

External Appraisal and Feedback Summary Guide

Tasmanian Opioid Pharmacotherapy Policy
and Clinical Practice Standards

Draft 2011



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Introduction

For many individuals and their families in Tasmania, opioid dependence and illicit opioid use has had a very significant impact on quality of life. The health, social and economic costs for individuals, families and the community are wide-ranging and include: overdose deaths; family breakdown; blood borne viruses; psychological distress; workplace absenteeism and the costs associated with law enforcement and drug related crime. It is well established that opioid pharmacotherapy treatment is effective in reducing drug use and the physical, emotional and social harms associated with opioid dependence.

Access to opioid pharmacotherapy assists individuals to stabilise their lives, to improve their physical and mental health, and their social functioning and relationships. The regulatory structures of this treatment program allow for the re-establishment of routine activities of daily living. Over time, and with continued participation in treatment, individuals are able to re-establish control over their lives' and to make meaningful contributions to the community. This important document will ensure that individuals and their families, affected by opioid dependence, receive high quality, contemporary, safe and effective treatment that will allow them to improve their quality of life.

The Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards (2011) informs the treatment of opioid dependence with methadone and buprenorphine. The Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards (TOPP) has been developed based on contemporary evidence and national and jurisdictional clinical policies and guidelines for the use of methadone, buprenorphine and naltrexone in the treatment of opioid dependence.

The TOPP's development has taken into account the local circumstances and needs of Tasmania including: epidemiological data; the patterns and types of opioid drug use in Tasmania; identified and documented

public health and clinical safety issues; legislative, regulatory; and administrative requirements.

This document provides the policy framework and clinical practice standards for the treatment of opioid dependence in Tasmania. Alcohol and Drug Services and private practitioners offering opioid pharmacotherapy should provide this treatment in a manner consistent with the Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards (2011).

As a consequence of a number of significant public and clinical safety issues that have been identified in Tasmania, this document has an emphasis on the identification and management of clinical risks. As a result, the clinical and policy approach of the TOPP is necessarily conservative.

In some sections of the TOPP the emphasis on the management of clinical risks may be construed by some readers as the adoption of an abstinence model in the treatment of opioid dependence. However, this emphasis on risk management does not negate harm reduction as the fundamental construct that underpins the TOPP. The document incorporates both harm reduction and risk management approaches.

A copy of the draft Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards will be made available at www.dhhs.tas.gov.au/mentalhealth/alcohol_and_drug from 3rd October 2011.

Features of the draft Tasmania Opioid Pharmacotherapy Policy and Clinical Practice Standards

The draft Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards contains the following features:

- Detailed policy requirements and clinical practice standards to support clinicians in the delivery of Opioid Pharmacotherapy in Tasmania;
- Increased clinical safety of clients receiving Opioid Pharmacotherapy in Tasmania through careful assessment and management of risk and protective factors; and
- Builds on the current evidence base, broadening treatment approaches to include a focus on psychosocial interventions for clients with complex needs.

TOPP External Appraisal and Feedback Process:

Feedback on the draft Tasmania Opioid Pharmacotherapy Policy and Clinical Practice Standards is invited including but not limited to the following:

How the new policy and clinical practice standards will work in practice

How the TOPP will impact on health care professionals involved in the delivery of the program and those individuals receiving this treatment

Whether the TOPP will help to minimise the risks and ensure the clinical safety of clients receiving Opioid Pharmacotherapy in Tasmania.

Whether the new policy will more adequately broaden the current treatment approaches for clients to include a focus on psychosocial and risk and protective factors.

The closing date for feedback is **Friday, 28 October 2011**.

You can provide feedback in the following ways:

- **Written Feedback:** Written submissions can be emailed to adstopp@dhhs.tas.gov.au

or posted to:

TOPP EXTERNAL APPRAISAL AND FEEDBACK

Alcohol and Drug Services
13 Mulgrave St
LAUNCESTON TAS 7250

- **Online feedback:** You can provide feedback online at www.dhhs.tas.gov.au/mentalhealth/alcohol_and_drug
- **Feedback in person:**
A series of Feedback Forums will be held around the State. Details of the forums are provided below. To express your interest in attending please email adstopp@dhhs.tas.gov.au or phone (03) 6336 5577.

Following the Feedback Process:

The new policy and clinical practice standards present significant changes in the way that opioid pharmacotherapy is delivered in Tasmania. Your feedback is important to ensuring the TOPP will work in practice.

All feedback received during the TOPP External Appraisal and Feedback process will be carefully considered and the draft TOPP will be amended as necessary. The TOPP External Appraisal and Feedback Report will be made available in late November 2011.

The Tasmania Opioid Pharmacotherapy Policy and Clinical Practice Standards will then be launched and implemented in early 2012.

If you have any questions about providing feedback or about any aspect of the TOPP please email adstopp@dhhs.tas.gov.au or call Anita Reimann, Manager Clinical Practice Development and Performance, Alcohol and Drug Services, on (03) 6336 5577.

Summary Guide Purpose

This Summary Guide is designed to assist with the external feedback and appraisal process. The purpose of this guide is to provide readers with a brief content overview for each of the 16 sections in the draft Tasmanian Opioid Pharmacotherapy and Clinical Practice Standards.

All content has been summarised from the main document, and if further clarification or information is required, please refer to the main document; the draft Tasmanian Opioid Pharmacotherapy and Clinical Practice Standards.

SECTION 1: Epidemiology of Opioid Use in Tasmania

Opioid dependence is a chronic, relapsing condition, requiring substantial and costly treatment.

The risks associated with opioid dependence can significantly impact on the biological, psychological, and social health of individual patients, their family, and the community.

The use of heroin in Tasmania is relatively uncommon, whilst use of pharmaceutical opioids is more widely reported.

The TOPP focuses on issues associated with pharmaceutical opioids.

SECTION 2: Clinical Features of Opioid Dependence

Substance dependence occurs when an individual continues using a substance despite it having a significantly negative effect on his or her life, including functional impairment and emotional distress.

Clients have to demonstrate neuroadaptation to be eligible for the Tasmanian opioid pharmacotherapy program.

There is a focus on the assessment and management of clinical risk in this policy document.

Opioid pharmacotherapy should not be time limited.

SECTION 3: Policy Framework

Harm minimisation is a core principle driving the Australian National Drug Strategy and the Tasmanian Opioid Pharmacotherapy Program.

The aim is to reduce harms associated with substance use by providing an overarching framework that supports a range of interventions.

Opioid pharmacotherapy is suitable for opioid dependent individuals.

Priority access to pharmacotherapy treatment should be provided to:

- Pregnant women and their opioid dependent partners;
- People with HIV and carriers of Hepatitis B and their opioid dependent partners; and
- Opioid dependent people recently released from prison.

Tasmanian Shared Care Model

The Tasmanian ADS will facilitate the development and support the implementation of the shared care model of opioid pharmacotherapy in Tasmania.

The ADS recognises the need to provide support and supervision for primary care physicians currently providing, or demonstrating potential to provide, pharmacotherapy services.

As the capacity of the specialist services improves, increased opportunity for support, education and professional development will be established.

Despite current service limitations, if a primary care physician cannot provide a safe treatment service within the current guidelines, then no opioid treatment should be provided.

If safe treatment cannot be provided, then no treatment should be provided.

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SECTION 4: Clinical Pharmacology

Opioid Pharmacotherapy Formulations

There are two opioid pharmacotherapy formulations: methadone and buprenorphine.

Methadone

There are two formulations: methadone syrup and biodone® forte.

Buprenorphine

There are two formulations of buprenorphine for the treatment of opioid dependence. These are Subutex® and Suboxone®.

Suboxone is the preferred agent for commencement and stabilization of patients in Tasmania.

The Suboxone® sublingual film was introduced in September 2011 and is an alternative preparation that may overcome the disadvantages of sublingual tablets.

The sublingual film formulation of buprenorphine with naloxone is intended to make dosing easier.

Buprenorphine sublingual tablets take approximately 2–10 minutes to dissolve and this can make supervision of dosing difficult, particularly in community pharmacies.

The sublingual film dissolves faster under the tongue than sublingual tablets (approximately 30 seconds : <16 mg & 1 minute >16mg) and therefore requires less supervision time.

It should be noted however that there are some adverse side effects that have been observed with the sublingual film. These include a redness of the mouth, sore tongue and numb mouth. These symptoms are not reported for the sublingual tablet.

Buprenorphine has similar actions and side effects to methadone.

Methadone

Methadone is rapidly absorbed from the gastrointestinal tract, with measurable concentrations in plasma within 30 minutes of oral administration,

and a long half life. The apparent half-life of a single first dose is 12 - 18 hours, with a mean half-life of 15 hours. With ongoing dosing, the half-life of methadone is extended to between 14 and 58 hours with a mean of 24 hours

Table 4.1: Summary of Methadone Pharmacokinetics

Onset of effects	30 minutes
Peak effects	Approx. 2-4 hours
Half life (in MMT)	14-58 hours
Time to steady state	5-10 days
Withdrawal onset	36-48 hours Peak intensity 5-7 days

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.11).

Methadone reaches steady state in the body (where drug elimination equals the rate of drug administration) after a period equivalent to four to five half lives of approximately three to ten days.

Buprenorphine

Buprenorphine is a long-acting drug with a terminal elimination half-life of 24-37 hours. Peak clinical effects occur one to four hours after sublingual administration. Typically, effects will continue to be experienced for up to 12 hours at low doses (2 mg), but as long as 24-72 hours at higher doses (16 - 32 mg). The prolonged duration of effect at high doses enables alternate-day (double), and even 3-days-a-week (triple) dispensing regimes.

Table 4.3: Summary of Buprenorphine Pharmacokinetics

Onset of effects	30-60 minutes
Peak clinical effects	1-4 hours
Duration of effects	8-12 hours at low dose (<2mg) 24-72 hours at high dose (>16mg)
Time to steady state	7-10 days
Withdrawal onset	3-5 hours, symptoms generally milder than withdrawal from other opioids.

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.16).

Patients should be advised that, because of buprenorphine's competitive affinity for opioid receptors, continuing to use other opioids once they have started to take buprenorphine is likely to make stabilisation difficult and is unlikely to reduce their withdrawal symptoms

Steady state does not automatically imply clinical stability of the patient.

Pregnancy and Breastfeeding

Methadone remains the only registered treatment for pregnant and breastfeeding women.

Whilst it is the preferred option for a woman continuing with her pregnancy to transfer to methadone maintenance treatment, there may be situations in which a woman may opt to remain on buprenorphine.

In such situations, it is essential that the client is clearly informed of the risks and issues associated with buprenorphine maintenance, both to themselves and their babies.

It is preferable for Subutex® to be used rather than the cessation of all opioid treatment during pregnancy.

Discontinuation of buprenorphine treatment results in increased risk to mother and baby.

Women who become pregnant while on the combination product (Suboxone®) should be switched to either methadone or to Subutex®.

The TOPP does not recommend switching female patients from buprenorphine to methadone if they become pregnant while in the program.

Comparing Treatment Options

With the availability of two major opioid pharmacotherapy treatment options, medical practitioners and their patients need to consider many factors when deciding on the most appropriate treatment.

A thorough assessment will help clinicians identify risk and lifestyle factors that will influence the choice of pharmacotherapy for their patients, thus improving clinicians' ability to match treatment to assessment.

It is important to remember that, despite the associated risks of both maintenance therapies, appropriate prescription and use of the medications is unlikely to lead to adverse consequences.

SECTION 5: Assessment for Entry into the Opioid Pharmacotherapy Program

The foundation of every treatment plan and intervention is a comprehensive assessment. It determines the clinical pathway for access to specialist programs and interventions, as well as informing the treatment plan.

Assessment of alcohol and other drug use is a complex and continuous process that occurs both at the commencement of, and throughout treatment.

Continuous assessment allows the clinician to identify changes that occur in the patient's life, and determine how these changes may impact on their risk status and treatment planning.

A carefully conducted alcohol and drug assessment should also be patient focussed and fulfil the following functions:

- to support the development of a therapeutic and trusting relationship;
- to assist patients to evaluate and consider their own drug use and motivation for change;
- to assist patients to make linkages between their drug use and current difficulties that they may be experiencing in their lives;

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- to assist the patient to review their past and current circumstances and to make linkages between these and current drug use; and,
- to assist the patient to review the choices that they have made and the consequences of their drug use behaviour

Risk and Protective Factors

Consideration of risk should be an integral component of every assessment and ongoing management of the patient (Reith, 1998). Patients accessing alcohol and other drug treatments often have comorbid mental health disorders, chaotic and unstable lives and are frequently at greater risk of suicide.

However, patients may also have protective factors that mitigate risks and facilitate or support treatment interventions. Clinicians should consider both risk and protective factors.

It is important to note that risk factors do not necessarily preclude the patient from accessing opioid pharmacotherapy, but may indicate the need for closer monitoring, second opinions, risk management strategies or caution around dosing practices (e.g. precluding them from take-away doses).

Risk factors may also have implications on longer-term treatment planning and referral, consultation or communication with other treatment services.

Considering risk and protective factors when assessing patients and developing treatment plans is a strengths based approach.

In adopting and applying this framework to Tasmanian ADS patients, it is expected that clinical safety will be enhanced.

Initial Assessment

The aim of the initial assessment is to establish the patient's suitability for opioid pharmacotherapy with either methadone or buprenorphine.

Suitability is established when there is clear evidence that the patient:

- is opioid dependent;

- meets the DSM-IV-TR criteria for opioid dependence; and,
- has been using opioids for an extended period of time.

All initial assessments must include a medical examination conducted by the prescribing doctor.

A supervised urine drug screen is compulsory for assessing suitability for treatment.

If there are multiple or significant clinical risks that cannot be managed in the practice setting, a second opinion and clinical review should be requested from the Alcohol and Drug Services.

SECTION 6: Entry into Opioid Pharmacotherapy

Once a thorough assessment is complete, the clinician (or pharmacotherapy team) is able to determine whether the patient is safe and suitable for registration into the pharmacotherapy program.

An important part of this process is ensuring that the patient has comprehensive knowledge about the program and the ability to consent to treatment.

The initial assessment will have identified some of the patient's treatment goals.

The patient's opioid management goals should be confirmed prior to commencement of treatment.

For example, the patient may want to achieve total abstinence following the program, or perhaps, long-term opioid maintenance. The latter is more likely to be a realistic option for many opioid pharmacotherapy patients.

Regardless of the exact goal, it is important that the patient and treating team are working towards an identified and shared goal and that this goal is documented in the patient file.

At this initial stage, the following should be clearly documented:

- starting date and dose of methadone or buprenorphine;
- early monitoring arrangements;
- initial harm reduction actions and advice; and case management arrangements.

Some patients may be better able to identify steps towards achieving their opioid management and general psychosocial goals once they have been stabilised in treatment, are in a more stable mental and physical state, and have established a working rapport with their treating team.

Therefore, treatment goals and management plans can be reviewed at any time, as long as changes are made in collaboration with the patient and documented in the patient file.

The treatment plan may include a range of harm reduction goals including the reduction and/or cessation of other drug/s of concern.

As part of the treatment planning process, it is important to ensure that an appropriate dosing facility has been located and a position secured for the patient.

Most community pharmacies will have limited numbers of patients that they are able to accept for dosing at any one time. Hence, the decision to commence opioid pharmacotherapy must include a consideration of availability of a suitable dosing site.

Once the dosing site has been secured, arrangements should be made for the direct receipt of the script from the prescriber to the dispensing site.

If scripts are stolen, lost, misplaced, forged, traded, modified or sold, they can pose significant risk to the community if misused. Therefore, patients should never be given a script for opioid pharmacotherapy.

Patients should never be given a script for opioid pharmacotherapy.

Special Warnings

As well as receiving information about the treatment, patients must be informed about the specific risks associated with opioid pharmacotherapy.

The following is a list of special warnings about treatment which patients must be informed.

Risk of overdose

Patients must be well informed about the risks of overdose associated with both methadone and buprenorphine, and that these risks are dramatically increased in the following circumstances:

- following a withdrawal period when the patient has less physical tolerance to opioids;
- when consumed by a non-opioid tolerant individual, e.g. other family members who have never used opioids, particularly children;
- when the medications are combined with other central nervous system depressants, such as, alcohol, benzodiazepines, and other prescription and illicit drugs;
- when the medications are taken against medical advice, e.g. escalation of dose; and
- when the medications are changed or administered via an alternative route leading to rapid absorption, e.g. intravenous or intranasal administration.

Fitness to Drive and Drowsiness

Both methadone and buprenorphine opioid pharmacotherapy treatment can affect the patient's ability to drive, operate machinery, work at heights, and participate in active sports, particularly:

- during the first 7-10 days of commencing treatment;
- for 3–4 days after a dose increase; and
- when combined with other sedatives and depressant medications such as benzodiazepines and alcohol.

Patients must be advised that they may have to restrict or cease driving, operating machinery, working at heights, and participating in active sports

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during these periods. Ability to engage in these activities is unlikely to be affected once the patient is stabilised in treatment or stabilised after a dose increase.

If a patient is unfit to drive due to impaired mental state or a medical condition, they have a responsibility to cease driving and notify the licensing authority in Tasmania. However, this often does not occur.

Women

Female patients should be informed that ovulation patterns are likely to stabilise once on the opioid pharmacotherapy program, particularly if they were engaged in uncontrolled drug use prior to entering the program. This means their risk of unplanned pregnancy is increased.

Keeping appointment times

Common courtesy is for patients to attend agreed appointment times or notify their treating team if they cannot attend.

Limited opening hours of some services that provide opioid pharmacotherapy treatment, and the busy schedules of both the doctors and nurses in these settings, means that attendance outside of scheduled times may have implications for the efficiency and effectiveness of treatment delivery.

This may consequently impact patients' treatment outcomes, particularly if doses are missed.

Polydrug Use

Patients are encouraged to report the use of other drugs to their case manager or prescribing doctor, as this is likely to affect the safety and success of their treatment.

Clinicians are required to monitor the use of other drug use, both prescribed and illicit, and manage patient and community safety accordingly.

Urine drug screens

- Patients are required to provide a random supervised urine drug screen upon request by the treating team.

- As in sports drug-testing and Random Breath Testing (RBT) for drink-driving, refusal to provide a urine sample request will necessarily be treated as a positive result during the maintenance phase.
- This will consequently affect their treatment status, and potentially affect future treatment decisions, such as excluding them for eligibility for take-away doses for a period of time.

Code of Conduct

All patients are expected to abide by a code of conduct, which the patient is to sign prior to program entry. The code aims to address two key issues: public safety and treatment engagement.

It outlines the behaviours that can cause immediate discharge from the program and potentially cause police involvement. These behaviours include:

- violence – including physical or verbal threats of harm or acts of harm against staff or other patients;
- property damage or theft from the service or dosing facility;
- diversion of prescribed medications, especially where there is an ongoing pattern of diversion; and dealing of substances in and around the service or dosing facility.

SECTION 7: Safe Treatment Induction

Induction into treatment takes a minimum of 2 weeks for methadone and 1-2 weeks for buprenorphine.

The TOPP recommends commencing a new patient on a Monday and no later than Wednesday.

During the first 4 days of stabilisation patients must be seen daily.

Patients who present intoxicated should never be dosed.

As treatment progresses, the treating team/prescriber should review the patient 2-3 times a week until stabilisation.

Once stabilisation is complete, patient reviews can occur fortnightly for 6-8 weeks after this period, medical reviews are required at 3 monthly intervals.

Induction to methadone pharmacotherapy

The TOPP supports a 'start low and go slow' dosing induction approach to methadone.

Induction into methadone pharmacotherapy takes a minimum of 2 weeks.

Patients will need access to a 7 day dosing pharmacy during methadone induction.

The maximum commencement dose of methadone is 25 mg on the first day of methadone treatment.

If a supplementary dose is provided, the maximum dose of 25 MG of methadone on the first day of treatment still applies.

Induction to Buprenorphine

The maximum commencement dose of buprenorphine is 8 mg on the first day of treatment.

Patients with no access to a 7 day dosing pharmacy may be double dosed from the first Saturday of buprenorphine induction – with the approval of an ADS addiction medicine specialist.

If a supplementary dose is provided, the maximum dose of 8 mg of buprenorphine on the first day of treatment still applies.

To manage precipitated withdrawal – a single dose of Clonidine 50 mcg may be administered under supervision.

SECTION 8: Maintenance Treatment

Once the patient has been successfully inducted into the program, maintenance treatment can begin.

While some patients can be successfully maintained on 30-50 mg of methadone, the therapeutic dose for most patients is 50-100mg.

There is little evidence to indicate that doses above 100mg are therapeutic for most patients, nevertheless, some patients may require more than 100 mg to reach a therapeutic dose.

Throughout the course of treatment, there are times when a patient may require a dose increase to maintain the therapeutic effects of methadone. The guidelines for dose increases during maintenance are the same as for dose increases during week two of induction, as the same risks and mechanisms for reaching a steady state apply.

The maximum total dose increase of methadone in any 7 day period is 10 mg.

The Tasmanian Opioid Pharmacotherapy Program cannot support methadone split dosing.

Buprenorphine Therapeutic dosing levels

Double dosing with Buprenorphine

Double dosing works best for patients on a daily dose of 8-16mg of buprenorphine.

Triple dosing with Buprenorphine

Triple dosing works best for patients on a daily dose of 8-10mg of buprenorphine.

The registration of buprenorphine in Australia specifies that a maximum dose of 32 mg can be prescribed per day.

This restriction applies whether it is a daily, double, or triple dose.

The TOPP recommends GP Prescribers seek advice from an ADS Addiction Medicine Specialist if the patient is requiring more than 24mg of buprenorphine per day.

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Ongoing Assessment and Review

Once stabilisation is complete and maintenance has commenced, patient reviews can be tapered to fortnightly for a further six to eight weeks. After this period, a medical review that includes a comprehensive assessment including a physical examination is required at minimum 3 monthly intervals.

Where there are significant changes to clinical risk indicators, a thorough review should be conducted. Any changes in medical management must be authorised by the prescribing doctor.

Within the ADS pharmacotherapy program, case management reviews should be conducted at least 6 weekly.

Regular contact with the case manager can assist in identification and coordination of the patient's health needs, as well as monitoring ongoing risk status and treatment effectiveness.

Clinical Safety

The main focus and drivers for the Tasmanian Opioid Pharmacotherapy Policy (TOPP) are safety, meaningful clinical outcomes and, in particular, the need to address the fundamental feature of drug addiction – impairment or loss of control over drug use.

In order to improve patient safety and to ensure the appropriate prescription and use of opioids, the Tasmanian Opioid Pharmacotherapy Policy is necessarily conservative and maintains that many of the patients on the program will not be suitable for take away doses.

Takeaway Doses – general considerations

Tasmanian Opioid Pharmacotherapy Policy maintains that many patients on the program will not be suitable for take away doses.

The Tasmanian Opioid Pharmacotherapy Program is primarily a supervised dosing program.

It is important that takeaway doses are not provided during the commencement and induction phase of treatment, particularly methadone treatment, as this is a period of high risk for polysubstance use, drug overdose and death.

Patients will be required to attend the pharmacy daily during the first two weeks of methadone induction and the first week of buprenorphine induction. One exception regarding buprenorphine, when the client may be double or triple dosed.

Patients treated with medium to high doses of benzodiazepines (>5 mg per day of diazepam or equivalent) are ineligible for takeaway doses.

Benzodiazepine treatment should not be initiated during opioid pharmacotherapy.

Takeaway doses should not be given without a thorough risk assessment.

Patients will only be given takeaway doses when there is clear evidence of clinical stability.

Safe storage of doses

If takeaway doses are approved, (according to the criteria below), then prescribers must advise patients of their responsibility for safe storage.

Patients should be encouraged to purchase a lockable device that can be placed out of reach of children to store their takeaway doses. In the public system, case managers can assist patients in finding a suitable storage device.

Even if clinically stable, takeaway doses should not be provided to patients in unpredictable and insecure living arrangements, in which the storage arrangements of takeaway doses may endanger public safety.

Patients should also be informed that the following are NOT suitable storage locations:

- anywhere within reach of children;
- transient accommodation such as motel rooms, boarding houses, caravans, tents, trucks;

- transport vehicles such as cars and motorcycle panels; and
- eskies or refrigerators.

Assessing eligibility for takeaway doses

When the prescribing doctor is assessing for eligibility for takeaway doses, he or she is specifically assessing for whether the patient meets criteria for clinical stability, ongoing safety, and whether providing takeaway doses will promote meaningful clinical outcomes.

Additional criteria regarding the level of clinical stability required prior to provision of takeaway doses for the specific treatment agents are described below.

Clinical stability is indicated once the patient has achieved all of the following clinical outcomes:

- no signs of injecting drug use, including no fresh or recent needle marks;
- no presentations of intoxication with alcohol or other drugs to the clinic or pharmacy;
- few (1-2 per month), if any, unexplained missed doses;
- few (1-2 per month), if any, unexplained missed appointments;
- no code of conduct violations;
- no traces of polysubstance use or unsanctioned opioid use in random supervised urine samples; and,
- compliance with supervised dosing requirements.

While the patient may have met the criteria for clinical stability, the doctor must also be satisfied that ongoing safety is likely to be maintained, which means that:

- the patient is not using more than 5 mg of diazepam or equivalent per day (as per policy above);
- the patient does not present with a risk of overdose, injecting drug use, or drug diversion; and

- the patient is able to safely store the takeaway dose. This also means that patients should be in stable living or housing arrangements.

Clinical outcomes:

- providing the takeaway dose will enhance the patient's clinical outcomes and wellbeing;
- the patient can maintain clinical stability with reduced supervision; and
- the patient will be responsible to take the dose on the day and time agreed.

In the ADS pharmacotherapy clinics, endorsement for the provision of takeaway doses is provided by the medical doctor in conjunction with the treating team. In the private system, the treating doctor is solely responsible for approving takeaway doses, although ADS should be consulted for complex clinical presentations.

Once the patient has met the criteria for eligibility for takeaway doses, all members of the treating team are responsible for ensuring that indicators of stability continue to be assessed. If the prescribing doctor is unsure that the patient is clinically stable, takeaway doses can be ceased until stability and safety is re-established. It is important to communicate this to patients prior to commencing takeaway dosing.

ADS patients, including patients transferred from interstate are required to sign a Takeaway Agreement (Appendix XX) prior to accessing takeaway doses. This agreement includes information about limitations and eligibility for takeaway doses.

Methadone takeaway doses

Patients are eligible for 1 takeaway dose once they are clinically stable for a continuous period of 3 months.

Most patients will demonstrate 6 months of continuous clinical stability before being eligible for 2 non-consecutive takeaway doses.

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Table 8.2: Guidelines for the provision of methadone takeaway doses

Time in treatment	Eligibility criteria	Number of takeaway doses permitted
Induction Phase	Not Applicable	No takeaway doses permitted
2 week – 3 months	Not Applicable	No takeaway doses permitted
3-6 months of continuous clinical stability	Demonstrated clinical stability Takeaway dose will facilitate meaningful clinical outcomes Ongoing safety likely to be maintained.	One takeaway dose permitted
6-9 months of continuous clinical stability	Demonstrated clinical stability on one takeaway dose Takeaway doses will facilitate meaningful clinical outcomes Ongoing safety likely to be maintained Clean urine sample in last 7 days	Two non-consecutive takeaway doses permitted

Two methadone takeaway doses per week is the maximum number approved by the TOPP.

Buprenorphine takeaway doses

The TOPP recommends patients on buprenorphine only be maintained on daily dosing schedules if alternative double dosing schedules within the guidelines have been trialed and were not successful.

Only patients on a daily dosing regimen are eligible to receive takeaway doses.

The Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards allows for a maximum of two buprenorphine takeaway doses per week.

Takeaway doses can only be provided if the patient is unable to double dose.

Requirements for accessing takeaway doses are the same as for methadone: that is, clinical stability is indicated, ongoing safety is likely to be maintained, and provision of take-away doses will promote meaningful clinical outcomes.

The Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards does not support patients on double or triple dosing regimens receiving takeaway doses, as their dosing schedule requires them to attend a pharmacy a maximum of 4 times per week, and can be designed to fit within their weekly schedules.

Table 8.3: Guidelines for buprenorphine takeaway doses for patients on daily dosing schedules

Time in treatment	Eligibility criteria	Number of takeaway doses permitted
Induction Phase (0-2 weeks)	Not applicable	No takeaway doses permitted Double dose on first Saturday permitted
2 weeks – 3 months	Not applicable	No takeaway doses permitted
3-6 months of continuous clinical stability	Demonstrated clinical stability Ongoing safety likely to be maintained Takeaway dose will facilitate meaningful outcomes	One takeaway dose permitted
6-9 months of continuous clinical stability	Demonstrated clinical stability on one takeaway dose Ongoing safety likely to be maintained Takeaway doses will facilitate meaningful clinical outcomes Clean urine sample in last 7 days	Two non-consecutive takeaway doses permitted

Weekends and Public Holidays

Whenever possible, the prescribing doctor should try to maintain current takeaway dose arrangements and avoid additional or consecutive takeaway doses during public holidays

This may require, for example, temporary change of days or double dosing around public holidays.

Prescribers can contact the ADS for advice or support around managing takeaway doses during holiday periods.

Exceptional circumstances

In exceptional circumstances, patients may be provided with additional or consecutive takeaway doses following consultation with an ADS Addiction Medicine Specialist. In this circumstance, the rationale for these additional takeaway doses, as well as the management plan, should be clearly documented in the patient file.

The ADS Addiction Medicine Specialist must provide confirmation in writing to prescribers regarding exceptional takeaway dose arrangements agreed upon during consultation.

Interstate Transfers

Patients being transferred from interstate will need to meet the same criteria prior to accessing takeaway doses and double or triple dosing arrangements as locally established patients.

Patients transferring from interstate will need to demonstrate the same length of continuous clinical stability in Tasmania before being eligible for takeaway doses. This is regardless of their previous takeaway dose arrangements interstate.

Suspension and Temporary Removal of Takeaway Doses

If the prescriber or treating team identifies changes in clinical risk factors for the patient and that takeaway doses are no longer suitable, then the provision of takeaway doses should be suspended.

The removal of takeaways doses can be challenging for both the clinician and the patient. Patients may perceive the removal of takeaway doses as a form of punishment and this may lead to overt expressions of frustration and anger.

It is also important to remember that many patients experience feelings of powerlessness and low self-worth and in this context they may interpret the removal of takeaways as confirmation of failure or inadequacies.

For this reason it is very important to talk to patients at the commencement of treatment about the reasons for the restrictions relating to access to takeaway doses and the circumstances that may lead to the removal of takeaway doses.

When takeaway doses are to be suspended, it is important to discuss this with the patient and outline the rationale for the suspension.

Clear advice should be provided about the conditions under which takeaway doses will be reinstated (e.g. 3 clean urines and no missed doses for a period of 3 months).

It is the responsibility of the prescriber to inform patients of any changes to their takeaway dose arrangements.

These changes must be communicated as soon as possible.

Missed Doses

The key to effective outcomes for patients receiving opioid pharmacotherapy is supervised dosing. This supports the patient to manage one of the key features of opioid dependence – impairment of control over drug use.

Patients are required to consume their prescribed dose at the time and location specified in their treatment plan.

While patients may miss doses due to personal circumstance, **regular unexplained missed doses** (i.e. more than three times a month) are often an

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indication of either clinical instability or unsuitability of the treatment plan and dosing arrangements.

Frequently missed doses can have a significant impact on the effectiveness of the treatment.

Ensuring the safety of the patient while in opioid pharmacotherapy treatment is the responsibility of all parties involved: this includes the treating team and pharmacist, as well as the patient themselves.

The treating team should communicate to the patient the consequences of a missed dose, including the increased risks to safety.

One missed dose:

- pharmacy will assess if the patient is suitable for dosing and notify prescriber (or ADS case manager) of missed dose; and
- record missed dose in patient file.

Two consecutive missed doses:

- pharmacy will not dose and inform the patient that he or she needs to contact the prescriber (or ADS case manager);
- prescriber (or ADS case manager) will review patient;
- if no evidence of intoxication or other risk factors, patient may have the usual daily dose;
- confirm with the pharmacy that it is safe to dose as per usual; and
- record missed doses and reason in patient file.

Three consecutive missed doses:

- pharmacy will not dose and will inform the patient that he or she needs to contact the prescriber;
- prescriber will review patient;
- if no evidence of intoxication or other risk factors, recommence on half the previous dose and re-titrate back up to therapeutic dose according to withdrawal symptoms displayed over subsequent days (or weeks). This will require further reviews of the patient;

- confirm the new arrangements with the pharmacy;
- document the new arrangement in the patient file, including reasons for missed doses; and
- if the patient is pregnant, refer them to the hospital as they are at risk of miscarriage.

Four consecutive missed doses:

- pharmacy will not dose and will inform the patient that he or she needs to contact the prescriber;
- prescriber will review patient;
- if no evidence of intoxication or other risk factors, recommence 40 mg OR half of usual dose (whichever is lower), and re-titrate back up to therapeutic dose according to withdrawal symptoms displayed over subsequent days (or weeks). This will require further reviews of the patient; and
- document the new arrangement in the patient file, including reasons for missed doses.

Five or more consecutive missed doses:

- pharmacy will not dose and will inform the patient that he or she needs to contact the prescriber; and
- prescriber will review patient and manage as a new induction.

Lost or Stolen Doses

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

Vomited Doses

In general vomited doses are not replaced. However, if this occurs it is important to consider the time that has elapsed and the possibility that some or all of the dose has been absorbed.

The treatment agent of choice (i.e. methadone or buprenorphine) will have a direct impact on how vomited doses are managed.

After oral consumption, methadone takes approximately 20 minutes to be absorbed. Therefore, if a patient vomits more than 20 minutes after the dose is administered, the patient can be reassured that the dose has been absorbed.

Replacement after a vomited buprenorphine dose is not required because buprenorphine is rapidly absorbed sublingually.

Continued Use of Other Drugs

Use of other drugs, both prescription and illicit, is common amongst opioid pharmacotherapy patients.

Polysubstance use is also common, particularly in the early phase of treatment.

In many cases, it is safer to continue with opioid pharmacotherapy than to withdraw the patient from treatment. However, consideration needs to be given to patient safety on the program.

Strategies for addressing the risks associated with concurrent drug use include:

- Regularly providing information about the risks of other substance use in combination with prescription opioids, including written information;
- Using motivational interviewing to discuss what the patient experiences as the positive and not-so-positive aspects of combining other drug use with opioid pharmacotherapy;
- Regularly discussing and encouraging harm minimisation strategies;
- Supporting access to psychosocial interventions and supports;
- Developing strategies for coping with withdrawal from other drugs;
- Discussing strategies for relapse prevention;
- Encouraging the use of non-drug strategies, such as sleep hygiene and relaxation training, to help manage psychological stressors;

- Consider changes in opioid pharmacotherapy treatment, for example, alterations to the dose or the dosing schedule (e.g. going from double day to daily supervised dosing for buprenorphine, removing or suspending takeaway doses);
- Consider change in treatment agent, for example, a switch from methadone to buprenorphine, which is the generally safer medication;
- Consider changes in dosing location; and
- If the risks of other drug use outweigh the benefits of remaining on the program, consider withdrawal from treatment.

Continued high risk drug use is challenging to manage and can seriously compromise the safety and efficacy of opioid pharmacotherapy.

Transferring Between Treatment Agents

When transferring between pharmacotherapy agents, private prescribers should seek specialist advice from Alcohol and Drug Services (ADS).

SECTION 9: Completing Treatment

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.

Patients should be encouraged to remain in the program for a minimum of 12 months.

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.

Patients have the right to withdraw from treatment at any time, even if they have been in treatment for

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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.

The use of medications to manage withdrawal symptoms is not recommended during planned and voluntary withdrawal from the opioid pharmacotherapy program.

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

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: 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).

Planned Buprenorphine Dose Reductions

Slow dose reductions of buprenorphine are more effective than rapid dose reductions. 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).

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 and then withdraw from buprenorphine treatment.

Involuntary Withdrawal

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

Private prescribers are advised to contact an ADS addiction medicine specialist prior to ceasing treatment to discuss possible treatment options or management strategies.

If a 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.

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.

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. Buprenorphine alternate dosing schedules (i.e. double and triple dosing) are also not appropriate.

Avoiding secondary problems with alcohol, sedative or hypnotic drugs

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.

Exiting patients

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.

Notifying the Dosing Site/Pharmacy

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 TOPP recommends that pharmacies do not allow patients to accumulate debts for dosing.

SECTION 10: Psychosocial Interventions in Opioid Pharmacotherapy

Psychosocial interventions in opioid pharmacotherapy
 Providing pharmacotherapy alone does not address the holistic needs of the client.

A range of factors can have an impact on a client's engagement and compliance with the pharmacotherapy program.

Psychosocial interventions aim to address factors that maintain addictive behaviour, enhance engagement

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with pharmacotherapy, or treat comorbid mental health issues that contribute to addiction or relapse.

The Tasmanian Alcohol and Drug Services will ensure that pharmacotherapy and psychosocial intervention programs are well integrated.

The ADS will ensure that private prescribers are aware of agencies or health professionals that are able to provide psychosocial interventions.

Types of Psychosocial Interventions in Opioid Pharmacotherapy

Many of the psychosocial interventions discussed in this section apply to a broad range of substance abuse and misuse problems.

Psychoeducation, motivational interviewing, cognitive behavioural therapy, drug refusal strategies and relapse prevention are all appropriate for clients with alcohol abuse problems as well as opioid pharmacotherapy clients.

Therefore, flexibility in approach, and providing an intervention suitable to the client's needs (and within the scope of the clinician's skills) are essential.

Psychosocial interventions can include assistance with accommodation, food, social networks, employment and community connectedness.

Relapse prevention is a key component of any drug and alcohol intervention, including opioid pharmacotherapy.

Relapse prevention encourages clients to identify triggers to their drug use and reduces the risk of relapse by increasing their capacity.

SECTION II: Specific Population Groups

A significant proportion of clients who present for opioid pharmacotherapy treatment will often have multiple and complex issues.

Mental Health

Opioid dependent clients often present with comorbid mental health disorders, including mood disorders, anxiety disorders and other serious mental illnesses.

The treatment of these issues can have an impact on the effectiveness of opioid pharmacotherapy.

Some antidepressant medications can have drug interactions effects when used in combination with opioids.

Treatment of anxiety disorders with benzodiazepines for people who are drug dependent or have a history of dependence is not recommended by the TOPP.

If self-harm or other mental health risk indicators are present, a referral must be made to an appropriately qualified mental health clinician for more thorough assessment.

Opioid treatment during pregnancy

Methadone remains the only registered treatment for pregnant and breastfeeding women.

Antenatal care should be managed collaboratively with obstetric services.

It is preferable for a woman to be maintained on methadone pharmacotherapy to the point of delivery.

The management of women with Suboxone® is absolutely contraindicated in pregnancy / breast feeding.

The use of opioid antagonists (e.g. Naltrexone) is strictly contraindicated for neonates born to opioid dependent mothers due to risk of seizures.

Blood- borne viruses

Clients accessing OPP should have their blood borne virus (BBV) status reviewed, and monitored throughout treatment.

Hepatitis A & B vaccinations should also be offered.

Culturally sensitive practice

Culturally sensitive practice recognises these differences between cultures and groups. It takes account of differences in the way that groups communicate, relate to one another and how this translates into interactions with health care providers.

It is important for health services ensure culturally responsive strategies that take into account the practices and beliefs of a particular population group.

Supporting Aboriginal Communities

The need for action to support the Aboriginal communities is identified in the National Drug Strategy and the Tasmanian Drug Strategy.

It is important to work closely with the Aboriginal communities to establish appropriate services and strategies that are designed to improve outcomes for clients.

The Alcohol and Drug Services recommends working collaboratively with the statewide Aboriginal Health Service and other Aboriginal organisations.

Culturally and Linguistically Diverse Groups

In general, ethnic groups are underrepresented in Alcohol and other Drug Services.

This is likely to reflect some of the difficulties associated with accessing treatment, rather than a lower prevalence of alcohol and other drug (AOD) use issues.

Whenever possible the client should be referred to a clinician of the same culture.

However, when this is not possible, efforts should be made to ensure that the client and the clinician are

linked to a 'cultural consultant' (e.g. key worker at the Migrant Resource Centre).

This consultant can assist both the client and clinician to identify any cultural issues that may need to be considered during treatment.

When there is a language barrier, an accredited interpreter should be used.

Clinicians should avoid using family members and friends as interpreters (except in emergency situations), as this can compromise the clinical interaction by restricting client disclosure and confidentiality.

Young people and opioid pharmacotherapy

Traditional adult style approaches to service provision are not appropriate or effective when working with young people because of the impact of the developmental processes, physical differences, and differences in belief and value systems.

If possible, consent should be obtained from the young person to involve a family member in the treatment process.

The success of opioid pharmacotherapy can be enhanced by inclusion of a family member who is able to provide support, assist with transport to appointments, monitor other drug use, and ensure regular daily dosing.

The nature of family relationships should be assessed and taken into consideration when developing the treatment plan.

Family members and significant others should be provided with detailed information about the program and its requirements so that they can support and facilitate treatment.

Treatment planning might also include linking the family member or significant other into additional support services that can provide AOD psychoeducation and skills in relationship building and boundary setting.

Issues such as intergenerational drug use in the family of origin and the nature of peer networks should also be considered.

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Peers and families can either mitigate or magnify the risks for young people so it is important to assess and monitor these relationships.

Regardless of the family's relationship to the young person's problem, they almost always need to be involved in the solution, as treatment that does not include the family is less likely to be successful.

If a young person is assessed as being suitable for opioid pharmacotherapy, buprenorphine is the preferred treatment option.

Recently released prisoners

Recently released prisoners with a history of opioid dependence or a history of pharmacotherapy treatment are at an increased risk of overdose or death if they return to high levels of opioid use after their release.

For these clients, the risk of overdose or death if not on the program may outweigh the risk of placing a non-neuroadapted client on the program.

Consequently, such clients are able to access the program even if they do not display neuroadaptation.

However, they should be commenced on a lower dose, titrated slowly, and reviewed more frequently than other clients during the early phases of treatment.

For recently released prisoners with a history of opioid dependence, the following strategies are recommended:

- a well developed release plan that specifies readily accessible dosing arrangements once released;
- an initial appointment with a case manager or prescribing doctor within 1-2 days of release from prison;
- an assertive follow up model of service delivery; and

- supported access to multiple services such as housing, employment, and family support services.

SECTION 12: Managing Complex Presentations

A significant proportion of clients who present for opioid pharmacotherapy treatment will have multiple and complex issues.

Managing hospitalised clients with opioid dependence

If an opioid pharmacotherapy patient requires hospitalisation, he or she is responsible for informing the in-patient facility that they are receiving opioid maintenance therapy.

Once informed, the hospital doctor should:

- Verify the patients identity;
- Contact the prescriber (PSB will be able to provide this information) or case manager to discuss:
 - the pharmacotherapy treatment agent;
 - the patients pharmacotherapy treatment requirements;
 - dosing arrangements, including access to takeaways;
 - date and time of last dose;
 - any issues related to patient management on the program; and
 - risks associated with the treatment of the patients medical condition.
- Contact the dosing pharmacy to confirm the date of the last dose and determine if the patient has any takeaway doses in their possession.

Once Admitted

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.

Once admitted, dosing at the patients usual pharmacy should be ceased and the prescription cancelled.

Dosing

Dosing by the hospital pharmacy can only occur after the patient 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.

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

During Admission

During the admission the patient 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

Patients with takeaway doses in their possession

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.

- 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).

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

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

Discharge

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 patients clinical management during the admission including any clinical or behavioural management issues.

Treating opioid dependent patients not currently registered on the opioid treatment program

If an opioid dependent patient who is not receiving opioid pharmacotherapy is admitted to hospital, they may experience opioid withdrawal while they are unable to access opioids.

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Consequently, patient experiencing withdrawal during an admission may become agitated and aggressive and may discharge themselves against medical advice.

Patients may also self-medicate with unsanctioned opioids creating difficulties for their medical management.

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 patient demonstrates clear signs of opioid withdrawal, the ADS should be contacted and an Addiction Medicine Specialist consultation review arranged.

Medically managing a patients opioid withdrawal during admission may reduce the likelihood of discharge against medical advice.

Anaesthesia

Patients being admitted for major surgery are responsible for informing their doctor that they are taking methadone or buprenorphine.

Patients 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.

Acute Pain

Patients 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 patients should receive analgesia (including parenteral analgesia if this is deemed appropriate treatment) for acute pain management.

Opioids in addition to the patients current methadone or buprenorphine dose may be administered to relieve acute pain.

However, the patients 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.

In primary care settings (e.g. General Practice), acute pain should initially be managed in the same manner as for patients who are non-opioid dependent.

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 patients registered on opioid pharmacotherapy without an authority due to regulatory requirements.

The significant risk of overdose and death associated with the use of opioids in combination is an important consideration.

Persistent Pain

Patients 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 patients receiving opioid pharmacotherapy may be at increased risk of persistent pain.

The management of patients 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.

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

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, which may have diminished in importance or resolved.

In Tasmania, many patients access the opioid pharmacotherapy program due to therapeutic opioid dependence.

Patients 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.

The treatment of therapeutic opioid dependence in association with persistent pain is complex.

Section 59E: Addiction Medicine Review

The Pharmaceutical Services Branch (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 patient is dependent on opioids.

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 patients 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 patients ongoing management (including dosing arrangements, referrals for specialist interventions, opioid withdrawal management); and
- determine the patients need and suitability for opioid pharmacotherapy or medication reduction regimens.

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 patients to be managed by the ADS.

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The ADS can provide access to comprehensive treatment planning and management through a multidisciplinary team.

The patients 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 patients should be clearly informed of the reason for the referral to the ADS and of the purpose of the Addiction Medicine Specialist assessment.

Sudden Cessation of Opioid Pharmacotherapy

Patients 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 patients risk of overdose and death.

Patients should be informed of the potential risks associated with the sudden cessation of treatment.

Managing Aggression and Threatening Behaviour

Prior to commencement of treatment with the ADS, code of conduct obligations are outlined to, and signed by the patient.

This process helps establish that physical and verbal aggression towards staff and other patients is not tolerated.

Violence or threatening behaviour towards the treating team/prescriber/pharmacist or other patients may lead to involuntary removal from the program.

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.

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.

If a physical assault occurs, police intervention should be sought immediately.

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.

Continued High Risk Drug Use and Polydrug Use

Unsanctioned substance use during the early stages of opioid pharmacotherapy is common.

Patients with problematic polydrug use may require assistance to reduce or cease other drug use.

It is important to collaborate with the patient 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.

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 should be implemented prior to or at the commencement of maintenance opioid pharmacotherapy treatment.

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

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 Services.

Alprazolam is listed as a declared restricted substance (Declared Restricted Substance Order, 1990) under the Tasmanian Poisons Act 1971.

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, 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.

Close monitoring and support are required to ensure that treatment is not compromised by the behaviours.

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 also 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 or 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.

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 Services.

Clients who are seeking intoxication can be difficult to assess and to determine if opioid pharmacotherapy is a safe and suitable treatment option.

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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 in patient admission for a selective detoxification followed by an opioid rotation or induction.

In these circumstances the in patient admission can significantly reduce the risks during stabilisation.

Diversions

Diversions occur when methadone and buprenorphine doses are not used as intended.

Diversions include:

- 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.

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.

Diversions have 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 diversions are suspected or attempted, the pharmacist should discuss with the client their concerns and clarify the requirements for dosing.

The pharmacist should also immediately notify the prescriber or case manager.

Diversions are a very serious concern: they require considerable planning, confidence and intent by the client. It is very rarely a spontaneous event.

Engaging in diversions 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.

Diversions are often related to a client being 'stood over' by another person. Hence, it is important that any factors contributing to diversions 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 diversions, and, if necessary, to seek police involvement.

When diversions occur 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 client's 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 diversions re-occur.

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.**

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

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 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 Services; and the pharmacist should inform the client that they will contact the prescriber.

Injecting takeaway doses

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.

Frequently Missed Doses

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.

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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**.

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.

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;
- 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.

Regular and Unexplained Lost or Stolen Dose

Lost or stolen 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/prescriber and a notification made to Tasmania Police.

Prescribers and case managers should discuss with the client the circumstances of any lost or stolen 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.

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.

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

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.

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.

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.

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.

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.

Overdose is a medical emergency and is best managed by emergency services.

SECTION 13: Transfers

In Tasmania scripts for opioid pharmacotherapy from other jurisdictions (states and territories) will not be recognised

Patients Travelling to Tasmania

Only methadone and buprenorphine prescriptions that are issued in the state of Tasmania are considered valid in Tasmania.

Transfers of patients into the Tasmanian OPP

All interstate transfers to Tasmania are managed by the Tasmanian Alcohol and Drug Services opioid pharmacotherapy program.

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Transfers to the Tasmanian public opioid pharmacotherapy **programs cannot be guaranteed.**

A temporary transfer to or from the Tasmanian OPP is generally for a period of **no more than 4 weeks.**

A temporary or permanent transfer request must be received **4 weeks prior** to the transfer date.

The transferring clinician will need to ensure that the patient has read and signed the Tasmanian OPP Treatment Agreement.

If the patient is accepted, a comprehensive transfer letter must be requested from the referrer.

Interstate transfers of Tasmanian opioid pharmacotherapy patients

The TOPP does not recommend continued prescribing by Tasmanian prescribers for temporary or permanent interstate transfers.

The TOPP recommends transfer to another prescriber in that jurisdiction.

The provision of opioid prescriptions for patients travelling interstate reduces the capacity of the prescriber to safely deliver opioid pharmacotherapy.

The decision to provide an interstate prescription for opioid pharmacotherapy should be made in consultation with the Tasmanian Alcohol and Drug Services.

Unsanctioned Transfers

Unsanctioned transfers will not be accepted

Patients will be advised to return to their opioid treatment provider.

A transfer cannot be accepted without the patient's consent to release information and the provision of relevant information.

SECTION 14: Legislative Requirements

Poisons Act 1971

The prescription of opioids in Tasmania is subject to regulatory requirements under the Tasmanian Poisons Act.

Prior to commencing opioid pharmacotherapy treatment, the authorised prescriber must obtain authority from the Pharmaceutical Services Branch (PSB).

Alcohol and Drug Dependence Act 1968

The Alcohol and Drug Dependency Act does not confer the power to compulsorily treat an individual

The act is primarily used for compulsory detention.

Mental Health Act 1996

Under the Mental Health Act, clients with an alcohol and drug dependency and a mental illness can be involuntarily detained for the purposes of treatment.

The Act does not provide authority for a person to be detained for the purpose of treating their alcohol or drug dependency.

Misuse of Drugs Act 2001

This legislation has implications for diversion; trading and selling of takeaway doses and also for the theft, forgery, changing or tampering of prescriptions.

While there are no mandatory reporting provisions in this Act, health professionals have a duty of care to consider the potential risks for individuals and the community.

If there is clear evidence of real and imminent risk to the individual or to the community as a result of these activities, a report should be made to Tasmania Police.

Guardianship Administration Act 1995

The Guardianship Administration Act is a substitute decision-making framework for persons with a disability.

The Act is not applicable to a person who lacks capacity to make decisions because of alcohol or drug dependence only.

Children, Young Persons and Their Families Act 1997

All health professionals in Tasmania have mandatory reporting obligations regarding concerns of abuse or neglect of children.

Family Violence Act 2004

The Family Violence Act provides for the safety, psychological wellbeing and interests of people affected by family violence.

Although it is not mandatory, all professionals in Tasmania have a duty or an obligation to report incidences of family violence to Tasmania Police.

Personal Information Protection Act 2004

The PIP Act regulates the collection, maintenance, use, correction and disclosure of personal information relating to individuals.

Health professionals should always strive to maintain confidentiality however, there are situations where clinicians will be required to breach client confidentiality to ensure clinical, client and community safety.

Right to Information Act 2010

The Right to Information Act 2010 provides members of the public the right to obtain information contained in the records of the government and public authorities.

Firearms Act 1996

The Firearms Act specifies that a person must not handle or use a firearm while they are under the influence of alcohol or any other drug.

A prescribed person is to inform the commissioner if a patient is likely to possess or use a firearm, and that this would be unsafe for the patient or another person.

Vehicle and Traffic Act 1999

Tasmanian OPP clinicians have a duty of care to the patient and community relating to fitness to drive.

If a clinician observes that a patient is unfit to drive, they have a duty to report this to the registrar.

Health Practitioners Regulation National Law (Tasmania) Act 2010

There is a mandatory reporting requirement where there is evidence that a health practitioner may be practising in a manner that may put patients at risk of harm, or when they may be practising under the influence of drugs.

SECTION 15: Prescriber Training and Authorisation

Prescriber training and authorisation

Medical practitioners who prescribe buprenorphine and methadone for the treatment of opioid dependence must be authorised.

Authority to treat a patient

A prescription for methadone or buprenorphine cannot be provided until an authority has been issued and an authority number provided by PSB.

Maximum Caseload

A medical practitioner in full time general practice can prescribe methadone or buprenorphine to a maximum of 20 patients.

Practitioners with clinical skills and an interest in this area can apply to increase this number.

Arrangements to cover absence from practice

Prescribers should take measures to ensure that all of their pharmacotherapy patients have sufficient prescription cover during periods of the prescriber's absence.

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SECTION 16: Pharmacy Instructions

The participation of pharmacists in the program is voluntary.

The role of the ADS includes supporting community pharmacies to register for, and provide services to opioid pharmacotherapy patients.

To become a dosing site for opioid pharmacotherapy, a pharmacy requires approval from the ADS.

In addition, each pharmacist involved in the provision of dosing is required to obtain accreditation.

The ADS can assist pharmacists and pharmacies with this process.

ADS should be informed as soon as possible when a pharmacy no longer wants to continue dosing a particular patient or they no longer want to be part of the opioid pharmacotherapy program.

Pharmacists can help patients establish a dosing routine.

Patients should be dosed at approximately the same time each day during the induction phase.

Prescriptions and Dispensing

Tasmanian pharmacists CANNOT dispense opioid pharmacotherapy for patients with prescriptions from interstate doctors.

Prescribers are required to send prescriptions for opioid pharmacotherapy patients directly to the pharmacist.

S4D medications prescribed to the patient by a doctor other than the pharmacotherapy prescriber should not be dispensed.

Do not dose the patient if the prescription is expired, regardless of the reason for the expiration.

All prescription changes should be confirmed with the prescriber prior to dispensing.

Prescribers must be notified of all dosing errors.

Dosing

Within a pharmacy, S8 medications can only be handled under pharmacist supervision.

Pharmacists are encouraged to have a contract with patients that outlines the pharmacy's code of conduct and patient rights and responsibilities.

The pharmacist has the right to refuse dosing either temporarily or permanently if the patient's behaviour contravenes the code of conduct.

Pharmacists are encouraged to contact police if there is any evidence of drug diversion, dealing, or other criminal activity in or around the pharmacy.

If you are unsure, DO NOT DOSE.

The ads can be contacted for advice at any time.

It is important to remember that dosing an intoxicated patient has the potential to result in severe harm or death.

Takeaway Doses

Only prescribers can authorise Takeaway doses.

A pharmacist can only nominate the day the takeaway is collected (in consultation with the patient) if it is not allocated on the prescription.

Providing takeaway doses outside of prescriber authorisation is against legislation and can place the pharmacist's registration at risk.

All takeaway doses must be provided to the patient in child-resistant packaging, as stated in national legislation (Therapeutic Goods Act 1989, Therapeutic Goods Order No. 80).

Takeaway dose should only be given directly to the patient DO NOT give the takeaway dose to a third party.

Do not dose or provide takeaway doses to intoxicated patients.

Missed Doses

If a patient misses 1 dose, the pharmacist should assess the patient's suitability for dosing. If the patient is not intoxicated and no other risk or concerns are identified, the pharmacist may proceed with dosing.

However, the pharmacist must notify the prescriber (or case manager) of the missed dose using the "Did not Dose Form" or by telephone.

If a patient misses 2 or more consecutive doses, the pharmacist can only resume dosing on the instruction of the prescriber (or ADS case manager).

If a patient misses 3 or more consecutive doses, the pharmacist can only resume dosing on the instruction of the prescriber (or ADS).

The prescriber will determine the appropriate commencement dose for the patient after two or more missed doses.

Replacement Doses

Replacement doses can only be provided after authorisation from the prescriber.

The pharmacist cannot authorise a replacement dose.

Payment

A policy of **no payment, no dose** is recommended.

