPS MedicineWise. Suboxone Film. 2021 [26.02.2025]. Available from: <https://www.nps.org.au/medicine-finder/suboxone-sublingual-film-2-mg-0-5-mg>.
19. NPS MedicineWise. Subutex. 2021 [26.02.2025]. Available from: <https://www.nps.org.au/medicine-finder/subutex-sublingual-tablets>.
20. Department of Health. Long acting injectable buprenorphine. Victoria State Government; 2020 [26.02.2025]. Available from: <https://www.health.vic.gov.au/publications/long-acting-injectable-buprenorphine>.
21. Grinzi P, Kennedy E, Lord S, MacCartney P, Lubman D, Thomas C, et al. Long-acting injectable buprenorphine: Brief clinical guidelines for use in the treatment of opioid dependence: Department of Health Victoria, Victorian Government; 2021 [06.06.2025]. Available from: [https://pabn.org.au/wp-content/uploads/2021/12/Long-acting\\_injectable\\_buprenorphine-Brief\\_clinical\\_guidelines.pdf](https://pabn.org.au/wp-content/uploads/2021/12/Long-acting_injectable_buprenorphine-Brief_clinical_guidelines.pdf).
22. Frost M, Bailey GL, Lintzeris N, Strang J, Dunlop A, Nunes EV, et al. Long-term safety of a weekly and monthly subcutaneous buprenorphine depot (CAM2038) in the treatment of adult out-patients with opioid use disorder. Addiction [Internet]. 2019 [26.02.2025]; 114(8):[1416-26 p.]. Available from: <https://adf.on.worldcat.org/oclc/8291779305>.
23. Haight BR, Learned SM, Laffont CM, Fudala PJ, Zhao Y, Garofalo AS, et al. Efficacy and safety of a monthly buprenorphine depot injection for opioid use disorder: a multicentre, randomised, double-blind, placebo-controlled, phase 3 trial. The Lancet [Internet]. 2019 [26.02.2025]; 393(10173):[778-90 p.]. Available from: <https://www.sciencedirect.com/science/article/pii/S0140673618322591>.
24. NSW Users and Aids Association (NUAA). Consumers' Guide to the Opioid Treatment Program: Depot Buprenorphine Starters' Guide. [Internet]. 2019 [06.06.2025]:[32 p.]. Available from: <https://static1.squarespace.com/static/61bc083a85af43143a2eb69a/t/621733f05516c95205520be3/1645687805724/Depot%2BBupe%2BStandalone%2BUpdate%2B240820.pdf>.
25. Australian Government Department of Health and Aged Care. About the Take Home Naloxone program. 2024 [16.10.2024]. Available from: <https://www.health.gov.au/our-work/take-home-naloxone-program/about-the-take-home-naloxone-program>.
26. Australian Government Department of Health and Aged Care. How to administer naloxone. 2023 [6.6.2025]. Available from: <https://www.health.gov.au/our-work/take-home-naloxone-program/how-to-administer-naloxone>.
27. The Pharmaceutical Benefits Scheme. Opioid Dependence Treatment Program. Australian Government Department of Health and Aged Care; 2025 [19.02.2025]. Available from: <https://www.pbs.gov.au/browse/section100-md>.
28. Harm Reduction Australia. Opioid Dependence Treatment Program (ODTP) Reforms Consumer Fact Sheet. 2023 [19.02.2025]. Available from: <https://harmreductionaustralia.org.au/wp-content/uploads/2023/06/ODTP-Reforms-HRA-Fact-Sheet-Consumers-final.pdf>.
29. Harm Reduction Australia. Opioid Dependence Treatment Program (ODTP) Reforms How will it work in practice? 2023 [19.02.2025]. Available from: <https://harmreductionaustralia.org.au/wp-content/uploads/2023/06/ODTP-Reforms-HRA-Fact-Sheet-Consumer-Examples-final.pdf>.
30. Scully M, Bain E, Koh I, Wakefield M, Durkin S. ASSAD 2022/2023: Australian secondary school students' use of tobacco and e-cigarettes. [Internet]. Centre of Behavioral Research in Cancer (VIC): Cancer Council Victoria; 2023 [06.06.2025]. Available from: <https://www.health.gov.au/sites/default/files/2023-11/secondary-school-students-use-of-tobacco-and-e-cigarettes-2022-2023.pdf>.
31. Australian Institute of Health and Welfare. Data tables: National Opioid Pharmacotherapy Statistics Annual Data collection 2023. Canberra: AIHW; 2024 [18.02.2025]. Available from: <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/data>.
32. Apsley HB, Brant K, Brothers S, Harrison E, Skogseth E, Schwartz RP, et al. Pregnancy- and parenting-related barriers to receiving medication for opioid use disorder: A multi-paneled qualitative study of women in treatment, women who terminated treatment, and the professionals who serve them. Women's Health (London, England) [Internet]. 2024 [26.02.2025]; 20:[12 p.]. Available from: <https://adf.on.worldcat.org/oclc/10154721369>.