Medication-assisted treatment for opioid dependence

Information for health professionals

Medication-assisted treatment is prescribed by doctors to some clients with opioid and other drug problems. It improves health and well-being and helps to reduce deaths, decrease criminal activity and improve social and living skills.

Medication-assisted treatments

Medication-assisted treatment for opioid dependence (MATOD) is a combination of medication and psychosocial support.
The medication controls withdrawal or cravings and blocks the euphoric effects of further opioid use. Psychosocial support refers to the many ways in which the psychological health and the social environment of the opioid user can be addressed to help improve both the quality and duration of life.

There are two main types of MATOD: long-acting opioid medications and opioid antagonists.

Long-acting opioid medications

Long-acting opioid medications such as methadone and buprenorphine, substitute heroin and other opioids in a dose that prevents withdrawal symptoms, reduces the patient's need to use illicit heroin or opioids, reduces risk of overdose, and helps retain people in treatment programs. Clinical trials have demonstrated that the best results of treatment are obtained when a sufficient dose of the treatment drug is prescribed and treatment is of longer duration.

Methadone

Methadone is a synthetic opioid with full morphine-like activity on opioid receptors. A sufficient daily dose is generally able to suppress withdrawal symptoms and opioid craving for at least 24 hours. There is little 'high' or peak effect after dosing with methadone because of the relatively slow absorption of oral methadone. Doses in the range of 60-100mg are usually adequate but doses up to 150mg may be prescribed.

Buprenorphine

Buprenorphine is a synthetic opioid that suppresses opioid withdrawal symptoms and craving through its partial morphine-like activity on opioid receptors. Its partial activity results in a ceiling effect on respiratory depression with increasing doses and is complemented by its strong binding to opioid receptors, which enables blocking of the effects of heroin and other morphine like drugs. The dosing interval can be extended to two days for many people because of buprenorphine's extended duration of action.

Buprenorphine has three different forumulations: a film placed under the tongue (Suboxone®), a tablet under the tongue (Subutex®) or a weekly/monthly depot injection (Buvidal® and Sublocade®).

Side effects and safety issues

Methadone and buprenorphine are opioids and may cause side effects in some people. Many side effects reduce over time. Known side effects include:

- sedation
- lethargy
- dry mouth
- sleep disturbances
- constipation
- eyesight problems
- headaches, nausea and vomiting
- weight gain, fluid retention
- hyperhidrosis (excessive sweating)
- decreased libido.

The Road Trafffic Act 1961 states that it is an offence to drive, or attempt to drive, under the influence of a drug. Many opioid substitutes can impair your ability to drive or operate machinery.

Using other drugs (e.g. benzodiazepine, additional opioids, alcohol) while receiving treatment may increase the risk of drug overdose.

Opioid antagonists

Opioid antagonists block the effects of other opioid drugs and can be useful for achieving abstinence. Best results are obtained with motivated clients who have a relatively stable and supportive social environment.

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Naltrexone

Naltrexone is a full opioid antagonist, which binds strongly to opioid receptors, but has no morphine-like activity. It can be a successful treatment if taken regularly for a period of six to 12 months. Oral naltrexone in a single daily dose of 50mg is sufficient to block the effects of opioid use. Over time this results in reduced craving.

Supporting continued use of naltrexone is important. Treatment compliance may be enhanced by:

> strong motivation
> resolution of withdrawal symptoms before naltrexone commencement
> strong social supports
> outlining concerns for resuming opioid use (eg: medical deregistration, revocation of parole)
> counselling for ongoing support.

Some private medical practitioners in Australia are using sustained-release (depot) and implant preparations of naltrexone off the label but there is little evidence for efficacy (especially in contrast to agonist treatment) and this treatment is not registered for therapeutic use by TGA. Some medical defence insurers do not cover practitioners engaged in this procedure.

Side effects and safety issues

Naltrexone blocks the effect of additional opioids and eliminates tolerance to opioids produced by previous use. Side-effects are transient and mild, and include:

> nausea
> sleep disturbance
> headache
> anxiety
> loss of energy
> muscle aches.

Patients with chronic pain conditions requiring frequent or regular use of opioid-containing pain killers should not be prescribed naltrexone.

Resumption of opioid use after stopping naltrexone treatment may lead to opioid overdose because of the loss of opioid tolerance. It is important to warn patients of this risk.

Use in pregnancy

Maintaining or initiating MATOD with methadone or buprenorphine is the preferred approach to management of opioid dependence in pregnancy. The benefits of treatment in terms of improved outcomes for mother and baby outweigh the problems of neonatal withdrawal. There is now sufficient evidence available to consider methadone and buprenorphine as equally effective in pregnancy. The choice of medication should be made in consultation with the client. Once engaged in MATOD treatment, it is strongly recommended not to discontinue this treatment during pregnancy because of the risk of withdrawal adversely impacting on the unborn child and the mother, and because of the risk of subsequent relapse to other opioid use (e.g. injecting heroin) during pregnancy.

Naltrexone and naloxone are contraindicated in pregnancy. If pregnancy is planned, the use of preparations containing naltrexone or naloxone should be ceased in advance. For women who become pregnant while on naltrexone, the risks of ceasing should be balanced against the risks of remaining on naltrexone.

Withdrawal from treatment

Withdrawal from methadone or buprenorphine treatment should be gradual to avoid the emergence of distressing withdrawal symptoms. Buprenorphine withdrawal symptoms are generally milder than those of methadone and there can be benefits in transferring from methadone to buprenorphine during the withdrawal phase. Clients should be monitored for signs of destabilisation – resumption of treatment is preferable to a return to unsanctioned opioid use. Importantly, following withdrawal from MATOD, the patient loses acquired opioid tolerance and therefore has increased vulnerability to opioid overdose; if relapse to heroin injecting does occur, the possibility of fatal overdose is increased. Hence, relapse prevention and risk management strategies are essential parts of the management of any MATOD or other long term opioid use (e.g. chronic pain patients having taken opioid analgesics for prolonged periods).

Naltrexone cessation is not associated with withdrawal symptoms but immediate resumption of opioid use is very dangerous because of reduced tolerance.

The key to successful cessation is stability. The best approach is to plan for cessation once unsanctioned drug use has ceased and other aspects of the client's health and lifestyle have stabilised, and thereafter to monitor the risk of relapse.

MATOD Prescribers

All General Practitioners are able to prescribe naltrexone and buprenorphine/naloxone (limit of ten patients). Those who wish to prescribe methadone must become accredited prescribers by undertaking additional training through the DASSA GP Program.

Treatment services

Information about alcohol and other drug services in South Australia can be accessed at the Know Your Options website (www.knowyouroptions.sa.gov.au) or by calling the Alcohol and Drug Information Service (ADIS) on Telephone 1300 13 1340.

For more information

Alcohol and Drug Information Service (ADIS)
Phone: 1300 13 1340
Confidential telephone counselling and information available between 8.30am and 10pm every day.
www.sahealth.sa.gov.au/dassa

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