

Managing Complex Presentations

In this section you will...

- *Be provided with specific recommendations on the management of clients who with complex presentations.*

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12 Managing Complex Presentations

A significant proportion of clients who present for opioid pharmacotherapy treatment will have multiple and complex presentations. Complexities relating to treatment contraindications, assessing for risk and protective factors, and managing missed doses are outlined in Sections 4, 5 and 8 respectively; Section 11 describes commonly treated population groups. This section provides specific recommendations regarding some of these complexities including managing challenging behavioural presentations.

12.1 Consultation and liaison services

ADS South provides access to a Consult Liaison Service (CLS) for the Royal Hobart Hospital. Services offered by the CLS include providing support for addressing actual or potential complications that may arise for in patients who are also receiving opioid pharmacotherapy. The service operates between 9 am – 4:30 pm and can be accessed by:

- phone (0413668043);
- pager (#9436); or
- email (ads-southconsultationservice@dhhs.tas.gov.au).

The Alcohol and Drug Services North and North West do not currently have a dedicated hospital consultation and liaison service. Clinical advice and support is provided to hospitals throughout the region by the local Alcohol and Drug Services medical officers.

For the **North/North East region of Tasmania** (including the central midlands and Flinders Island) the **Alcohol and Drug Services North, Launceston (6336 5577)** should be contacted.

The **Alcohol and Drug Services North West, Ulverstone (6429 8555)** provides services to the **North West coast** from Deloraine to Smithton, Queenstown, and King Island.

12.2 Managing hospitalised clients with opioid dependence

If an opioid pharmacotherapy client requires hospitalisation, he or she is responsible for informing the in patient facility that they are receiving opioid maintenance therapy from. Once informed, the hospital doctor should:

- Verify the client's identity;
- Contact the prescriber (PSB will be able to provide this information) or case manager to discuss:
 - the pharmacotherapy treatment agent;
 - the client's pharmacotherapy treatment requirements;
 - dosing arrangements, including access to takeaways;

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- date and time of last dose;
 - any issues related to client management on the program; and
 - risks associated with the treatment of the client's medical condition.
- Contact the dosing pharmacy to confirm the date of the last dose and determine if the client has any takeaway doses in their possession.

12.2.1 Dosing during admission

Once admitted, dosing at the client's usual pharmacy should be ceased and the prescription cancelled. Pharmacists should await confirmation from the prescriber before recommencing dosing. The prescriber must be notified of the client's admission to hospital and make the necessary arrangements to cease dosing. Dosing should then be conducted by the hospital pharmacy.

The client should also be closely monitored for signs of intoxication or withdrawal. The prescriber should be actively involved and informed of any issues relating to the management of the client's opioid pharmacotherapy treatment during admission. A specialist alcohol and drug consultation and review can be obtained if there are any concerns about the client (via the CLS outlined above).

During admission, clients are requested to hand their takeaway opioid pharmacotherapy medication to ward staff. Hospital staff should then:

- check that the container has not been tampered or altered;
- verify the takeaway dose with the prescriber and/or Alcohol and Drug Services; and
- ensure secure storage of takeaway doses.

Clients admitted to hospital are required to hand takeaway medications in their possession to the ward staff.

If a client refuses to hand over their takeaway doses, they should not be dosed by the hospital pharmacy.

Dosing by the hospital pharmacy can only occur after the client has handed staff takeaway medication in their possession. If methadone or buprenorphine are not available at the hospital pharmacy, the verified takeaway doses may be dispensed after consultation with the prescriber. If the dose is no longer required it should be returned to the pharmacy or destroyed in accordance with the guidelines presented in the *Poison's Act, 1971*.

Prior to discharge, follow up arrangements should be made with the opioid pharmacotherapy prescriber to re-establish pharmacotherapy post-discharge. Takeaway pharmacotherapy doses should not be given back to clients on discharge. The pharmacotherapy prescriber will need the following information:

- confirmation of the discharge date;
- confirmation of the date and time of the last dose;

- information about any take away doses that the client may have had in their possession and how these were managed and;
- details of the client's clinical management during the admission including any clinical or behavioural management issues.

Takeaway doses should never be given back to clients on discharge.

12.2.2 Treating opioid dependent clients not currently registered on the opioid treatment program

If an opioid dependent client who is not receiving opioid pharmacotherapy is admitted to hospital, they may experience opioid withdrawal while they are unable to access opioids. Consequently, clients experiencing withdrawal during an admission may become agitated and aggressive and may discharge themselves against medical advice. Clients may also self-medicate with unsanctioned opioids creating difficulties for their medical management. Therefore, it is important that opioid withdrawal is identified and effectively managed during admission.

Methadone and buprenorphine can be used to manage opioid withdrawal during an admission; however this can only be provided and managed by an ADS medical officer. Buprenorphine is the treatment agent of choice: it allows for easier transition to other treatments (i.e. methadone or buprenorphine maintenance treatment) post discharge. If a client demonstrates clear signs of opioid withdrawal, the ADS should be contacted and an Addiction Medicine Specialist consultation review arranged. Medically managing a client's opioid withdrawal during admission may reduce the likelihood of discharge against medical advice.

Prior to the commencement of treatment for opioid withdrawal, the client will require a comprehensive assessment (including the commencement on the Clinical Opiate Withdrawal Scale (COWS): see Appendix X). Medical withdrawal management is initiated when:

- there is clear evidence of withdrawal symptoms;
- withdrawal symptoms are likely to impact on treatment of the medical condition; and
- there is an increased risk that the client may discharge themselves from hospital prematurely, placing them at risk.

The client's analgesic requirements also need to be considered. As discussed throughout this document, buprenorphine can complicate analgesic use because of its partial agonist properties and high μ -Opioid receptor affinity. In this circumstance, it may be more appropriate to use methadone to manage opioid withdrawal or provide alternative symptomatic relief.

Ideally, methadone and buprenorphine treatment for opioid withdrawal during admission should be ceased prior to discharge. If further treatment is required, discharge planning

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should include arrangements for the client to be managed by an approved prescriber post-discharge.

The client should also be informed that treatment of withdrawal with methadone or buprenorphine does not constitute opioid maintenance therapy. If maintenance therapy is required, a specialist alcohol and drug consultation can be arranged to help facilitate access to an opioid pharmacotherapy prescriber.

12.2.3 Anaesthesia

Clients being admitted for major surgery are responsible for informing their doctor that they are taking methadone or buprenorphine. Clients may require higher doses of anaesthesia if there is evidence of cross tolerance between methadone and other anaesthetic agents. Sharing this information with the treating doctor allows for the development of an effective treatment plan that informs both the surgical procedure and the management of postoperative pain.

If a client treated with high dose buprenorphine is admitted for surgery, the last dose of buprenorphine can be administered 48 hours before surgery to ensure sufficient μ -opioid receptors are available for a full μ -OR agonist to work on and provide adequate analgesia (e.g. morphine). If the client is prescribed a buprenorphine dose higher than 16mg daily, reducing the last dose to 16mg or less will make it more likely that there will be sufficient unoccupied μ -ORs available.

12.2.4 Acute Pain

Clients receiving opioid pharmacotherapy who experience acute pain often receive inadequate treatment of their pain. This is because analgesia is sometimes withheld due to fear that it may create problems of dependence. Opioid dependent clients should receive analgesia (including parenteral analgesia if this is deemed appropriate treatment) for acute pain management. Opioids in addition to the client's current methadone or buprenorphine dose may be administered to relieve acute pain; however, the client's level of intoxication and respiratory function should be closely monitored. A well developed treatment plan that actively involves the prescriber and includes plans for the reduction of the amount and frequency of the analgesia dose is recommended prior to discharge.

Managing acute pain in clients on buprenorphine

Due to the 'blocking' effect of the buprenorphine on full opioid agonists, clients maintained on buprenorphine will have a diminished response to opioids prescribed for analgesia. Consequently, clients on buprenorphine who suffer severe or persistent pain will require considerably higher doses of opioid analgesia than individuals not in buprenorphine treatment (Lintzeris et al., 2001).

Furthermore, buprenorphine has a long duration of action due to its high receptor affinity, slow receptor dissociation characteristics, and long elimination half-life. It is possible to slowly overcome these barriers with morphine delivered by patient controlled analgesia (PCA), but caution is indicated to avoid overshooting when buprenorphine comes off the receptors.

If possible, simple analgesia should be used (i.e. aspirin, paracetamol, tramadol). Short-term options for managing acute severe pain include:

- use of non-opioid analgesics (e.g., a NSAID such as ketorolac);
- regional analgesia;
- sedation with a benzodiazepine;
- general anaesthesia;
- nitrous oxide;
- ketamine;
- tramadol;
- fentanyl infusion; and
- oxycodone, which may be effective because much of its analgesic effects are thought to be mediated via its action on k -opioid receptors as well as on μ -opioid receptors.

In acute pain situations the client's current buprenorphine dose should be maintained. A temporary increase in the buprenorphine dose may provide additional analgesic cover. The following options should be considered:

Option 1: Continue buprenorphine treatment, increasing the dose by 25%.

This may be sufficient for time limited and moderately severe pain, especially when the present buprenorphine dose is ≤ 12 mg daily. This strategy is less likely to work if the daily buprenorphine dose is 16mg or more since all of the μ -ORs will be occupied.

Option 2: Continue buprenorphine and titrate short-acting opioid analgesic to effect.

Higher doses of full opioid agonist analgesics may be required to compete with buprenorphine at the μ -OR; therefore, caution is required if buprenorphine therapy is abruptly discontinued. This is because there is increased sensitivity to full agonist activity, for example, sedation and respiratory depression, as the buprenorphine comes off receptors.

Option 3: Divide the buprenorphine daily dose and administer every 6 to 8 hours to take advantage of its analgesic properties.

Effective analgesia may require the use of additional opioid agonist analgesics (e.g. morphine).

Option 4: Discontinue the buprenorphine therapy and treat the client with a full opioid agonist, titrating to effect to avoid withdrawal and then to achieve analgesia.

Morphine is often given intravenously or by PCA in the first 24-48 hours after admission or post-operatively. As the pain begins to settle the PCA can be ceased and oral opioid analgesia commenced with a combination of an immediate-release plus sustained-release opioid medication. This may be done with morphine or oxycodone.

Once acute pain is resolved, the full opioid agonist is discontinued and maintenance therapy with buprenorphine is resumed after awaiting adequate washout and emergence

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of opioid withdrawal signs, utilising the usual induction protocols. This would seem the most sensible option when one anticipates acute severe pain lasting 12 hours or more.

In a client hospitalised for surgery, the buprenorphine dose can be reduced to 6mg on the day of surgery, and intravenous morphine via PCA following surgery can be provided, switching to oral oxycodone (OxyContin plus Endone to titrate) as the pain settles. The 6mg buprenorphine leaves sufficient μ -ORs available on which a full μ -OR agonist can act. If a client is hospitalised with acute severe pain, baseline opioid requirement can be managed and opioid withdrawal can be prevented by converting buprenorphine to methadone at 30 to 40 mg/ day.

The methadone will prevent acute withdrawal in most clients. If opioid withdrawal persists, subsequent daily methadone doses can be increased in 5 to 10mg increments. This approach allows for titration of another opioid analgesic such as morphine or oxycodone for pain control in the absence of opioid withdrawal. When the acute pain resolves, the methadone and other full opioid agonist is discontinued and maintenance therapy with buprenorphine is resumed after awaiting washout of the full opioid agonist, utilising the usual induction protocol.

Regardless of which approach is adopted, if the client is discharged while full opioid agonist analgesics are still required for pain, the methadone is discontinued and the client can be managed as stated in the fourth buprenorphine approach. It is important to ensure there is a clear plan for reducing and ceasing the full agonist and that this is communicated in writing to the GP and client. It is also important the medication is provided in a safe manner. This will usually mean daily dispensing.

For example, if the client is managed with OxyContin and the pain is stabilised at 50mg BD post-operatively, the dose can be reduced by 10mg BD each day so that this medication is ceased after five days. If the client is discharged when the OxyContin dose is down to 30mg BD, the treatment would be tapered and ceased after three days.

Managing acute pain in clients on methadone

Methadone also reduces the analgesic effectiveness of opioids by inducing cross tolerance to all opioids. Hence, a higher dose of opioid medication will be required when managing acute, moderate to severe pain.

As previously stated clients taking methadone have an established tolerance for opioids and therefore may require higher doses for adequate pain relief. In these circumstances the initial dose and route of administration should be the same as for clients with acute pain who are non-opioid dependent. If clients require analgesia for longer than two days, oral administration is preferred.

A temporary increase in the methadone dose may also assist with pain management. This should be done in consultation with the prescriber and with a clear plan for dose reduction prior to discharge. A pain specialist may need to be consulted in situations where analgesia is not achieved.

12.3 Managing Acute Pain in Primary Care

In primary care settings, acute pain should initially be managed in the same manner as for clients who are non-opioid dependent. As outlined in the previous subsection (managing

hospitalised opioid dependent clients), prescribers should be aware of the reduced effectiveness of analgesia as a result of increased tolerance. Consideration should also be given the possible risk of increased sedation associated with combining opioids and analgesia.

Other opioids cannot be prescribed to clients registered on opioid pharmacotherapy without an authority due to regulatory requirements. In addition, the significant risk of overdose and death associated with the use of opioids in combination is an important consideration.

Due to regulatory requirements, other opioids cannot be prescribed to clients registered on opioid pharmacotherapy without an authority.

12.4 Persistent Pain

Clients with persistent pain require a comprehensive assessment, care planning and treatment interventions provided by a specialist clinical team (usually a Pain Service). There is some evidence to suggest that continued opioid use reduces an individual's pain threshold and may increase somatic focusing. This would suggest that clients receiving opioid pharmacotherapy may be at increased risk of persistent pain.

The management of clients with persistent pain who have developed dependence is complex and consideration should be given to the range of psychosocial issues that contribute to the client's situation. The treatment of persistent pain focuses primarily on psychological and behavioural aspects. The aim of these interventions is to minimise disability and enhance functional capacity (National Pain Summit Initiative, 2010). It is not appropriate to prescribe additional opioids for clients receiving opioid pharmacotherapy.

The management of pain should be in accordance with the principles outlined in the National Pain Strategy (2010) (www.painsummit.org.au/strategy/Strategy-NPS.pdf/view). This strategy is an integrated approach to improving the care provided for the management of acute, persistent and cancer-related pain.

It is not appropriate to prescribe additional opioids for clients receiving opioid pharmacotherapy.

In the rare event that a client does require additional opioids post an acute pain admission a detailed plan with a reduction regimen and the input of an addiction and pain specialist should be developed prior to seeking approval from PSB.

12.5 Therapeutic Dependence

Therapeutic opioid dependence is defined as dependence that has developed following the use of opioids for the treatment of acute pain associated with a medical condition; consequently, the dependence is on prescribed opioids. In such cases, dependence on the opioid medication can become a larger problem than the underlying medical condition,

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which may have diminished in importance or resolved. In Tasmania, many clients access the opioid pharmacotherapy program due to therapeutic opioid dependence (see also Section 2).

Clients who state that they are in severe pain and request opioid treatment can present a therapeutic dilemma to the clinician. Determining whether the problem is principally one of (severe) pain or opioid dependence can be difficult. Furthermore, the treatment of therapeutic opioid dependence in association with persistent pain is complex.

Good clinical assessment and management requires attention to a range of psycho-social factors, as well as biological or medical factors. Furthermore, a clinical team may be required to address the complexity of the client's needs. This team may include specific treatment services or specialists such as:

- multidisciplinary pain clinic (Royal Hobart Hospital);
- specialist medical practitioner;
- General Practitioner;
- Addiction Medicine Specialist;
- allied health (physiotherapist; occupational therapist; psychologist; social worker); and
- key worker or case manager (either a nurse or allied health professional) who coordinates the key services.

Clients with therapeutic opioid dependence can be referred to ADS for a specialist Addiction Medicine Assessment in accordance with Sect 59E of the Poisons Act 1971 (See below). The ADS will provide advice in relation to potential substance dependence and offer specialist advice and treatment strategies. The client may then be appropriately managed by their General Practitioner and medical specialist if:

- there is no history or evidence of illicit or unsanctioned drug use;
- the client is not associated with drug culture;
- there is a significant medical condition; and
- persistent pain is the predominant presenting problem.

Effective treatments for clients with therapeutic opioid dependence require realistic treatment goals and clear boundaries that are negotiated between the client and clinician. These clients are often resistant to treatment and reluctant to engage with AOD services. This is because they do not identify themselves as drug users. Clinicians should be sensitive to the client's perceptions and experience of being referred to an alcohol and drug service.

A nonjudgmental approach, open and honest communication, working with resistance, and using motivational approaches can facilitate the successful engagement of reluctant clients (Marsh and Dale, 2006). Psychoeducation in relation to drug dependence and effective pain management can assist the client's understanding of their situation and help facilitate a shift in their perceptions about treatment.

12.6 Section 59E: Addiction Medicine Review

The PSB monitors and issues authority scripts for the supply of Schedule 8 drugs under Section 59E of the Poisons Act 1971. As part of this process, the PSB may advise a medical practitioner to seek a specialist alcohol and drug assessment to review whether a client is dependent on opioids (see Figure 12.1).

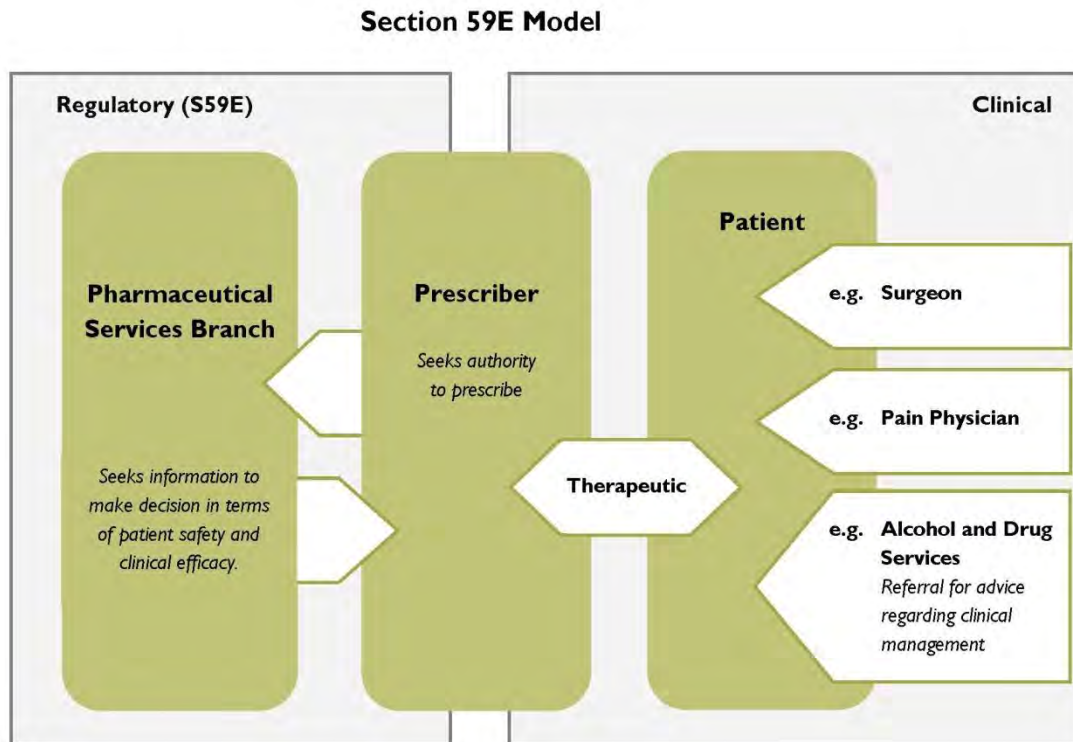


Figure 12.1: Section 59E Model

These recommendations are usually made once a client has come to the attention of the PSB (e.g. as a result of opioid drug seeking behaviour or concerns related to escalating doses), or at the request of the Expert Advisory Panel (EAP). Membership of the EAP includes the Chief Pharmacist, a Pain Medicine Specialist and an Addiction Medicine Specialist (as well as other specialists). The EAP is a non-statutory panel that provides specialist advice to the PSB on the management of clients receiving long term Schedule 8 medications.

When receiving these referrals and recommendations, the ADS will:

- request and obtain collateral clinical information including specialist reports and investigations;
- undertake a comprehensive specialist assessment (including a supervised urine drug screen);
- make recommendations about the client's ongoing management (including dosing arrangements, referrals for specialist interventions, opioid withdrawal management); and
- determine the client's need and suitability for opioid pharmacotherapy or medication reduction regimens.

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If there is clear evidence of illicit drug use, high risk polydrug use, drug seeking behaviour (prescription shopping), or other problematic behaviours, the recommendation may be for the client to be managed by the ADS. The ADS can provide access to comprehensive treatment planning and management through a multidisciplinary team.

The client's GP (or doctor who was prescribing the opioids) is responsible for providing information to the client about opioid dependence and ADS processes. This means that the client should be clearly informed of the reason for the referral to the ADS and of the purpose of the Addiction Medicine Specialist assessment. Appendix X provides an overview of the specialist medical assessment and regulation under Sect 59e consent points.

The client's GP (or doctor who was prescribing the opioids) is responsible for providing information to the client about opioid dependence and Alcohol and Drug Services processes.

12.7 Sudden Cessation of Opioid Pharmacotherapy

Clients who suddenly cease opioid pharmacotherapy usually experience withdrawal symptoms and are at increased risk of overdose and death if they return to illicit drug or unsanctioned opioid use.

Sudden cessation of opioid pharmacotherapy increases the client's risk of overdose and death.

While there are many factors that influence treatment retention, the client should be informed of the potential risks associated with the sudden cessation of treatment.

Dropping off the program

Sometimes clients unexpectedly exit treatment. This can occur once a client has been stabilised for sometime; however, it more frequently occurs during the stabilisation phase. Unexpected drop-out often indicates a return to other drug or illicit opioid use. However, for longer term and stabilised clients, it can also indicate sudden relocation or, in some instances, incarceration.

If a client unexpectedly drops out of the program:

- attempt to follow-up with the client to ensure their safety; and
- reinstitute treatment if safe to do so.

If a client intentionally disengages from treatment:

- provide harm reduction advice;
- provide advice about withdrawal management and risk of overdose; and
- inform the client that they can return to treatment in the future.

In Tasmania, the opioid pharmacotherapy program is a maintenance program and not an access program (i.e. sporadic access to treatment rather than regular, daily access); therefore, retention in treatment is preferred. Some clients may make several attempts to commence treatment before they are able to sustain and commit to treatment and associated lifestyle change: this is normal in the process of behaviour change. Potentially each time the client makes contact or engages in treatment, their trust and confidence increases and maintenance treatment is often achieved.

12.8 Managing Aggression and Threatening Behaviour

Prior to commencement of treatment with the ADS, code of conduct obligations are outlined to, and signed by the client (see Section 6 and Appendix X). This process helps establish that physical and verbal aggression towards staff and other clients is not tolerated. Staff are also obliged to adhere to the agency's code of conduct and not engage in aggressive behaviours.

Challenging behaviour, including aggression, can be the result of poor communication and interpersonal skills or poor emotional regulation. Furthermore, some individuals may display this type of behaviour due to a trauma history. Identifying and managing challenging behaviours, such as intimidation, aggression, and verbal abuse, is an important skill for clinicians delivering pharmacotherapy. The ADS provides regular training for staff and has policies and procedures to support and guide clinicians in managing aggressive and threatening behaviour.

12.8.1 Defining Aggressive Behaviour

Aggressive behaviour is defined as any behaviour that creates intimidation and fear or causes offense to others. Aggressive behaviours can be directed towards an individual, a group of individuals or property, can occur in any location (on or off site), and at any time (during or out of work hours). It may be face to face, over the telephone, or by written correspondence.

Aggressive behaviour is more than being upset. Aggressive behaviour can manifest in a number of ways, including:

- threats to harm others or self;
- physical or verbal harassment or bullying;
- physical violence (e.g. hitting, kicking, grabbing, holding, spitting, punching, use of weapon) towards people or objects (including departmental property);
- raised or shouting voice and use of obscenities;
- use of innuendoes, racist, or sexist comments;
- vulgar noises, expressions or gestures;
- stalking and exhibition of offensive material;
- blocking entry or exits and refusal to move when requested;
- unlawfully detaining staff, other clients and general public; and
- other violent conduct contradicting accepted community norms.

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12.8.2 Warning Signs of Aggression

Not all people display the same warning signs: some may become restless and agitated whereas other can become quiet and withdrawn prior to an aggressive episode. The following is a list of common physical cues or warning signs preceding aggression:

- flushed face and neck;
- protrusion of blood vessels in the neck, forehead and temples;
- rising volume and pitch of voice;
- grimacing or frowning;
- clenched jaw muscles;
- teeth grinding;
- flared nostrils;
- rapid, shallow breathing;
- increased gesticulation and increased excitability;
- sweating and beading along the forehead, hairline or upper lip;
- trembling limbs;
- clenching fists;
- fidgeting hands;
- increased coarseness of language;
- sanding during a seated interview;
- agitated pacing;
- fixed and prolonged gaze; and
- entering personal space.

In addition to physical cues, there are three main verbal cues:

- verbal threats, which should always be taken seriously;
- ritualistic repetition of the same thing over and over; and
- depersonalising language, including foul or demeaning language, which may signal the impending onset of an attack (e.g. scum, dog).

12.8.3 Responding to Aggressive Behaviour

Clinical responses to aggression include diffusion, control of aggression, and termination of contact.

Step 1: Informal Warning: Diffusion of aggression

Attempt to defuse the situation by using personal communication skills to refocus the client on the matter being discussed and issue an initial warning. It is important to give this warning as soon as a client becomes threatening or aggressive. Furthermore:

- use concise and calm communication including active listening techniques;

- speak clearly and slightly slower than normal;
- adopt a balanced neutral posture;
- use simple words and short sentences to avoid confusion;
- allow the client time to process what has been said;
- remain focused on the issue and avoid negative statements;
- use non-verbal listening skills to indicate interest;
- allow the client to tell their story;
- acknowledge the client's story using both verbal and non-verbal communication skills;
- reflect the content of the client's story by paraphrasing and summarising key points without being obtrusive or unnecessarily interrupting; and
- use open questioning to clarify and/or direct the conversation where possible.

If an extremely aggressive person is encountered, it may be more appropriate to attempt to take control of the situation by use of assertion and direction, rather than initial warning and attempting to refocus. This will be determined by several situational variables including the circumstances, location, the client and personal skills of the staff involved. If a physical assault occurs, police intervention should be sought immediately.

Step 2: Formal Warning: Controlling aggression

If step 1 does not result in diffusion of anger, assume control of the situation by use of a consequence warning that is outcome focussed and uses assertive negotiation skills. (e.g. "I will have to terminate this visit if we can't keep to the issue and I don't want to have to do that." Or "If you continue to swear at me, I will end this interview"). Furthermore:

- maintain the use of balanced neutral posture to reinforce the verbal request;
- use non-threatening gestures to emphasise the verbal message, if appropriate;
- continue to use concise and calm communication including active listening techniques; and
- use assertive repetition to take control and direct the conversation by using the same simple message.

Step 3: Termination of the Contact

If the situation escalates, ask the person leave, remove yourself from the situation, or terminate the telephone call. If a co-worker has requested a client to leave the premises, try not to inflame the situation: avoid threatening language and maintain personal safety. If a person refuses to leave when requested, the most senior person on location not involved in the incident should call the police to remove the aggressive person from the premises. Inform the person that the police have been called.

If a staff member cannot withdraw to safety or the situation has escalated to a physical or potentially physical encounter, the worker should raise attention and seek immediate help. Some workplaces (e.g. ADS) have duress alarms in interview rooms.

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Step 4: Reasonable Force

If a worker cannot retreat in response to a physical threat, he or she is entitled by law to use such reasonable force to defend themselves, enabling them to escape to safety until further assistance arrives. Reasonable force is an amount of force sufficient to stop an attack or to prevent injury and should not be greater than required. Legal expectation is for retreat from a situation of violence whenever possible. Occasionally a situation may occur wherein the only protection is by occurrence of actual harm to the offender. If this is absolutely necessary, then it is acceptable in law.

In extreme situations when there are concerns about ongoing risk to staff and others, legal advice may be sought in relation to the use of legal orders and other strategies to ensure safety and manage risk.

12.9 Continued High Risk Drug Use and Polydrug Use

Unsanctioned substance use during the early stages of opioid pharmacotherapy is common. In addition to the strategies highlighted in Section 8, clients with problematic polydrug use may require assistance to reduce or cease other drug use. It is important to collaborate with the client to achieve the identified treatment goals. Strategies for achieving these goals may include:

- selective detoxification;
- planned reduction regimens;
- relapse prevention;
- skills to cope with withdrawal symptoms; and
- contingency management techniques that reinforce behaviour change.

Establishing a therapeutic alliance with the client is important for maintaining engagement in treatment. This also requires ongoing review and assessment of the risks and benefits of treatment for the client, including the potential risks associated with withdrawal from treatment. Given the intensity of treatment required for clients with continued high risk polydrug use, a multidisciplinary treatment team approach through the ADS is recommended (see also Section 3).

12.9.1 Benzodiazepines

The use of benzodiazepines amongst clients receiving opioid pharmacotherapy is not uncommon. Generally, these clients can be classified into three groups: those who occasionally use benzodiazepines when opioids are unavailable; those who are benzodiazepine dependant, and those who are seeking intoxication (on any drug) (Queensland Health, 2008).

Those clients who use occasionally have usually had experience in using benzodiazepines to relieve uncomfortable withdrawal symptoms when they have been unable to obtain opioids. These clients are more likely to use benzodiazepines during the stabilisation phase of opioid pharmacotherapy treatment (to manage discomfort), when methadone and buprenorphine doses are still relatively low.

Clinicians should be aware of any such history and should actively encourage clients to use strategies such as rest, hot baths, positive self talk, self soothing, and relaxation strategies to relieve discomfort during stabilisation. Clients should also be informed about the risks of concurrent benzodiazepine use and opioid pharmacotherapy.

Those clients seeking intoxication states are often the most challenging to manage as a result of their potential to use any substance to achieve intoxication. This can create challenges in terms of clinical safety. In these circumstances a careful and thorough assessment is required to determine the client's suitability for opioid pharmacotherapy.

12.9.2 Benzodiazepine Dependence

Some clients may have comorbid benzodiazepine dependence. Opioid pharmacotherapy is not a treatment for benzodiazepine dependence. Consequently, benzodiazepine use does not automatically cease following stabilisation on opioid pharmacotherapy. These clients will require more assertive management and monitoring.

A benzodiazepine reduction regimen must be implemented prior to or at the commencement of maintenance opioid pharmacotherapy treatment.

If the client is dependent on benzodiazepines, a benzodiazepine reduction regimen must be implemented prior to, or at the commencement of maintenance opioid pharmacotherapy. It is important not to abruptly cease benzodiazepine medication, as this may increase medical risks associated with benzodiazepine withdrawal (such as seizures and delirium). The doctor should transfer the client to a long acting benzodiazepine (such as diazepam) and commence a reduction regimen. In these situations it is important to complete a Benzodiazepine Reduction Agreement with the client (see Appendix X). This will assist the client to understand what to expect and the restrictions associated with the reduction regimen.

Benzodiazepine cessation can be very challenging and as such the client should be offered a range of strategies to assist them. A carefully developed treatment plan should include;

- detailed reduction regimen;
- regular assertive follow-up;
- daily supervised dosing or restricted quantity/pick up;
- referral for specialist AOD psychosocial interventions;
- registration and monitoring with the Medicare Prescription Shopping Information Service; and
- Selective detoxification if required.

In addition, benzodiazepines should not be commenced for clients receiving maintenance opioid pharmacotherapy.

Benzodiazepines should not be commenced for clients receiving maintenance opioid pharmacotherapy.

Given the substantial risks associated with concurrent use of benzodiazepines and opioids, the advice of an Addiction Medicine Specialist should be obtained in relation to assessment and the development of an appropriate reduction regimen to achieve cessation of benzodiazepines.

12.9.3 Alprazolam Restrictions

It is important to be aware that alprazolam cannot be prescribed for clients receiving opioid pharmacotherapy without the written approval of the Clinical Director of the Alcohol and Drug Service (Section 59C, *Poisons Act, 1971*). Alprazolam is listed as a declared restricted substance (Declared Restricted Substance Order, 1990) under the Tasmanian Poisons Act 1971.

Alprazolam cannot be prescribed for clients receiving opioid pharmacotherapy in Tasmania without the written approval of the Clinical Director of the Alcohol and Drug Service.

12.10 Drug Dependent Behaviours

People with significant alcohol and other drug use issues, particularly those who are drug dependant, often develop maladaptive patterns of behaviour that support or enable their drug dependence. These behaviours are referred to as drug dependent or drug related behaviours.

In general, these behaviours, as discussed below, were not usually part of the individual's patterns of behaviour prior to the development of their substance dependence. During the early stages of treatment, it is common for these drug dependent behaviours to occur, however, after time spent in therapeutic treatment, these behaviours become less necessary, and tend to decrease. For some clients these behaviours and associated activities are more entrenched. Therefore, close monitoring and support are required to ensure that treatment is not compromised by the behaviours. It is also necessary to regularly review the treatment plan with the client and to include strategies that may assist in reducing other drug use.

12.10.1 Drug Seeking

Entrenched patterns of drug use and strong urges and cravings to use can result in clients engaging in drug seeking behaviours. This may include presenting to hospitals or a doctor's surgery afterhours seeking medications. Clients receiving opioid pharmacotherapy may present complaining that they are experiencing significant

withdrawal as a result of a missed, lost, vomited, or stolen dose. These clients may be seeking additional methadone or buprenorphine for a range of reasons.

In these situations, the prescriber should be contacted as soon as possible and the dose should never be replaced. The client should be referred back to their prescriber for assessment and support. It is important to remember that both methadone and buprenorphine have a long half-life, and as a result, it is unlikely that a client will experience significant withdrawal after missing one day's dose: this is particularly the case for stabilised clients.

12.10.2 Intoxication

It is not uncommon for some clients to seek intoxication states. In general these clients tend to seek opioids and/or benzodiazepines. This client group can be difficult to manage in private practice, as their behaviour can, at times, be chaotic, and the combination of drugs used, unpredictable. These clients are at high risk of falls, accidents, overdose and death, particularly during opioid stabilisation.

It is advisable for these clients to be referred to the Alcohol and Drug Service. Clients who are seeking intoxication can be difficult to assess and to determine if opioid pharmacotherapy is a safe and suitable treatment option. The complexity of their drug use behaviours and psychosocial circumstances are best addressed by a multidisciplinary team. In some instances, these clients may also require an inpatient admission for a selective detoxification followed by an opioid rotation or induction. In these circumstances the inpatient admission can significantly reduce the risks during stabilisation.

12.10.3 Diversion

Diversion occurs when methadone and buprenorphine doses are not used as intended. For the purposes of this document, diversion includes:

- selling, trading or giving opioid medication to others;
- removal of doses from the dosing point;
- secretion of doses for selling and injecting; and
- injection of doses.

Possession, use, administration, sale and supply of a controlled drug are criminal offences under Part 3 of the *Misuse of Drugs Act 2001*. Diversion should be reported to the Tasmania Police if there is clear evidence of real and imminent risk to the individual or to the community.

While most clients do not divert their medication the potential for this to occur remains. There are a number of risks associated with the use of diverted medications such as overdose and death. Diversion has implications for client and public safety as well as the reputation of the program. These activities may sometimes discourage pharmacists from becoming or remaining involved in the program.

When diversion is suspected or attempted, the pharmacist should discuss with the client their concerns and clarify the requirements for dosing. The pharmacist should also

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immediately notify the prescriber or case manager. The client's management and continued participation on the program should be reviewed by the prescriber or the clinical team. The following actions are recommended:

- If there is clear evidence of diversion, takeaway doses should be ceased immediately and daily supervised dosing instituted for a period of 6 months;
- If diversion of supervised buprenorphine dose occurs, takeaway doses should be ceased immediately for 6 months;
- If diversion of a supervised methadone occurs, doses should be made up to 200ml with water or cordial and administered in 50ml aliquots and takeaway doses removed for 6 months;
- When there is continued diversion of buprenorphine, a transfer to methadone may be considered if a comprehensive clinical assessment indicates that this is safe and appropriate treatment;
- In circumstances of high risk polysubstance use, a decision might be reached that continuing treatment with Buprenorphine is on balance, still the safer option albeit with removal of take away dose privileges and increased clinical monitoring and supervision; and
- If there is a subsequent or repeated diversion, the client will be removed from the program and will undergo an involuntary detoxification and may not be considered for re-entry to the program for 3 months.

Diversion is a very serious concern: it requires considerable planning, confidence and intent by the client. It is very rarely a spontaneous event. Engaging in diversion also raises issues about the client's engagement in treatment, compliance and stability. For this reason a six month period of supervised dosing and increased review and monitoring is recommended.

Diversion is often related to a client being 'stood over' by another person. Hence, it is important that any factors contributing to diversion are considered and that the client is offered strategies to deal with intimidation. If a client discloses that they are being intimidated or harassed for takeaway doses, it may be necessary to transfer them to another pharmacy. A return to daily dosing can also assist in these situations as the client will no longer be targeted for their takeaway doses. Dosing pharmacies (pharmacists) should also be made aware of any issues associated with intimidation of clients for takeaway doses. This will allow them to monitor events at the dosing site, notify prescribers of possible diversion, and, if necessary, to seek police involvement.

When diversion occurs the clinician should discuss this event with the client. The client should be made aware of the breach of the treatment agreement and a warning letter be provided detailing the reasons for the clinical concern and consequences of any further breaches. The treatment plan must be reviewed and should include increased monitoring and review and any other changes to the clients management (such as cessation of takeaway doses).

In reviewing the client's management and continued participation on the program, the prescriber and clinical team should consider the therapeutic benefits of the program for

the client, the risk to clinical and public safety, damage to the reputation of the program, and the management options in the event that diversion re-occurs.

The risk of diversion can be reduced by:

- the careful assessment of a client's suitability for takeaway doses;
- the provision of clear information to clients about the risks and consequences of diversion;
- clear guidelines and policies for dosing sites and pharmacies about the process for the management of diversion; and
- regular communication and support (liaison visits) to dosing sites/pharmacists.

12.10.4 Requests for Additional takeaway doses

It is not uncommon for clients to feel restricted by the requirements for supervised dosing. This may result in clients attempting to secure additional takeaway doses from their prescriber or dosing pharmacist. It is important for all those involved in the delivery of the Tasmanian OPP to be aware of the regulatory requirements outlined in this document (see Section 8) in relation to the provision of takeaway doses. It is acknowledged that there are situations in which some clients do attempt to procure takeaway doses for the purposes of diversion. This policy and the restrictions associated with the provision of takeaway doses have been developed in the interest of client and public safety.

Prescribers and pharmacist should not feel compelled or allow themselves to be coerced into providing takeaway doses. The clinician should clearly explain the opioid pharmacotherapy guidelines and clinical practice standards and the restrictions that this places on their practice. When a client continues to pursue this issue they should be told that nothing more can be done without further advice. The prescriber should advise the client that they will seek clarification from the Alcohol and Drug Service; and the pharmacist should inform the client that they will contact the prescriber.

12.10.5 Injecting takeaway doses

As outlined in Section 4, the injection of methadone and buprenorphine poses significant risks to the individual, including venous damage, emboli and tissue necrosis, and the transmission of infectious diseases such as HIV and hepatitis (if injecting equipment is shared). There is also a very significant risk of overdose associated with the injection of takeaway doses. Injecting buprenorphine or combined buprenorphine-naloxone can also result in precipitated withdrawal in opioid dependent clients.

As methadone and buprenorphine are designed for oral administration, injection of these drugs changes the rate of metabolism, and as a result, clients may report that their dose is not adequate. Prescribers should always check for evidence of injection as part of a regular review. When there is clear evidence of the injection of takeaway doses, all takeaway doses should be ceased and daily supervised dosing initiated.

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12.10.6 Frequently Missed Doses

As discussed earlier in Section 8, opioid maintenance therapy requires the client to be to be dosed daily (with the exception of twice or third daily buprenorphine dosing regimens). Missed dosing may result in suboptimal dosing and the client may experience opioid withdrawal. Clients who miss three or more consecutive doses of methadone are at increased risk of overdose, this is possibly related to loss of tolerance (reversal of neuroadaptation), or the use of other depressant drugs. Missed doses may be more common amongst clients receiving buprenorphine as they are less likely to experience uncomfortable withdrawal symptoms (Queensland Health, 2008).

Pharmacists are required to notify the prescriber of any missed doses. It is important to monitor the frequency and regularity of missed doses as this may be a sign of instability. Missed doses do not always mean that a client is using other substances. However, where there is a recent history of intoxication or polydrug use, it is important to closely monitor and review the client to ensure they are not at risk of overdose.

Careful attention should be paid to any regularity or patterns associated with missed doses, such as missed doses following takeaway doses, or where there may be some indication of planned drug use concurrent with takeaway doses. Missed doses may also reflect changes in psychosocial factors and may signal social or psychological distress or other increased stressors.

It is important to always explore with the client the circumstances associated with any missed doses. For example, the client may be experiencing difficulties with: transport, dosing around work hours, or may be feeling uncomfortable with pharmacy staff or feel pressured by other clients accessing the same pharmacy. The clinician should also explain to the client the impact that missed doses may have on the effectiveness of their treatment. Frequently missed doses have an impact on stabilisation and can result in a 'steady state' never being attained or maintained (see Section 7 Safe Treatment Induction), particularly during induction. In these situations, re-stabilisation should be considered in order to achieve steady state.

Where regular unexplained missed doses continue (i.e. three or more times a month) and every attempt has been made to ensure the suitability of the treatment plan and dosing arrangements, the prescriber should review the client's suitability for treatment. This should include a consideration of the risks associated with missed dosing and any other identified risks that contribute to the client missing doses. Motivational interviewing should be used to encourage the client to consider the harms and risks associated with their current circumstances, versus the advantages and disadvantages of continuing or discontinuing opioid maintenance therapy.

Within the public programs, the prescriber and case manager are required to review and discuss with the multidisciplinary team any clients who are facing difficulties with program compliance as a result of regular and unexplained missed doses. Where the clinical team identify serious concerns related to the client's continuation on opioid pharmacotherapy, they should also seek the guidance of the Clinical Director, ADS. Private prescribers are also encouraged to seek the advice and support of the ADS in similar circumstances. This may involve a review of the client by an Addiction Medicine Specialist, or the

temporary transfer of the client to the public program where more assertive follow-up and case management may assist with stabilisation and enhanced program compliance.

12.10.7 Stabilised Clients Seeking Dose Increases

It is not uncommon for clients who have been well stabilised on their dose for some time to present describing withdrawal symptoms and requesting an increase in their methadone or buprenorphine. In general, most clients will remain on the same dose for lengthy periods or even indefinitely once stabilised.

Where a client presents requesting a dose increase, it is important for the clinician to undertake a comprehensive review. This should include a thorough medical examination and assessment of client's presentation; intoxication and/or withdrawal state; recent drug use and psychosocial circumstances. There may be other reasons for the client's discomfort, including liver disease; drug interactions; alcohol and drug use/cessation, missed doses, injection or diversion of takeaway doses, difficulties with emotional regulation, anxiety or a number of social stressors.

In managing this situation the prescriber should try to explore a range of other solutions and options including increased support, regular review and referral. Methadone and buprenorphine doses should not be increased without clinical evidence of opioid withdrawal. Prescribers are encouraged to seek specialist advice and review in these circumstances.

12.10.8 Prescription Theft and Forgery

Prescription theft and forgery is a criminal offence under Part 3 of the Misuse of Drugs Act 2001. Changing or tampering with prescriptions and prescription theft should be reported to the Tasmania Police if there is clear evidence of real and imminent risk to the individual or to the community.

Clinicians are strongly encouraged to seek advice and guidance in relation to these complex clinical matters. Within the ADS these complex clinical issues should be reviewed by the multidisciplinary team with the involvement of senior managers and, where appropriate, the Clinical Director, ADS. Private practitioners involved in the delivery of the Tasmanian OPP are also encouraged to contact an Addiction Specialist within the ADS for support and advice.

If there is clear evidence of script theft by a client, the client's continued participation on the program should be reviewed. Script theft may warrant involuntary removal from the program. However, careful consideration should be given to the therapeutic benefit to the individual and risk to the community.

12.11 Involuntary Removal from the Opioid Pharmacotherapy Program

At the commencement of treatment, the client is required to sign a treatment agreement that outlines activities or circumstances that may lead to involuntary removal from the program. These include:

- violence or threatening behaviour towards the treating team or other clients;

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- theft or other illegal behaviour at the treatment centre or at the dosing site;
- diversion, trading and selling of takeaway doses;
- prescription theft or forgery;
- continued high risk polydrug use; and
- poor treatment compliance.

When reviewing a client's suitability for continued treatment on opioid pharmacotherapy, consideration should be given to:

- the safety of those involved in the delivery of treatment;
- the safety of other clients;
- the safety of the client receiving treatment; and
- the safety of the community.

Clients should be made aware of any breaches of the treatment agreement by the provision of a formal warning letter, including the consequences associated with any further breaches.

There are circumstances where rapid or abrupt cessation of opioid treatment is warranted, such as violence, assault or threatened assault to members of the treating team or other clients (see Section 9, Completing Treatment).

12.12 Public Safety Issues

12.12.1 Regular and Unexplained Lost or Stolen Dose

As outlined in Section 8, lost doses pose a significant risk to the community. There is a very high risk of overdose and death should another individual (other than that for whom the medication is prescribed) consume the methadone or buprenorphine dose. Clients who report lost or stolen doses should be asked to make a formal report to the police. When the client does not comply with this request or the notification to police does not occur in a timely manner, the matter should be reviewed by the clinical team and a notification made to Tasmania Police.

Clients who report lost or stolen doses should be asked to make a formal report to the police.

Both methadone and buprenorphine are schedule 8 medications and therefore are subject to the *Tasmanian Poisons Act 1971* and its accompanying regulations. Prescribers and case managers have a responsibility to ensure public safety and should routinely review how clients store and manage their takeaway doses.

Regular and unexplained lost or stolen doses are a significant cause for concern. It may signal:

- a return to unsanctioned drug use;

- a change in the individual's psychosocial circumstances;
- diversion of takeaway doses; or
- intimidation by others seeking illicit methadone or buprenorphine.

Prescribers and case managers should discuss with the client the circumstances of any lost doses. As the secure storage of medication is a requirement for access to takeaway doses, the client's suitability for unsupervised dosing should be reviewed. A return to daily supervised dosing is recommended until the client is able to demonstrate improved stability following a trial period.

As outlined in the section 12.9.6 (Frequently missed doses), regular and unexplained missed doses may sometimes indicate that opioid pharmacotherapy is an unsuitable treatment option. Prescribers are advised to review the client's suitability for the program and to explore with them the risks and benefits of continuing or discontinuing treatment. Decisions about treatment cessation should be made with the input and advice of the multidisciplinary team and the ADS Clinical Director. Private prescribers should also seek the advice and guidance of the ADS in these situations.

12.12.2 Consumption of methadone/buprenorphine by a child

Ingestion of methadone or buprenorphine is extremely dangerous for a child. These drugs are potentially fatal when consumed, even in small quantities. Such a situation is a medical emergency, and is best managed by emergency services.

The ingestion of methadone or buprenorphine by a child is a medical emergency and is best managed by emergency services.

The circumstances in which ingestion by a child may occur include:

- failure of clients to secure takeaway doses adequately; and
- deliberate administration of the substance to a child by a client or other child.

Recommended Procedure in case of Actual or Suspected Ingestion by a Child:

- assess the level of consciousness and monitor this continuously until the child is in the care of ambulance or other qualified staff;
- refer the child to a hospital emergency department without delay, providing as much information as possible regarding the amount and time of ingestion;
- administer oxygen if available;
- give consideration to the administration of naloxone in circumstances where the child is displaying signs of respiratory depression. Any treatment given should be documented;
- notify the prescriber, the PSB and the Alcohol and Drug Service of the incident.

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As a result of the prolonged half-life of methadone and buprenorphine there may be a delay in the onset of symptoms of overdose. For this reason prolonged observation (a minimum of 24 hours) is required for a child suspected of overdose.

As a result of the prolonged half-life of methadone and buprenorphine longer observation (a minimum of 24 hours) is required for a child suspected of overdose.

If a child has ingested methadone or buprenorphine, the child has been placed at risk of harm and the appropriate authorities must be notified. Child Protection Services should be notified as a matter of priority by phoning 1300 737 639 (24 hours). Tasmania Police may become involved at the request of Child Protection or if urgent action or assistance is sought by the notifier.

In the case that a child has ingested methadone or buprenorphine by any means, the child has been placed at significant risk of harm and the appropriate authorities must be notified.

12.12.3 Consumption of methadone or buprenorphine by a non-opioid dependent adult

As with children, the consumption of methadone or buprenorphine (outside of a clinical setting or without clinical advice and direction) by a non-opioid dependent individual is dangerous and can result in overdose and death. The same medical emergency procedures should be followed as outlined for children. However, consideration should also be given to the possible recent use of other substances, in particular other opioids, alcohol or benzodiazepines.

12.13 Managing Overdose

Symptoms of opioid overdose may last for 24 hours or more, depending on the opioid used. Death generally occurs from respiratory depression. Signs and symptoms of opioid overdose include:

- pinpoint pupils;
- nausea;
- dizziness;
- feeling intoxicated;
- sedation/loss of consciousness (nodding off);
- unsteady gait, slurred speech;
- snoring;

- hypotension;
- slow pulse (bradycardia);
- shallow breathing (hypoventilation);
- frothing at the mouth (Pulmonary Oedema); and
- coma.

Symptoms may last for 24 hours or more.

Death generally occurs from respiratory depression.

12.13.1 Methadone

In Australia, the delivery of opioid pharmacotherapy is very safe. However deaths can occur during stabilisation on methadone. These are usually associated with the concurrent use of other drugs, particularly alcohol, benzodiazepines, and antidepressants (Henry-Edwards et al., 1993). Naloxone promptly reverses opioid induced coma and should be administered as a prolonged infusion when treating methadone overdose. It is insufficient to administer a single dose as it will wear off within one hour, leaving clients at risk of relapse into coma as a result of the long lasting effects of methadone. Prolonged observation is required for those clients suspected of overdose (at a minimum 12 hours).

As a result of the prolonged half-life of methadone and buprenorphine longer observation (a minimum of 12 hours) is required for an adult suspected of overdose.

12.13.2 Buprenorphine

For opioid tolerant individuals, the risk of lethal overdose on buprenorphine is lower than for other opioids such as methadone. Buprenorphine has a high affinity for μ (mu) opioid receptors, and is not easily displaced by the antagonist, naloxone. Doses of 10 - 30 times the normal naloxone dose used to reverse heroin overdose (up to 10 - 35 mg/70 kg) may be required to partially reverse the effects of buprenorphine toxicity. Conversely, cases have also been reported where much smaller doses (2-4 mg) of naloxone have been effective in reversing the effects of buprenorphine.

In the event of depression of respiratory or cardiac function:

- establish a clear airway;
- begin assisted or controlled ventilation with oxygen;

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- intravenous fluids and other supportive measures should be employed as indicated; and
- the long duration of action of buprenorphine should be taken into consideration when determining the length of treatment needed to reverse the effects of an overdose.

12.14 Boundary Violation and Boundary Crossing

The term 'boundary' is defined as the edge of appropriate professional behaviour (Gutheil & Gabbard, 1998). Boundaries help to create an environment of safety and predictability within which the therapeutic relationship can develop. An understanding of professional boundaries and ethical practice is essential for working with clients in the opioid pharmacotherapy program. Professionals must be aware of departures from good practice and how such departures can be prevented or addressed.

Serious boundary violations often begin with less serious departures from accepted practice. Gutheil and Gabbard (1998) discuss a number of examples of boundary crossings or violations, including:

- giving or accepting gifts to or from a client;
- self disclosure of the clinician during treatment;
- the use of threats by the clinician;
- inappropriate physical contact with the client;
- meeting with the client outside of the treatment setting; and
- providing the client with access to personal mobile or home phone numbers.

Following correct or agreed procedure is an essential part of professional integrity, objectivity, and ethical practice. Abiding by correct procedure is one way in which a practitioner expresses respect for clients and fellow colleagues. Bypassing procedure and disregarding professional boundaries can introduce inequality and exploitation of clients.

Boundary violations and unprofessional behaviour by clinicians can result in significant harm to clients, including psychological, physical and sexual harms. Exploitation of clients can also reinforce long held feelings of worthlessness and abandonment and can increase their risk of engaging in high risk behaviours including self-harm.

Clients should receive respectful and professional treatment from professionals within the program, which literally means equal attention to all clients and in accord with professional standards of practice.

12.15 Professional Reporting

If the client is a registered health care professional, there are mandatory reporting requirements as part of The Health Practitioners Regulation National Law (see Section 14 Legislative Requirements). When there is evidence that a health practitioner may be practising in a manner that may put clients at risk of harm, including practising under the influence of drugs and/or alcohol, there is a requirement to notify the Australian Health Practitioner Regulation Agency (AHPRA).

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Health professionals are strongly encouraged to contact the Australian Health Practitioner Regulation Agency (1300 419 495) to seek advice and guidance in relation to these issues. Within the ADS, these complex clinical issues should be reviewed by the multidisciplinary team with the involvement of senior managers and where appropriate the Clinical Director, ADS. Private practitioners involved in the delivery of the Tasmanian OPP are also encouraged to contact an Addiction Specialist within the ADS for support and advice.

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