

Completing Treatment

In this section you will...

- *Learn how to complete treatment and exit patients from the opioid pharmacotherapy program.*

Section Contents

9	Completing Treatment	141
9.1	Planned and Voluntary Withdrawal from Opioid Pharmacotherapy	141
9.2	Withdrawal from Treatment Plan	141
9.2.1	Managing Withdrawal Symptoms	142
9.2.2	Review and Monitoring	143
9.2.3	Planned Methadone Dose Reductions	143
9.2.4	Planned Buprenorphine Dose Reductions	144
9.2.5	Switching from Methadone to Buprenorphine	144
9.2.6	Involuntary Withdrawal	145
9.3	Rapid Withdrawal from Opioid Pharmacotherapy	146
9.4	Avoiding secondary problems with alcohol, sedative or hypnotic drugs...	147
9.5	Exiting patients	148
9.5.1	Notifying the Dosing Site/Pharmacy	148

SECTION: 9

9 Completing Treatment

9.1 Planned and Voluntary Withdrawal from Opioid Pharmacotherapy

Evidence indicates that patients are more likely to have positive long-term outcomes if their opioid treatment episode lasts at least 12 months, and additional benefits if patients remain in treatment for 2-3 years. Therefore, patients should be encouraged to remain in the program for a minimum of 12 months (Ward, Mattick & Hall, 1998).

The decision to withdraw from the program should involve the patient, prescriber, and case manager (if relevant). The dispensing pharmacist can also be an important source of information about the patient's stability on the program.

However, patients have the right to withdraw from treatment at any time, even if they have been in treatment for less than the desired minimum of 12 months, are clinically unstable, or have psychosocial stressors. In these circumstances, it is important to discuss the risks associated with early treatment termination and to develop a mutually agreeable approach to dose reduction.

Factors that indicate that the patient may be ready to successfully cease treatment include:

- a significant period of clinical stability on the program;
- cessation of other drug or harmful drug use for at least 12 months;
- confidence in ability to abstain from unsanctioned drug use in the absence of opioid pharmacotherapy treatment;
- absence of pressure from others to cease the program; and
- stable psychosocial supports conducive to maintaining abstinence from harmful drug use.

9.2 Withdrawal from Treatment Plan

When the patient enters treatment it is essential to develop, in conjunction with the patient, a treatment plan based on the entry assessment. Similarly, prescribers and case managers should discuss in detail with patients their treatment exit plan. This plan should consider the patient's strengths and skills that they may have developed during treatment, as well as a stepped plan for dose reductions.

Established dosing arrangements should be continued if they are suitable. This means that patients may continue to have access to takeaway doses and alternate day dosing schedules, as part of the withdrawal plan. It may be necessary to return to daily dosing once dose reductions reach lower levels in order to reduce any discomfort.

When planning an exit from treatment, it is important to consider and discuss the following points with the patient.

SECTION: 9

Completing Treatment

Dose reductions:

- a flexible approach is recommended with an individualised reduction regime tailored to the patient;
- a slow reduction rate is preferable; and
- if relapse is likely or the patient cannot tolerate the dose reductions, dose reduction can be delayed or the dose may be temporarily increased by 2.5 – 5 mg for methadone and 2-4 mg for buprenorphine.

Increased support as dose decreases:

- increased frequency of review, either from prescriber or ADS case manager, is recommended to monitor progress during dose reduction;
- increased access to counselling, with a focus on skills training and relapse prevention, and other psychosocial supports is recommended;
- increased access to support during the final stages of exiting from opioid pharmacotherapy treatment, during which the patient is likely to experience opioid withdrawal symptoms, is recommended;
- psychoeducation and strategies such as cognitive restructuring can assist patients to develop realistic expectations about the withdrawal process and to develop adaptive coping skills to alleviate the discomfort associated with withdrawal;
- patients should be advised about the likely signs and symptoms of opioid withdrawal, with a plan for managing these symptoms. This might include, for example, information about sleep hygiene as sleep disturbance is a common symptom of withdrawal and can be managed without medications; and
- enlist the support of significant others.

Aftercare:

- ensure the patient has access to a GP;
- encourage ongoing access to counselling and support services, either by referral or as direct support from the treating team; and
- where possible, a structured aftercare program should be offered, either by the treating team or by referral, for at least 3-6 months after treatment completion. This might include planned follow up by the ADS case manager with a focus on relapse prevention, problem solving skills or vocational skills training.

Readmission:

- patients can also re-access treatment if they relapse and they are clinically suitable for opioid treatment; and
- rapid readmission should be available for at least one month after leaving the program.

9.2.1 Managing Withdrawal Symptoms

The use of medications (such as benzodiazepines) to manage withdrawal symptoms is not recommended. The use of medications to manage withdrawal symptoms is not

recommended during planned and voluntary withdrawal from the opioid pharmacotherapy program. When a patient presents with evidence of significant withdrawal symptoms, this may be an indication that the rate of dose reduction has been too rapid. In this situation a careful assessment should be conducted and one or more of the following instituted:

- increase the dose to reduce the level of discomfort; and
- temporarily cease the reduction regimen.

The use of medications to manage withdrawal symptoms is not recommended during planned and voluntary withdrawal from the Opioid Pharmacotherapy Program.

9.2.2 Review and Monitoring

In general, patients should be reviewed at 10-14 days post dose reduction, by which time any withdrawal symptoms from previous dose reductions should be evident. This will enable the clinician to assess whether to continue with a reduction regime, to cease dose reduction temporarily, or to increase the patient's dose.

Patients should be reviewed at 10-14 days post dose reduction.

9.2.3 Planned Methadone Dose Reductions

Slow dose reductions are more likely to promote positive outcomes than rapid dose reductions. Patients usually tolerate dose reductions down to approximately 40 mg, after which symptoms of methadone withdrawal increase.

Withdrawal symptoms peak approximately two to three days or longer after the final methadone dose, with some patients experiencing withdrawal symptoms for up to 20 days after cessation, depending on the methadone taper.

Table 9.1 provides a guide to methadone dose reductions that are generally well tolerated by patients.

Table 9.1: Recommended methadone dose reductions

Dose of Methadone	Recommended reduction rate
Above 80mg per day	10mg per fortnight
40-80mg per day	5mg per fortnight
Below 40mg per day	2.5mg per fortnight

Note: Adapted from Department of Health, Western Australia Government and the Drug and Alcohol Office, (2006). *Clinical policies and procedures for the use of methadone and Buprenorphine in the treatment of opioid dependence*, (p.86).

SECTION: 9

Completing Treatment

9.2.4 Planned Buprenorphine Dose Reductions

Slow dose reductions of buprenorphine are more effective than rapid dose reductions. Table 9.2 provides a guide to buprenorphine dose reductions for patients receiving daily or less-than-daily dosing that are generally well tolerated by patients.

Table 9.2: Recommended buprenorphine dose reductions

Dose of Buprenorphine	Recommended reduction rate
Above 16mg per day	4mg per week or fortnight
8-16mg per day	2-4mg per week or fortnight
Below 8mg per day	2mg per week or fortnight

Note: Reproduced from Department of Health, Western Australia Government and the Drug and Alcohol Office, (2006). *Clinical policies and procedures for the use of methadone and Buprenorphine in the treatment of opioid dependence*, (p.86).

Most patients are uncomfortable on less-than-daily doses below 8 mg. Once patients on less-than-daily dosing reduce to a dose of 8mg, it is preferable to transfer them onto a daily dosing equivalent and continue with a daily dosing reduction regimen. This also permits closer monitoring during withdrawal, with enhanced support from the case manager. Some patients may wish to remain on alternate day dosing whilst reducing, but the offer of a transfer to daily dosing if symptoms of withdrawal become distressing should remain open.

There is no evidence to support dose reductions in decrements less than 2 mg using 0.4 mg tablets, since at lower doses the duration of action of buprenorphine diminishes. However, some patients may benefit psychologically from these lower dose decrements. Only patients prescribed Subutex® will be able to access these lower dose decrements. Suboxone® patients requiring access to these lower dose decrements may be switched to Subutex®. Since the withdrawal is likely to be protracted and there is little further reduction in symptom severity, very low dose tapers should not be routinely adopted.

All patients should be asked to attend for daily reviews for five days after their last dose of buprenorphine. This allows for monitoring and appropriate treatment of delayed withdrawal, often seen after finishing a course of buprenorphine.

9.2.5 Switching from Methadone to Buprenorphine

Some patients report that it is easier to withdraw from buprenorphine than methadone. Patients who are experiencing difficulty in withdrawing from methadone may find it easier to reduce their methadone dose to 30 mg, transfer to buprenorphine after a period of stabilisation (as per procedure in Section 8.12), and then withdraw from buprenorphine treatment.

There has been some discussion in the literature about the use of naltrexone to assist in relapse prevention and withdrawal from opioids. However, the research and efficacy of its use for opioid withdrawal is limited, with buprenorphine found to be superior (O'Connor et al., 1997). At the time of writing, naltrexone is only approved under the PBS as a relapse prevention pharmacotherapy for the treatment of alcohol dependence. Naltrexone is not registered with The Australian Register of Therapeutic Goods for use

in accelerated opioid withdrawal (rapid opioid detoxification) or maintenance substitution therapy. For further information on naltrexone, see Appendix XX.

9.2.6 Involuntary Withdrawal

At the beginning of opioid maintenance treatment, patients are informed in writing of their responsibilities to the code of conduct (Section 6). It is sometimes necessary to discharge a patient from treatment for the safety or wellbeing of the patient, other patients or staff.

Involuntary rapid reduction is rarely undertaken, and only done so in extreme instances. Such action must be considered on a case by case basis. Situations that may warrant this action include:

- violence or threat of violence against staff or other patients;
- property theft or damage of the service or dosing location;
- drug dealing on or near the treatment program premises or dosing location;
- repeated diversion of methadone or buprenorphine (see also Section 12);
- unacceptable disruption to the local amenity;
- poor treatment compliance; and
- continued high risk polydrug use.

Involuntary rapid reduction is rarely undertaken, and only done so in extreme instances such action must be considered on a case by case basis.

In some cases, it may be possible to transfer the patient to another program, service provider, or prescriber, instead of withdrawing them entirely from opioid treatment. If no options remain, methadone or buprenorphine treatment is withdrawn without the patient's agreement. This is consistent with the 2007 National Opioid Pharmacotherapy Guidelines. Private prescribers are advised to contact an ADS Addiction Medicine Specialist prior to ceasing treatment to discuss possible treatment options or management strategies. If possible, involuntary withdrawal should take no more than 21-28 days for methadone and 14 days for buprenorphine.

Private prescribers are advised to contact an Alcohol and Drug Services Addiction Medicine Specialist prior to ceasing treatment to discuss possible treatment options or management strategies.

When a patient is being discharged involuntarily, the treating team or prescriber should:

- advise the patient that they are being discharged;

SECTION: 9

Completing Treatment

- provide, in writing, reasons for the discharge;
- remind the patient of their reduced tolerance to opioids and increased risk of overdose or death if they resume unsanctioned opioid or other drug use;
- provide relapse prevention strategies;
- inform them of alternative treatment options; and
- if appropriate, provide referrals to alternative treatment options.

If the patient is being removed from treatment due to serious violence or threat of violence, immediate discharge from the program may be required to protect the safety of others. In such cases, clinicians are required to execute their duty of care and notify parties involved in the patient's care (e.g. dosing site and other relevant health professionals). Potential risks about the patient's behaviour should be promptly communicated.

If the patient is being removed due to serious violence or threat of violence, immediate discharge from the program may be required to protect the safety of others.

Readmission

A management plan regarding subsequent readmission for each patient involuntarily withdrawn from the program should be developed and documented in the patient's file. In cases of serious assault or threat against clinicians or other patients, it may be necessary to decline further treatment. Advice should always be sought from an Addiction Medicine Specialist of the Alcohol and Drug Service in such cases, and the details of the clinical discussion documented in the patient's file.

9.3 Rapid Withdrawal from Opioid Pharmacotherapy

Although gradual dose reduction is more effective than rapid dose reduction, the latter may be considered under certain circumstances. These circumstances include:

- when the patient wishes to withdraw from the program after only a short period of treatment;
- if the patient is going to prison where there is no access to opioid pharmacotherapy; or
- when the patient is being withdrawn on an involuntary basis due to serious code of conduct violation.

Rapid dose reduction is preferably conducted either in an inpatient setting, or an outpatient setting in which there is significant support and opportunity for review. It is recommended that the advice of an Addiction Medicine Specialist is sought before commencing any rapid withdrawal from opioid pharmacotherapy.

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Tables 9.3 and 9.4 present the suggested dosing regimens for rapid withdrawal from methadone and Buprenorphine.

Table 9.3: Suggested dosing regimen for rapid withdrawal from methadone

Dose of Methadone	Recommended reduction rate
Above 80mg per day	10 mg per day until the dose reaches 80 mg per day
80mg or less per day	5 mg per day until withdrawal is completed
Withdrawal should be completed within 21-28 days.	

Table 9.4: Suggested dosing regimen rapid withdrawal from buprenorphine

Dose of Buprenorphine	Recommended reduction rate
Above 16mg per day	4mg per day
16mg or less per day	2mg per day until withdrawal completed
Withdrawal should be completed within 14 days.	

Patients undertaking a rapid withdrawal should be returned to daily supervised dosing. Takeaway doses should not be provided. Alternate dosing schedules (i.e. double and triple dosing) are also NOT appropriate when undertaking a rapid buprenorphine reduction.

Patients undertaking a rapid withdrawal should be returned to daily supervised dosing. Takeaway doses should not be provided. Buprenorphine alternate dosing schedules (i.e. double and triple dosing) are also not appropriate.

9.4 Avoiding secondary problems with alcohol, sedative or hypnotic drugs

During and after withdrawal from opioids, excessive use of alcohol and the inappropriate prescribing of sedative or hypnotic medication are common. This can often result in a long-term shift to alcohol and other drug dependence. The clinician should remain vigilant to the possibility that alcohol consumption or other drug use may increase to hazardous or harmful levels or may lead to a switching in the drug(s) of dependence and provide appropriate interventions.

SECTION: 9

Completing Treatment

The prescribing and use of psychotropic medication (in particular, sedative medications of all descriptions) is not recommended for people with a history of alcohol and drug dependence and who have recently withdrawn from opioid pharmacotherapy.

The prescribing and use of psychotropic medication is not recommended for people with a history of alcohol and drug dependence and who have recently withdrawn from opioid pharmacotherapy.

If a patient has a history of recent withdrawal or substance abuse or dependence, the advice of an Addiction Medicine Specialist should be sought prior to prescribing sedative or hypnotic medication. When seeking this advice, prescribers should outline:

- the rationale for the medication;
- identified risks associated with the medication;
- monitoring and review of clinical benefit, risk and harm of the treatment plan;
- the planned duration of treatment/s;
- arrangements for supervision; and
- any dispensing restrictions.

9.5 Exiting patients

When a patient exits an opioid treatment program, or transfers between prescribers, a Notification of Termination of Methadone/Buprenorphine form (available from the Pharmaceutical Services Branch [PSB]) must be completed. This form must be immediately forwarded to the PSB.

Patients must be exited from treatment with one prescriber before commencing treatment with another. This prevents patients being registered on two programs simultaneously.

Patients must be exited from treatment with one prescriber before commencing treatment with another.

A notification of termination of methadone/buprenorphine form must be completed by the current prescriber.

9.5.1 Notifying the Dosing Site/Pharmacy

The prescriber or treating service is responsible for exiting a patient from opioid pharmacotherapy. When preparing to exit a patient from the program, the pharmacy should be notified by the prescriber or case manager. If the patient has outstanding debts

with the pharmacy (for dosing), the pharmacy is responsible for managing this issue and putting in place any necessary strategies to ensure payment.

The prescriber or case manager should, however, make the patient aware that failure to pay any outstanding debts with the dosing pharmacy may compromise their potential to re-enter the program in the future. Securing a position with a dosing pharmacy can be difficult if a patient has a history of outstanding debts for dosing.

The patient should be made aware that failure to pay outstanding debts with the dosing pharmacy may compromise their potential to re-enter the program in the future.

The Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards recommend that pharmacies do not allow patients to accumulate debts for dosing. Patients should be advised that they are required to make payment prior to dosing (see Section 16 for further information on the roles and responsibilities of pharmacists).

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SECTION: 9
Completing Treatment