

Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards

External Appraisal and Feedback Report

Draft V4

External Appraisal and Feedback Report

Introduction

The TOPP External Appraisal and Feedback Report is a summary of the processes undertaken and the feedback received during the External Appraisal and Feedback including:

- Feedback on the content and breadth of the TOPP;
- Summary of identified gaps for consideration and possible inclusions in the TOPP;
- Implications for the practical application of the TOPP for service delivery including challenges and barriers;
- Summary of training and resource requirements to inform the TOPP implementation plan;
- Level of active participation and engagement of key stakeholders in the appraisal and feedback process and;
- Feedback on the TOPP External Appraisal and Feedback Process.

Agreed recommendations (endorsed by the ADS Executive) for adoption and inclusion in the final TOPP are not contained within this report. The review and consideration of feedback received is still underway and a summary of recommendations will be provided in the coming months.

This report has been provided to all key stakeholders who participated in the TOPP External Appraisal and Feedback process.

Background

The TOPP External Appraisal and Feedback process was undertaken during October 2011.

Scope

A broad and traditional consultation process was not adopted as the TOPP incorporates regulatory aspects of clinical service delivery and establishes standards for practice. Regulatory aspects of clinical service delivery cannot be modified or altered, and as a result consultation in this context is restricted. For this reason it was determined that a feedback and appraisal process would be undertaken. These limitations were communicated to key stakeholders.

Objectives

- To obtain feedback on the content and breadth of the TOPP (including key policy positions) and identify gaps.
- To obtain feedback on the practical application of the TOPP for service delivery.
- To identify training and resource implications associated with the implementation of the TOPP.

- To create awareness of future directions and changes in the delivery of opioid pharmacotherapy in Tasmania.
- To increase awareness about changes in the public program and the enhanced clinical capacity of the Alcohol and Drug Services.

Audience

The External Appraisal and Review process sought feedback from key stakeholders. Healthcare professionals, services, advocacy groups and independent overseeing bodies involved in the delivery of this program were identified and invited to participate in this process. (A key stakeholder list was been developed see Attachment A).

The TOPP External Appraisal and Feedback was not a broad whole of population process. As this document informs the delivery of a specific clinical treatment (and therefore requires a level of clinical knowledge or direct personal experience) general community feedback was not considered appropriate.

Key stakeholders were identified as:

- individuals and their families receiving treatment services;
- health professionals and services (government and community sector organisations) directly or indirectly involved in the delivery of opioid pharmacotherapy; and
- health professionals and services (government and community sector organisations) directly or indirectly involved in the delivery of opioid pharmacotherapy alcohol and drug services.

Mode

Feedback on the TOPP was obtained in a number of ways including participation in regional feedback forums; written submissions and by completing an online survey.

Method

The provision of feedback was facilitated and guided by:

1. TOPP Variations Summary: Variations from current National policy and clinical practice guidelines
2. TOPP External Appraisal and Feedback Summary Guide.
3. Feedback Forums: Client Journeys (4) that demonstrate the application of the TOPP to clinical practice. The scenarios (see Attachment B) covered:
 - Re-Stabilisation, missed doses and diversion
 - Assessing & preparing for opioid pharmacotherapy induction;
 - Interstate transfer; and
 - Inpatient admission.
4. Online survey (see Attachment C).

This survey was developed using Survey Monkey and provided a quick and easy way for feedback to be provided anonymously online.

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Consumer Feedback

Consumer Feedback was encouraged and led by Advocacy Tasmania. Flyers were distributed to clients receiving treatment through the public programs (Alcohol and Drug Services, DHHS) and posters were placed in waiting rooms.

Peer Review

A peer review process was also undertaken concurrent to the external appraisal and feedback process. Four eminent professionals (nationally recognised) in the area of addiction were identified and invited to participate in the peer review process. In addition, reviews were requested from the National Drug & Alcohol Research Centre, UNSW and the Chapter of Addiction Medicine, RACP.

Communication

Communication strategies included information flyers distributed via the ADS, ATDC, GP Divisions, and AMA on-line newsletters. Individual invitations were sent to key stakeholders for the feedback forums and reminder correspondence was sent via email throughout the process to encourage participation and feedback. Additional letters were sent to a number of General Practitioners (private prescribers) inviting feedbacks after an administrative error revealed that they had not received communication about the process.

Outcomes

A total of 184 key stakeholders were contacted and encouraged to participate in the external appraisal and feedback process.

- The feedback forums were reasonably well attended with 50 participants across the state.
- Eight written submissions were received along with 13 email responses.
- Two face to face discussion meetings were held with the statewide Coroners and a General Practitioner (private prescriber) unable to attend a regional forum.
- Six on-line surveys were completed only 2 of these were fully completed.

Summary of Key Stakeholder Feedback

In order to collate the feedback a summary table was developed (See Table 1). As much as possible feedback received has been recorded verbatim and is largely unaltered. Please note that recommendations are not provided relating to the adoption or modification of the document based upon this feedback. The careful review and consideration of feedback is time consuming and this work is currently underway. Once this work has been completed and endorsed by the ADS Executive a full summary of recommendations (including rationales for decisions taken) will be forwarded to all key stakeholders.

TABLE 1: TOPP External Appraisal and Feedback Summary Table

I	Epidemiology of Opioid use in Tasmania	Mode of Feedback
	Reference is made to the increase in use of prescribed opioids, but we would suggest that it would be appropriate to have more up to date figures regarding growth in use, especially regarding oxycodone use of which has increased a great deal since 2003. Useful data in this regard is in the public domain via data from PBAC	Email
	Covers some of same issues as above – but here more up to date data is used – we suggest there is an opportunity for greater consistency. The message you are trying to get across here may be clearer if the data was provided in the form of a table.	Email
	Whilst the focus is around the most widely used potent oral opioids – would it be useful to set this information against a wider background of opioid use in Tasmania (and compared to Australia in general) i.e. total opioid use (to include other potent opioids such as hydromorphone, weaker opioids such as codeine and tramadol and transdermal opioids), as without this context data on high levels of oxycodone, morphine and methadone use could be misleading.	Email
	Last paragraph. Second PSB to read Pharmaceutical Benefits Scheme	Email
	Prescribing of other GP's is Naïve need to improve training for doctors. This could include a training models such as: case conferencing; presenting the statistics 'dry facts'/data by regions and for the state; undergraduate and post graduate training; Intern rotation; link with GP Divisions; and master classes	Individual meeting
	Access to prescribing of non-opioid analgesia prescribing	Individual meeting
	Do we have any data on the relationship between diversion/deaths – by the Regions?	Individual meeting
	Dexamphetamine is also a problem with over prescribing and diversion from child – parents	Individual meeting

2	Clinical Features of Opioid Dependence	
No Feedback Received		
3	Policy Framework	
	Reference is made to the biopsychosocial model in terms of substance abuse, but given that the same approach should be applied to management of pain, would it be appropriate to specifically refer to this? It could be argued that over-reliance on and expectations of analgesic therapy in pain management have led to some of the issues we face regarding unsanctioned opioid use.	Email
	Suggest reference to clinicians (in first dot point) is changed to 'health professionals'	Email
	Reference is made to the transfer of care to GPs, but requirements listed only relate to the GP. Additional requirements relating to the dosing of patients in community pharmacy should be included here, as it is feasible that a GP may be willing and able to take on prescribing and other aspects of care, but that a community pharmacy may be unwilling/unable to take on dosing. In rural/remote settings where there may only be one pharmacy available this scenario would be problematic.	Email
	ADS support should also include community pharmacies providing services	Email
	Should there be some reference to the willingness/ability of community pharmacies to provide dosing services here?	Email
	"many opioid dependent opioid people"	Email
	Reference to community health care centres doing dosing. Do CHCC do dosing? There are no hospital pharmacies in rural settings other than maybe Latrobe (otherwise only Hobart, Launceston, Burnie)	Email
	A key step in the TOPP model is the transfer of a client to/from community prescribing. A shortcoming is that TOPP addresses this only broadly at 3.10 – 3.11.3 i.e. 3 pages (c/f Transfers -14 pages) Practical mechanisms are especially required to support 3.11.3 Specialist – primary care interface: 1. GP and Pharmacist training and credentialing requirements needs to be set out so everyone is clear on training requirements for community prescribing.	Email

<p>Who is responsible for conducting the training? What is the training – exams, face to face,</p> <ol style="list-style-type: none"> 2. Following the training, what are GP’s allowed to do, what can they do prior to the training 3. Mechanisms to support the transfer of clients from ADS to GP prescribers 4. Mechanisms to support ongoing community GP prescribing - phone numbers, business hours, after hours 5. Rapid referral mechanisms from community to ADS- criteria for transfer, phone numbers, business hours, after hours 	
<p>It is not clear whether this refers to:</p> <ol style="list-style-type: none"> 1. people who were opioid dependent prior to prison and now opioid intolerant at release 2. Or on opioid substitution therapy either commenced or continued in prison 3. Or opioid dependent – illicit use <p>Suggest rephrase in line with 11.10 page 182: recently released prisoners with a history of opioid dependence or pharmacotherapy treatment</p>	Email
<p>The Tasmanian ADS will also provide care for patients who have begun to display behaviours of increased risk including non compliant or moderate to high risk while being managed in primary care services ... Sentence not clear - suggest rephrasing:</p> <p>Suggest: The Tasmanian ADS will also provide care for patients being managed in primary care services who have begun to display moderate to high risk behaviours including non compliance.</p>	Email
<p>Care needs to be taken that internal processes are not projected as expected practices for all settings. The case management section of the TOPP reflects internal processes are not projected for all settings.</p> <p>There are practical challenges for regional and local providers and clients being reviewed by the “treating team’ (which has not been defined in document - which we have found). Can it be assumed, for example that, during induction in the community setting to meet the requirements on page 97 (e.g. daily review by the treating team for the first 3-4 days of dosing, and repeated daily observation of patients be available for at least two weeks) - that some of these reviews and observations can be undertaken by different members of the treating team such as the pharmacist, prescriber or case manager?</p> <p>It is therefore recommended that clinical judgement, involvement of community pharmacists (and others) as part of the treating team be emphasised, and client circumstances regards travel , employment and geographical location and other commitments allow some flexibility in developing an induction plan, especially as 3.11.2 provides for authorised GP providers to induct people if they are considered low risk clients. Acknowledging that induction highlights the most risky time for clients and significant vigilance is essential.</p>	Email

<p>It is very appropriate that the TOPP states that treatment is not time limited and the inclusion of principles for effective treatment (pp. 34-35) are welcome, however there is an omission of any reference to the treatment meeting the consumer's preferences and needs.</p> <p>The dot point reference to the quality of the therapeutic relationship captures the need for non-judgemental attitudes on the part of the clinician, but there is no acknowledgement that effective treatment is significantly enhanced when consumer values and preferences are taken into account. This is an apparent anomaly when contrasted with section 3.3 (p.31) which references evidence based practice as informing the guidelines and clearly includes consideration of "patients circumstances, preferences, and values. " To include acknowledgment and respect of the consumers perspective to the principles for effective treatment does not negate clinical risk assessment.</p> <p>The introduction of a case management approach is very welcome and supported. However the capacity to deliver this from within the ADS is not apparent. Difficulties in recruitment of pharmacotherapy staff, in particular nurses, are a problem in many jurisdictions, and Tasmania is no exception. The risk of continual re-investment in the ADS recruitment at the expense of private and community providers should be closely monitored. A workforce strategy to address this issue will need to be in place if the shared care, case management and access to service are to be enhanced.</p>	Email
<p>MOU/Communication CSOs & ADS - MOU with ADS that worked quite well to engage with a CN to work out a care plan for the client, was a good communication channel, identified gaps, discussed issues and worked really well and ensured good access to the service.</p>	Email
<p>Shared care model is a good approach.</p>	Individual Meeting
<p>They will think that ADS can offer more than ADS actually offers</p>	On-line Survey
<p>Clarification of TOPP as 'guidelines' rather than policy. Pg88 refers to section 9.2.7 which does not exist.</p>	On-line Survey
<p>Need to indicate what will change</p>	On-line Survey

4	Clinical Pharmacology
Does the figure showing chemical structure (and chemical name) of methadone really add any value to the document? If retained, it may be appropriate to check the footnote/reference which refers to Subutex not methadone	Email
Suggest insert word 'community' before pharmacy in paragraph referring to formulation choice. Given the advantages of Biodone listed, should consideration be given to recommending that community pharmacies use this product in preference to syrup?	Email
The paragraph regarding half-life and time to steady state could be open to misinterpretation – consider rewording	Email
Should amphetamine use be added to list of factors contributing to high risk of dental problems	Email
Inconsistent italicisation of mu symbol	Email
As above re methadone, does the figure showing chemical structure of buprenorphine really add any value to the document? If retained, it may be appropriate to check the footnote/reference which refers to methadone not buprenorphine	Email
(Line 9) States that both preparations are sublingual tablets – which seems at odds with reference to availability of Suboxone as a s/l film?	Email
Reference to Temgesic mentions indicated for short term pain, should reference to Norspan have parallel mention of indication for chronic pain?	Email
Reference is made to nifedipine as a CYP3A4 inhibitor, other calcium channel blockers such as diltiazem or verapamil are more potent inhibitors, reference to nifedipine is inappropriate Final line, grammatical error - drugs should read drug (singular)	Email
Regarding mortality risks, the confidence intervals do not add value to the context in which the policy will be used –consider removing	Email
Methadone syrup should be written as Sigma Methadone Syrup® to be consistent with the format of the Biodone syrup, and on p53 I'm not sure that (approximately 153535353 hours) is an approximation or correct	Email
For this reason in Tasmania....” This last sentence clashes with the second last sentence. Suggest interchange these sentences.	Word Doc

15.35 is repeated	Word Doc
Norspan Patches - education for doctors, injecting from patches	Forum
Strong evidence for methadone to be effective as treatment. Less evidence for buprenorphine, why is it recommended in the TOPP to start clients on buprenorphine? Bupe is longer acting and more flexible.	Forum
Still a place for subutex - small doses, pregnancy, all other cases – Suboxone	Forum
<p>If an outcome from engagement in treatment is to improve the health and quality of life of an individual then the possibility of unsupervised dosing is an important step toward a normalised life. The right of the individual to determine what level of “other drug” use they engage in is also an element of a normal life. Not only is access to unsupervised dosing very limited, it also seems that access to treatment could well be denied for an individual who does not accept an abstinence goal as suggested on page 56 which states, “Patients should be advised that commencing opioid pharmacotherapy is contingent (my emphasis) on the patients agreement to address other drug use through supervised daily dosing where appropriate and selective withdrawal management.”</p> <p>Commitment to harm reduction is important along with a need to recognise that consumer self- determination is a critical element to service provision.</p>	Forum
<p>Will the Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards help to minimise the risks and ensure the clinical safety of clients receiving opioid pharmacotherapy in Tasmania?</p> <p>The move to increase the use of Buprenorphine in Tasmania and the currency of the TOPP in regard to the use of these substitution therapies is a very positive aspect of the Policy and Standards. This coupled with very strict eligibility criteria for acceptance on the program and then stringent compliance measures for maintenance on the program are highly likely to result in reduced clinical risk in that group.</p> <p>The flip side however is that due to the perceived risk, prescribers may be reluctant to place opioid dependent individuals on pharmacotherapy, with fewer people gaining access to treatment. Implementation of the TOPP should not lead to a reduction to individuals seeking treatment.</p>	Email
Strong evidence for methadone to be effective as treatment. Less evidence for buprenorphine, why is it recommended in the TOPP to start clients on buprenorphine? Bupe is longer acting and more flexible.	Forum
Still a place for subutex? small doses, pregnancy, all other cases – Suboxone	Forum

New patients entering program. What happens when the patient is only there because their partner is pushing them to be?	Forum
5 Assessment for Entry into the Opioid Pharmacotherapy Program	
problems with over the counter medication controls over the counter medication have been successful	Forum
Over the counter pain medication. Clients able to obtain significant doses.	Forum
<p>• How will the Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards impact on clients and health care professionals involved in the delivery of the program?</p> <p>The TOPP labels itself conservative and this has several implications for clients and health professionals. In the first instance the emphasis on clinical risk management is fully endorsed. No practitioner within the alcohol and other drug field would deny the importance of risk management however the potential for this to result in rigid decision making exists.</p> <p>The TOPP notes on page 69 that "risk factors do not necessarily preclude the patient from accessing opioid pharmacotherapy..." however the suggestion is that they would. Although paragraph 5.14 refers to the clinicians' discretionary decision making in regard to managing risk, this is almost invisible in the document when compared to the inclusion in section 5 of an extensive list of potential risk factors, many of which are</p> <p>Common to any person dependent on any substance. The possibility exists that for a risk- adverse service or practitioner very few if any individuals will be assessed suitable for pharmacotherapy treatment. More extensive discussion in relation to the clinical discretion in managing risk should be included.</p> <p>It is also noticeable within the document that multiple references are made to seeking advice from an Addiction Medicine Specialist or sometimes more specifically the ADS Addiction Medicine Specialist. This issue of a second opinion or advice could be more clearly defined in the document. For instance there are some issues for which approval from the Clinical Director ADS is required whereas there are other matters where a second opinion from a private specialist could be preferred. This could be of particular importance where grievances or complaints are involved.</p>	Email
Alprazolam/Other opioids- I am happy with this restriction	Individual Meeting
If implemented TOPP provides clarity for limitations around benzodiazepines.	On-line Survey

	If resourced adequately it has a holistic approach. Safe framework for clients to be treated within.	On-line Survey
	Urine Drug Screens Mindful of peoples previous fragilities..."chaperone" is not an appropriate word.	Forum
6	Entry into Opioid Pharmacotherapy	
	Securing a dosing site No mention of patient identification to go to pharmacy and no mention of patient details to go to pharmacy	Email
	Do you never allow patients to carry their script to the Pharmacy? Even after long term treatment?	Email
	Provision of urine for screening is compulsory -is this always the case? How often are patients screened? We had a patient here who had a history of sexual abuse as a young person who was terrified of producing supervised urine and it affected his progress very badly.	Email
	Needs to outline Clients Rights under the Program. Better to outline this section within a Rights and Responsibilities Framework. There is also no mention of complaints / feedback process – needs to comply with new feedback form	Email
	"pharmacological guidelines for immediate cessation of treatment are included in Section 9.2.7" Should read : pharmacological guidelines for immediate cessation of treatment are included in Section 9.2..6	Email
	Resources/ Breathalysers - Breathe testing devices-can these be provided to community pharmacies?	Forum
	Clarify which sections will be implemented by ADS and over what time frame. A review of the restrictions to entering treatment that the TOPP will create for some people on low incomes who will struggle to meet the obligations the TOPP has of clients eg section 6.3.2	On-line Survey
7	Safe Treatment Induction	
	Reference is made in these sections to methadone but the section 7.3 relates to buprenorphine only, methadone is covered in 7.2	Email

There needs to be a sub-section specifying that notifications to dosing pharmacies must be in writing from prescribers or ADS. This would be in line with the risk reduction strategy of the policy. Communication can be by other route in addition, but must be confirmed in writing.	Email
Diagrams are incorrect – 3 days dosing and steady state are reversed	Email
Figure 7.2 and 7.3. These figures do not appear to relate to their titles. Have the graphs been substituted?	Email
Heading to read “Missed doses during induction”	Email
The way you have approached consideration of risk and protective factors as part of assessment is great. I am thinking that you might also mention the need to consider these factors on an on-going basis as part of the client’s case management and review processes as there may be a change in circumstances for the client that increases (or decreases) the level of risk. At the moment the focus of review is about treatment (although in practice I am sure staff do consider psychosocial issues on an on-going basis).	Email
Patient must be seen daily in first 4 days by whom? I like the stipulation of maximum 25 mg dose of methadone on first day	Email
Alternate dosing point from LGH Pharmacy, to dosing in community, 7 day dosing. Patients often go past 6 or 7 pharmacies to get to dosing pharmacies	Forum
It will be very useful if the treating team in the community setting was defined..The treating Team in the community would ideally consist of – GP Prescriber, Community Pharmacist, possibly other government services (MHS), and NGO providers, parole officers, counsellors etc.	Email
A tool could be developed to shape consistent observations and responses to (induction) or Rx by some of these community professionals. This tool can then be used to report back to prescriber or clinic.	Email
<p>Improve phrasing of non medical reviews by Nurses</p> <p>Within ADS Case management reviews will be conducted 6 weekly (section 7 page 108). A review is only medical when conducted by a medical officer. Nurses will undertake a clinical review or a nursing review rather than a non medical review.</p> <p>Nursing reviews will always have a ‘medical content’ e.g. undertake clinical assessments and clinical interventions and respond accordingly such as BBV screening and immunisation, withdrawal assessment and intoxication assessment and general health assessments.</p> <p>This suggests clients will be reviewed 6 weekly and this is incorrect. Policy indicates case reviews 3/12. Even with a full complement of staff it will be</p>	Email

challenging to conduct reviews 6 weekly. Review rates will vary and be based on clinical need and presentation rather than time lines – even during maintenance. If it is not going to happen the TOPP should be edited to reflect what can be achieved.		
8	Maintenance Treatment	
	Reference is made to encouraging prescribers to register with the Prescription Shopping Information Service – is ‘encouraged’ strong enough?	Email
	Number of permitted take away doses needs to be qualified by ‘...per week’	Email
	Could these sections be simplified to aid understanding – there appears to be some overlap?	Email
	Reference to pharmacist contacting the prescriber before administering dose (after vomiting) should come before dot point regarding instructions to administer, to reflect actual process	Email
	I think its great to have a resource document that allows the look up of the correct thing to do with a missed dose etc and what you need to do so once again thanks for all the effort that has been put into it	Email
	The conversation re the double dosing buprenorphine and missing a dose was because I interpreted the protocol as saying the pharmacist could administer the half dose (daily dose) without contacting the prescriber first – something I wouldn’t have done before. I guess Rosie made a lot of sense when she described how the script should be written – if the script did indeed have on it the daily dose as well as the double dose regime (eg 16mg daily. Dose 32mg on Monday and Wednesday etc) I would be more comfortable with that. However if the doctor hasn’t written the script like that I think I would still want to confirm the dose with the prescriber before administering – especially seeing as you need to let them know the patient has missed a dose anyway.	Email
	Currently divided into < 40mg or > 40mg – should use one of ≤ or ≥ so as to include 40mg within recommendations Consider being consistent with ideal methadone dose before starting buprenorphine – is it < 40mg or is it 30mg – not consistent across sections at present	Email
	“Suspension and Temporary Removal of Take-Away Doses” – page 127 paragraph 2; last sentence – I thought we needed 4 consecutive clean urines, not 3. “Missed doses” page 130 – Clients who miss 2 doses are dosed and currently are not seen by Case Manager or prescriber, only after 3 consecutive missed doses are they then not dosed and redirected from Pharmacy to service	Email
	Provisions for Flexibility	Email

<p>I accept the point made at the feedback session that the TOPP is a guideline document only. However, it does read as being prescriptive and I got the impression I was not the only one who interpreted it in this way. Given this, the reduction of take away doses from three to two and the conservative nature of the TOPP does not provide guidance in managing clients who are relatively successful on the program.</p> <p>I respect that issues such as diversion, polydrug use and drug seeking behaviour are serious with potentially irreversible negative outcomes, making them an essential focus of a document such as the TOPP.</p> <p>However, the TOPP discusses the biopsychosocial approach which incorporates the engagement principles and is inherently person centred. Based on this there needs to be acknowledgement that clients come to the program from varying starting points with varying levels of success.</p> <p>There are some clients who, once stable, are able to continue on the program with little to no deviation. For these clients the restrictions can not only seem excessive but can start to impede on their ability to fully participate in the community (employment, volunteering, social connections). Outcomes such as these are contrary to the person centred approach as the individual begins to feel they are forced to make a choice between maintaining positive lifestyle choices and participating in a community that has become valuable to them. Subsequently it can potentially lead to deviance as a desperate attempt to maintain community links that it appears the program is hindering. This would not be a success for anyone involved.</p>	
<p>Provisions for Review/Second Opinion</p> <p>Health care is a very personal matter. In all other aspects of health care individuals have a right to seek a second opinion or a review of a medical professional's opinion. They also have the right to be comfortable and have trust in the medical professionals who are providing them with a service. Clients of pharmacotherapy are not currently afforded this right in part due to resource restrictions but in part due to their membership in a particular social group (recipients of pharmacotherapy).</p> <p>Denial of rights based on membership of a particular social group is potential discrimination. I understand multidisciplinary teams within the public sector go some way to addressing this by ensuring arbitrary decisions are not made about individual clients health care. However, it is often the case that clients do not understand this process and still feel very strongly that either their case manager or prescriber has full control over them and can take away their treatment or alter their treatment on a whim.</p> <p>I feel the TOPP needs to look at how, in a person centred approach, we can make sure clients are in an equal relationship with their medical professional and are able to seek review, change providers or lodge concerns/complaints without unjustified negative impact on their treatment. There is of course the added layer of complexity in ensuring drug seeking behaviour is not enabled for clients who are at risk.</p>	Email
<p>'... motorcycle panels ...' Should this be 'motorcycle panniers'</p>	Email
<p>Holidays: In a non-7-day pharmacy with a long weekend due to a Monday holiday or with recurring holidays of Easter and Christmas, how do they deal</p>	Email

with the recommendation for: Non-consecutive doses & No additional doses	
<p>Transitional arrangements / Training</p> <p>What is the plan for moving current patients with takeaway dosage schedules that don't match the draft guideline to a 2 x non-consecutive takeaway dosage schedule? What provisions have been made for training of dosing pharmacists and prescribers about the change? What education will be provided to current clients about the changes to takeaway dosing?</p>	Email
<p>Where the doctor changes or cancels takeaway doses:</p> <p>The dosing pharmacy should be informed in writing, regardless of whether the patient has been contacted or is unavailable.</p>	Email
<p>Missed doses; Confirmation to recommence dosing with the dosing pharmacy should be in writing.</p>	Email
<p>Could provide ADS prescribers with a Fax at home to send a copy to the Pharmacy when needed. Cost would be around \$200 and all requirements for PSB would be met.</p>	Email
<p>My own personal view on lost or stolen doses of S8 drugs.</p> <p>Lost or stolen doses should be treated as notify able to the police by the case worker, regardless of what circumstances are given by the patient. Due to the nature of possible fatal consequences. The account of the circumstances, is just too unbelievable to make any allowances .Driving a car can turn into a deadly weapon, so can lost doses. No room for excuses ever.</p>	Email
<p>The limitations of the Prescription Shopping Information Service should be noted. The prescribing of low cost benzodiazepines may not be notified by pharmacies under this scheme.</p>	Word Doc
<p>Third dot point has a word missing</p>	Word Doc
<p>The way you have approached consideration of risk and protective factors as part of assessment is great. I am thinking that you might also mention the need to consider these factors on an on-going basis as part of the client's case management and review processes as there may be a change in circumstances for the client that increases (or decreases) the level of risk. At the moment the focus of review is about treatment (although in practice I am sure staff do consider psychosocial issues on an on-going basis).</p>	Email

<p>What if 'Methadone and Ageing', was an addendum to the original draft and not applicable in any way to the norm?</p> <p>Something along the lines of :</p> <p>once a person reaches a certain amount of years on the program(I'd like it to be about 13yrs) and has proven themselves to be doing well in their job, community etc., has never caused any problems with their prescriber or pharmacist and is prepared to open up their life to scrutiny by the 'powers that be', couldn't they then be given the choice of entering into an incentive program whereby they are offered say, more takeaways, freer movement (travel etc.) access to support for problems occurring whilst ageing on methadone etc. and of course, many, many, more. This would be on an individual basis and not available to anyone under the time limit.</p>	Forum
<p>that some sort of addendum could be attached to the original document for 'methadone and ageing' ONLY. Nothing to do with inductees and short term recipients (up to about 10 years). Maybe along the lines of incentives for long termers with excellent records so that their lives become a bit easier as far as travel etc. which is just one example.</p> <p>Limiting takeaways to those who are proven to be responsible i.e.: working, homeowners, active community members etc., could be disastrous as it would put those people who, like me, have removed themselves from that scene and everything involved with it, back into the company of using addicts etc.</p> <p>I don't really see myself as a methadone recipient anymore because I only go to the pharmacy once a week, I always get there first thing in the morning so that I don't see anyone else. I never speak to any of the others if I do happen to encounter anyone and I'm back home and back into my life quickly and without fuss. If that were to change and I was taken off my takeaways and put back to a couple each few days, it would mean more visits to the pharmacy, more chances of my reserve failing me and the list goes on. It would have a detrimental effect on me mentally, if not any other way, as I would start to see myself as a criminal again, which is how it used to make me feel in the early days.</p>	Email
<p>Can pregnant women have split dosing of methadone? Are patients ever allowed 2 consecutive days TADs for weekends etc?</p> <p>Are interstate patients who are considered stable in their own states expected to bring their own medication when in Tasmania holidays/business? Are pregnant women allowed to have replacement dose if they vomit their dose?</p>	Email
<p>When patients transfer between methadone and buprenorphine, why do their prescribers need advice from ADS? Even when they start on bupe and transfer to methadone?</p>	Email
<p>I suspect we might disagree on the TAD policy because I think 2 TADs together for a weekend is acceptable and maybe another for during the week if someone is very stable and has been in treatment for a long time.</p>	Forum

Our policy may change when it is reviewed. Hopefully that will be soon.	
Dealing with opening times of pharmacies for t/a's . People trying to hold a proper job, all doctors believe t/a's are being used properly.	Forum
Access for takeaways, for exemplary clients, focussing on negative side, being penalised, there must be more people out there who are honest, and trying to change their life. Very stressful. Doesn't want to have to go in to pharmacies to get methadone in 20 years 5 times a week with junkies etc.	Forum
If you take methadone away, after 12mths they are just back on it.	Forum
What to do about clients on more than 2 takeaways at the moment	Forum
Is it ok to share information with pharmacists? Yes it is valid sharing information with the pharmacists, if the client knows their information is being shared between pharmacists, then it should be a problem	Forum
A further implication for clients and health professionals could emerge in defining clinical stability (pp119-120). According to the TOPP, traces of polysubstance use in random urine screens would indicate instability and therefore prohibit unsupervised dosing. This restriction seems to contradict other sections of the TOPP where reference is made to the acceptance of a harm reduction approach to substance use. For instance page 29 states that "potential outcomes of the therapeutic strategies may range from reduction to cessation of the drug/s of concern."	Word Doc
Case manager has to see client - not enough to just to dose it is important for pharmacies to let prescriber know	Forum
Concerns for pharmacists about telling clients that they won't be dosed if they missed doses.	Forum
Double dose and triple dosing after missed daily dose. Where do we stand with Nurse dispensing of dose and administer	Forum
Concerns around how the missed doses notification procedure will work in practice for pharmacists, particularly after hours. Encourages proactive practices by pharmacists rather than no action. If missed 2 doses may be more complex.	Forum
Data collection opportunity ADS Pharmacy has a computer program to track doses. Program is basic but effective. Real life daily dosing records/data collection through DORA/DAPAS will be welcomed.	Forum
Daily dosing sheets could be faxed through at the end of the week.	Forum

A pregnant woman with 3 x missed doses and is sent to hospital, what happens then? Weekends/ Holiday periods/after hours, who can provide assistance?	Forum
If the pharmacist cannot reach the doctor poses difficulties. If the patient presents intoxicated, do not dose? If doctor says dose but pharmacist feels unsafe to do so?	Forum
What is the therapeutic evidence for takeaways?	Forum
Reporting - No process for the CSO's to report missed doses etc. There has been no engagement with these services. CSO's are placed in an awkward position with their clients, no process in place to pass on complaints, no engagement. How do we come together to not jeopardize the relationship with clients?	Forum
Takeaway doses - Changes in takeaway - a lot of patients receiving more than 2 doses. Is there a transitional plan to help adopt the changes in the TOPP?	Forum
Takeaway doses - How do we mainstream pharmacotherapy so that it is accepted as a treatment plan in the acute sector. Independent review/second opinions. Communication strategies for pharmacists around takeaways due to changes the TOPP is proposing.	Forum
Takeaways - Having a practice where more takeaways than the policy allows, that way they had to ask for more takeaways each time it is needed. Needs to be justified. (WA)	Forum
In terms of takeaway doses 5/7 dosing is a challenge for working clients, this means they have takeaway doses only on weekends rather than during the working week when they need them. This limitation is for methadone and the issues mainly relate to pharmacy opening times The restrictions on Bupe are OK because you can double dose. Generally use bupe and I am reluctant to commence people on methadone because of this reason.	Individual meeting
No takeaway doses – because of transfer is understandable. It would be good to have a checklist /risk assessment management to help look at risks for unsupervised dosing.	
Retention in program in rural setting will be compromised because of only 2 takeaway restrictions.	Individual meeting
Urine drug screens and the use of random UDS is a positive approach	Individual

		meeting
Missed doses: usually by day 4 – pharmacists refers them back. Not always aware of patterns of missed dosing –particularly if double/missed dosing Not often advised by pharmacist. NEED “ standing orders ‘ for missed doses and private prescribers		Individual meeting
Less clients will be treated due to the increase in requirements to see them more frequently		On-line Survey
Not clear what has changed.		On-line Survey
9	Completing Treatment	
No Feedback Received		
10	Psychosocial interventions in Opioid Pharmacotherapy	
The statement that ADS will ensure pharmacotherapy & psychosocial interventions are well integrated? How do you manage this? we'd like to be able to do it!		Email
We recognise the hard work that has gone into this document and wish to be constructive in our feedback. At the same time, we are passionate about having a document that reflects the evidence, best practice. If a re-write of this section to reflect the current evidence-based psychosocial interventions is not possible within the time frames, we would suggest the section be removed. As stated in the feedback document, psychosocial interventions could be mentioned in the introductory chapter with the reader directed to key literature (e.g., WHO 2009) and the forthcoming psychosocial framework. The bulk of the TOPP is largely medically focussed and this small section does not currently do justice to psychosocial interventions for drug dependence.		Word doc
Remove first 2 paragraphs of section 10 as only serve to reinforce medical model. This has been covered in depth in the rest of the document. Start the section with paragraph 3 WHO Guidelines and include other key literature.		Word doc

Biopsychosocial model of drug dependence should be included in TOPP and especially in this section	Word doc
Case management – outline models. No need to specify which model ADS uses in this document (internal policy and procedure)	Word doc
Better coverage of Relapse Prevention to include reference to Marlatt and Gordon, also Clinical Guidelines for implementing RP (Marlatt, Parks & Witkiewitz, 2002), concepts of lapse vs relapse.	Word doc
Section 10.4 Benefits of Including Psychosocial interventions should be introduction to this section. Summarise bullet points into 1-2 paragraphs. Include summary of the evidenced based approaches in section 10.4	Word doc
Pg 159 paragraph about “when appropriately trained, pharmacotherapy clinicians can directly deliver many of these interventions” confusing. What is meant here? What message does this send to the sector?	Word doc
Figure 10.1 confusing as psychosocial interventions usually determined according to stages of change model (Prochaska & DiClemente). Interventions certainly can be applied across treatment spectrum but confusing to present it this way.	Word doc
Group psychosocial interventions should be included	Word doc
TOPP Paraphrased p 155, last paragraph: “The most commonly applied psychological intervention is cognitive behaviour therapy, which is delivered in various forms (Drummond & Perryman, 2007). It is based on the principle that addiction is a learned behaviour, and, consequently, can be altered. Modification occurs by applying a combination of cognitive approaches that address faulty cognitions, promote positive thinking, and enhance motivation to modify behaviour (Beck at al., 1993).	Word doc
The following core interventions should be covered in detail in this section: <ul style="list-style-type: none"> • Behavioural Interventions (covered in detail in WHO guidelines, also • Motivational Interviewing (currently mentioned or alluded to in various sections but deserves a section e.g. 10.2.1, then CBT 10.2.2) • Better coverage of CBT model for drug dependence with reference to Beck, Ellis etc., including concept of cognitive case formulation (see attached), ABC model, Socratic method for eliciting change in cognition and core beliefs 	Word doc

<p>Also attached is the link to the source document for this section of the TOPP: http://www.who.int/substance_abuse/activities/psychosocial_interventions.pdf</p> <p>This particular paragraph (page 8, paragraph 2) has been paraphrased in the TOPP document in a way that is misleading and suggests that CBT is about “positive thinking”</p> <p>Original from Drummond and Perryman 2007 link above:</p> <p>CBT in addiction is based on the principle that addictions are learned behaviours that are capable of being modified. Cognitive approaches primarily aim to change addictive behaviour through changes in faulty cognitions (e.g. dysfunctional beliefs) that serve to maintain the behaviour, or through the promotion of positive cognitions (E.g. self efficacy) or motivation to change behaviour (Beck et al., 1993).</p>	<p>Word doc</p>
<p>In relation to Section 10 of TOPP, the brief chapter 8 in the “Co-occurring guidelines” provide better coverage of psychosocial interventions than the current draft of the TOPP See attached</p>	<p>Word doc</p>
<p>Overall recommendations:</p> <p>1a) Complete literature review of psychosocial interventions in opioid dependence and</p> <p>1b) Re-write this section to reflect all evidence based approaches & key literature reviews (MI, Behavioural Interventions, CBT, Relapse Prevention etc., Cochrane collaboration, NICE guidelines, WHO,) with clear outline of each intervention and reference to key research on efficacy of each</p> <p>OR</p> <p>2) Remove this chapter (rest of TOPP very medically focussed) but include acknowledgement of the value of psychosocial interventions in ORT in introduction to TOPP, referencing WHO, the Co-occurring guidelines, and the forthcoming ADS Psychosocial Framework</p>	<p>Word doc</p>
<p>The implementation of case management in the ADS opioid pharmacotherapy program further develops and extends the program, focussing on the psychosocial needs of the client. Suggest change to: The implementation of case management extends the program to also address psychosocial needs of the client</p> <p>(Case management – adequately resourced and structured will allow greater opportunity to focus on all needs i.e. bio and psychosocial) - We cannot dictate what case managers or case management will focus on. This will depend on the client presentation</p>	<p>Word doc</p>

11	Specific Populations receiving Opioid Pharmacotherapy	
	<p>Current terminology is pre and post test discussion – the terms pre and post counselling are outdated several years nationally – although the HIV Protective Measures Act uses them - the Act is being reviewed to fall into line.</p> <p>At the same time National HIV Testing Policy is being reviewed – with an expected move from the onerous and inhibiting pre and post discussion requiring “appropriately trained clinicians” - to informed consent. National Hepatitis B Testing Policy would be expected to then follow suit.</p> <p>TOPP is in line with Australian Immunisation Guidelines and National Policies regards hepatitis A immunisation for the client group. However - in collaboration with the ADS Drs - I am developing a meeting paper attempting some outline of the cost/benefits for hepatitis A immunisation for the Tasmanian client group. Presently this State does not fund any specific program, the immunisation is relatively expensive, and currently ADS has no Policy nor are the ADS Drs doing much - although Havrix or Twinrix are stocked in the ADS pharmacy.</p>	Email
	<p>Agreement, that ADS MO will, if needed take over re induction of Pharmacotherapy in pregnant women presenting to hospital after missed doses and at risk of miscarriage.</p>	Email
	<p>Methadone reduction post partum by 20-30% when the dose is 100mg/20mL or more.</p> <p>Patients/Clients should be made aware of this reduction during the progress of the pregnancy by their caseworker (It could be part of the contract for female patients).Private prescribers need to be educated /or informed for safety of the patient.</p> <p>During the hospital admission, need to see and assess the patient during this reduction period on a daily basis. This reduction approach should not be used as a blanket statement, but rather as an individual approach.</p>	Email
	<p>Amend to read “...and with the advancing stages of pregnancy alter the distribution and reduce the bioavailability of methadone</p>	Email
	<p>What if ‘Methadone and Ageing’, was an addendum to the original draft and not applicable in any way to the norm.</p> <p>I had to go through menopause with no literature available to me about the effect of methadone on menopause, what it was doing to my body, bones, heart etc. as I get older, and lots of other things, especially the terrible grief felt by having to leave a previous lifestyle (even though it was terrible) and move into a whole new way of living. It is extremely hard especially when you have no family or friends (which you have had to leave behind) or any kind of support system and no literature because you are one of the original recipients and there IS no literature.</p> <p>The grief does not go away, it actually gets harder as you get older. Maybe that is one of the reasons for the low success rate in people coming off the</p>	Email

<p>program after being on it for a fair while. Also going through chemo was a nightmare on methadone. Boy, could I tell you a lot about that!</p> <p>'Methadone and ageing' would be about humanising the end part of the process because the longer a person has been on the program then obviously the older they have become, which (one would hope) has made them a bit wiser, more settled, hopefully tired of the very stressful existence of a user, and realising the need to blend into their community instead of always being an outsider. I know that trust and respect were two of the things I craved desperately.</p> <p>Removing the stigma attached to methadone by letting the older recipient become more anonymous in their community as opposed to regularly being seen in clinics, pharmacies, doctors surgeries, etc. etc.</p>	
Nothing further to add – great work	Email
Can pregnant women have split dosing of methadone? Are pregnant women allowed to have replacement dose if they vomit their dose?	Email
Do you allow pregnant women to remain on Subutex?	Email
Do all patients have BBV assessed or is it voluntary?	Email
These people are high risk regardless of stability if they have to be reviewed in 1-2 days of release from prison - there needs to be an option for clinical decision making.Suggest adding: that there should be good communication between Correctional Health and ADS to manage this priority group safely and within each service's resources to achieve a seamless clinical handover and more planned response for the client.	Email
<p>HIV Section needs some rework. Current terminology is pre and post test discussion – the terms pre and post counselling are outdated several years nationally – although the HIV Protective Measures Act uses them - the Act is being reviewed to fall into line.</p> <p>At the same time National HIV Testing Policy is being reviewed with an expected move from the onerous and inhibiting pre and post discussion requiring “appropriately trained clinicians” to informed consent. National Hepatitis B Testing Policy would be expected to then follow suit.</p> <p>TOPP is in line with Australian Immunisation Guidelines and National Policies regards hepatitis A immunisation for the client group. Consideration needs to be give to the cost/benefits for hepatitis A immunisation for the Tasmanian client group. Presently this State does not fund any specific program, the immunisation is relatively expensive.</p>	Email
<p>Currently ADS has no Policy however Havrix or Twinrix are stocked in the ADS pharmacy.</p> <p>We should be ramping up the importance of offering Hep B immunisation BBV discussion for all new and returning clients (as appropriate) and regularly</p>	Email

reviewing for existing clients (Hep A where clinically indicated) in light of prevalence morbidity and mortality of Hep C.	
Consider adding that the presence Hep C - either Ab positive or PCR positive - should be considered a marker for Hepatitis B immunisation if not already completed	Email
<p>“Hepatitis B vaccinations should be available and provided to all clients on the OPP who do not have immunity to the virus. It is strongly recommended that vaccinations should be provided to the sero-negative partners and close family contacts who are hepatitis B sero-positive and potentially infectious”.</p> <p>1. There will be a considerable cost associated with serology and it is not routinely recommended by the NHMRC for the target group in this procedure.</p> <p>2. Pre-immunisation serology is not cost effective. Vaccination given to individuals who have immunity in not contraindicated.</p> <p>Suggest referring this issue to the Public Health Immunisation Nurse, ID Physician or Sexual Health.</p>	Email
The inclusion of guidelines around on Blood-borne viruses and in particular the offering of Hep B vaccinations for new and current clients is a sound inclusion to improving the health outcomes for clients	Word Doc
<p>Will the Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards adequately broaden the current treatment approaches for clients to include a focus on psychosocial and risk and protective factors?</p> <p>The recognition of the psychosocial aspects of treatment for individuals receiving pharmacotherapy treatment is a very positive and references to liaison with mental health services (p.163) are important.</p>	Word Doc
Liaison, collaboration and shared care with community sector organisations however are less apparent. Whist the document refers to well integrated programs and awareness of agencies and health professionals there is little more than a list of the types of psychosocial interventions that might be used. It is difficult to determine how the information being provided will be translated into a broadening of the treatment approaches unless processes such as referral, case conferencing, joint treatment planning, and professional development are included.	Word Doc
Many of the individuals who currently, or potentially could, receive pharmacotherapy treatment, access the services provided by the community sector. Due to the limited resources in Tasmania’s AOD sector, psychosocial approaches cannot be broadened without inclusion of the community sector so once again, the success of the TOPP in achieving its goal to broaden the current treatment approaches for clients to include a focus on psychosocial and risk and protective factors will only be possible if the sector are engaged with this Policy and these Standards	Word Doc

12	Managing Complex Presentations	
	First paragraph refers to simple analgesics and includes aspirin and tramadol – this is not appropriate – analgesic doses of aspirin should be considered NSAIDs and tramadol as (at least in part) an opioids	Email
	Consider adding 5th dot point – to exclude clients who are known to seek OTC opioids from pharmacies	Email
	Should reference to Alprazolam and patients receiving opioid pharmacotherapy be qualified – the term pharmacotherapy is not uniquely applied to management of addiction.	Email
	Should include reference to clients who seek OTC opioids from pharmacies	Email
	Hospitalisation & admission; need confirmation in writing of ceased dosing and prescription cancellation to pharmacy; When restarting – written confirmation of new script	Email
	I think we did agree on destroying all medication brought in by patients.	Email
	I may have missed it but there appears to be no reference to shared care arrangements with other services (esp. high risk clients with comorbid conditions) and how this is managed. Within SMHS the withdrawal of services to a client also requires a number of processes to be undertaken. I don't expect that you should replicate any state-wide policy requirement in the document but you might make mention of these requirements.	Email
	Do ORT patients who go to emergency rooms have adequate and timely pain relief in emergencies? We often find doctors are reluctant to offer this in ER and it can be a problem.	Email
	Patients cannot be prescribed alprazolam - fantastic. I wish we would say this!	Email
	Regular support etc to dosing sites - who does this?	Email
	Are prescribers expected to look for injecting sites on every visit? Are warning letters effective in decreasing problematic behaviour?	Email

Overdose: I suggest the emergency number be inserted as a reminder on this page (twice).	Email
Important to identify professional responsibilities to reduce risk of aggression	Email
Important to provide options for a client to choose - to promote change from aggression to responsibility.	Email
Takeaways/ Acute Pain relief/ Obtaining medications from patients: How can you accept a takeaway? How can you tell if it has been tampered with? Destroy all takeaway doses that have been brought in by the patient? What if the takeaway seal has not been broken?	Forum
There are difficulties determining if person is using benzodiazepines illicitly when we are trying to reduce benzodiazepines use	Forum
Should refuse to prescribe benzodiazepines at all if putting person on a program	Forum
Scripts/ hospital admission/ communication: Communication between hospitals and Community Pharmacies is a huge issues and has resulted in double dosing. Can there be a better system for this?	Forum
13	Transfers
Temporary Transfer within Tasmania: Need confirmation in writing to pharmacy about start and stop; Policy uses the word 'Ask'	Word Doc
Permanent Transfer within Tasmania • Need confirmation in writing to pharmacy about start and stop • Last point says to de-register client in Tasmanian Program – look like a document editing 'paste' problem from the Interstate transfer section	Word Doc
Transfers Interstate • Need confirmation in writing to pharmacy about start and stop	Word Doc
Transfer of Dosing Location	Word Doc

• Cancellation of old site needs to be in writing		
The position taken on Interstate Transfers is understandable from the perspective of high demand and insufficient resources. However the reality of human nature is that individuals will arrive unexpectedly and circumstances may be extenuating. The guideline on p 228 states, “if a client chooses not to return to their treatment provider and to cease opioid maintenance treatment, withdrawal medications for symptomatic relief should not be provided.” This as a very severe response which denies the person any treatment whatsoever. Circumstances that prevent an individual returning to their previous prescriber may be legitimate, or otherwise. Nonetheless, it seems unreasonable that the ADS in its specialist public role would provide no assistance to individuals who are opioid dependent irrespective of a consideration of the individual circumstances or the potential impact of such a decision.		Word Doc
This section could be shortened (14 pages). Feedback is that TOPP (300pages) is too long – i.e. much will be not read therefore wasted effort and lost opportunity to focus attention on critical points. Material at pp 217- 221 could be extracted and dealt with as internal/external procedure – leave the key principles / standards in TOPP - alternatively compile all required information (e.g. that required at 13.3) as a Form in Appendix.		Email
Transfers/ National registration: Tas will not accept scripts from any other state. Some other states do accept scripts; this is not the case in Tas. Some interstate patients/patient's GPs demand to jump the queue.		Email
Transfers (Interstate).Can a patient transferring from interstate transfer onto our waiting list?		Email
What happens when patients enter the program temporarily and then end up staying on permanently?		Forum
Transfers: there are a lot of disorganised and itinerant clients and unsanctioned transfers. It would be good to have international transfers managed by the public program and to provide support for interstate transfers.		Individual Meeting
14	Legislative Requirements	
Misuse of drugs act 2001 Should report be to police and/or ADS?		Email
Firearms Act -Is this relevant in all states or just Tasmania as I've not seen it mentioned before?		Email
This is a prime place where the observation should be reflected. The section should explain that the power to provide authorisation under s 59E		Letter

lies with the Secretary, but has been delegated to officers within PSB.		
Section 14.9 might be thought to imply that all requests to government for information must be made under the Right to Information Act 2009. In fact, requests for personal information - which includes one's own health records, a type of information which is likely to be of major interest to people affected by the TOPP - are made under clause 6 of Schedule 1 to the Personal Information Protection Act 2004.		Letter
The first sentence to this section needs review, since the national scheme is now in place.		Letter
The legal or administrative basis upon which the system of prescriber authorisation is imposed upon practitioners should be clearly stated.		Letter
It may be appropriate to include, perhaps in Section 14, a reference to the rights of review which are open to practitioners and patients affected by the TOPP. Either type of individual would have the right to make a complaint to the Ombudsman under the Ombudsman Act 1978 with respect to a relevant administrative decision taken within the PSB or other Government agency. A patient would have the right to make a complaint to the Health Complaints Commissioner under the Health Complaints Act 1995 with respect to the provision of a relevant health service.		Letter
Pharmacist part of dosing team. PIP act covers the pharmacist if he gives information in the best interest of the patient.		Forum
15	Prescriber Training and Authorisation	
What happened to the doctors we have trained at ADS, and who have gained their prescribing license? They are at the hospital, but refusing to be available for patients who are not mental health patients .We might have to think if this investment of extra time and supervision is well invested.		Forum
The introduction of an audit process/ cycles is a good change. It would be good to have an educational network. In terms of recruiting more private prescribers it might be useful to look at reaccrediting and maybe incentives- these would have to be at a national level i.e. Medicare scheduling/fees		Individual meeting
Limitation on number of clients for private prescribers of 20 seems appropriate but perhaps nit all at once. Maybe- 5+5+5+5 (to manage induction rates new patients)		Individual meeting

16	Pharmacy Instruction	
<p>Why do we refer to 'instructions' – odd choice of language – why not accreditation, training and guidance (or similar) reflecting their role more appropriately?</p>		Email
<p>From a pharmacist's point of view I feel TOPP helps empower the pharmacist to make those difficult calls when they are unsure of a patient's behaviour, and the lists of acceptable and unacceptable behaviour are important. In my experience with new pharmacists dealing with this group of patients it's very easy to either be too harsh or too lenient in how you handle them because they are "that sort of patient". Having guidelines helps in making the decision of what acceptable and what's not and can give an individual a lot of confidence.</p>		Email
<p>However while it offers guidelines it still doesn't address what a pharmacist can do (short of refusing to deal with the prescriber and their patients) when they are concerned about patient/community safety with excessive takeaways or whatever. This is the issue Rob Davies brought up. Many years ago when we (LGH) dosed many more patients we went through the process of getting the Medical Director of the hospital to sanction our refusal to replace lost takeaways for any reason – as a public hospital we felt we needed to have that backup but maybe more could be written in TOPP about enabling pharmacists to maybe make an agreement to only dispense if the TOPP guidelines are followed unless sanctioned by Drug and Alcohol – this would need to be agreed to by doctor and patient before the patient was commenced on treatment. However I can see the doctors not agreeing to this. It is a tricky situation as it's hard enough to get GP's involved without then telling them about all the conditions and you reiterated that you are not a regulatory body in any way. I'll have to think more on that one before I can offer a solution!</p>		Email
<p>A few comments as I have actually read the 297 pages. My impressions of the document was it was highly detailed which covers almost any situation. I can see why it took so long to produce. It is a great document and a source of much information - congratulations to the authors.</p>		Email
<p>My concerns with such a detailed document are that no one will read it – however having the PDF document with search capabilities will certainly help this situation. I can still see it being ignored unless it is backed up with education sessions.</p>		Email
<p>Does this not duplicate information on missed doses provided elsewhere?</p>		Email
<p>Consider adding requirement for the old prescription to be cancelled</p>		Email
<p>The draft recommends the use of Breath Testing Devices to objectively assess a zero alcohol policy. Is there going to be the provision of devices to pharmacies to provide this intervention to reduce the risk to the clients in line with the overall strategy of the TOPP?</p>		Word Doc

Is there going to be a standardised report or template form for dosing pharmacies to send to doctors or ADS for missed doses, stolen doses, and client problems by fax or secure email?	Email
There is an error in stating that the peak Methadone effect occurs within 20-30 min. It should read that the onset occurs within 20-30 min and the peak effect within 2-3 hours after ingestion, as per section 4 in the clinical pharmacology table 4.1.	Email
Prescription number (a requirement of the Poisons Regulations). This dot point should be mentioned under takeaway labelling arrangements for methadone, Subutex and Suboxone. Also "Prescription Number "should be included on the sample takeaway label	Email
Missed doses: Concerns about allowing a case manager authorise dosing	Email
Dosing: we refer to agreement not contract as there is an inherent power imbalance in the word contract. If patient cannot legitimately get to pharmacy, can someone be authorised to collect the dose?	Email
The basis upon which the approval and accreditation process is imposed on pharmacists should be clearly stated.	Letter
Pharmacists concerns about GP's regulating controlled doses. Cost associated with dispensing controlled doses	Forum
How to highlight missed doses, should it go on Dora?	Forum
Do you have to get permission from the prescriber to give out half doses, if the dose has been missed? Half doses can be given if only 1 dose has been missed. But if 2 doses have been missed they have to go to their case manager/prescriber.	Forum
Do not confuse mg & ml.	Forum
Suggest this be reemphasised as a statement at p269 e.g. Pharmacists must exercise extreme care not to confuse mg and ml. Such errors can be fatal.	Email
Communicating changes to pharmacists in writing. No section in the TOPP regarding communication. Big issue for pharmacists is communication with the pharmacies i.e. follow up in writing. As a risk management policy. Changes in dosing, scripts etc. Written notification to come from the Doctor. Needs to have clearly written the name of the pharmacy on the top of the fax/letter/script.	Email

Develop capability and equip pharmacists. Development of the capability of pharmacists. Equipping pharmacists with better skills especially psychosocial skills, this will help support the prescribers in achieving the patient treatment goals.	Email
Clearer outlines for management for pharmacist	On-line Survey
Not clear what has changed.	On-line survey
GENERAL COMMENTS	
Although “script” is acceptable and in common use, the use of the term “prescription” would be more correct and is the terminology used in the legislation. Suggest use of prescription only.	Word Doc
I am extremely impressed by the presentation of the document and commend all involved re the production of such a high quality, well laid out and very readable document. Hope these comments are constructive and once again well done on an excellent document.	Email
Client numbers and case complexity not resourced adequately. Inability to implement current ADS P&P with current staffing let alone implement the new guidelines	On-line survey
Expectation that ADS will be implementing the changes outlined in the TOPP.	On-line survey
Case management training around how to manage safely huge case loads. Time management training to allow staff to conduct 6 weekly reviews as indicated in the TOPP.	On-line survey
Additional case managers. Access to patient transport schemes for times when clients dose changes or induction is occurring.	On-line survey
Resourcing issues- how can the TOPP be implemented with current resources?	On-line survey

Lovely document in theory but in practice most of the document will not be implemented and may give false expectations of the service that ADS will be providing.	On-line survey
Policy is presented clearly and effectively. We remain committed to supporting the delivery of pharmacotherapy.	Letter
Noted that the draft TOPP considers the role of Tasmania Police in dealing with opioid issues and acknowledges relevant legislation.	Letter
DPEM has reviewed the draft TOPP and no issues have been identified.	Letter
DPEM support the introduction of the TOPP to assist in ensuring an appropriate policy & practice base that will supportive effective, consistent and safe pharmacotherapy treatment services in Tasmania.	Letter
I would like to congratulate you on the work on what ended up a very extensive document (nearly "War and Peace"). I was a bit daunted by the size of it initially but I think that the policy hit the mark and it is readily readable (Any required advice is found fairly readily).	Email
I assume when you use the term "should" it indicates that the direction is policy not legislation	Email
As a matter of legal principle, it is good to have policies in place which guide discretionary decisions made under statute, because this helps to make sure that the decisions are well informed and generally consistent. However, it is wrong to apply a policy slavishly, without proper regard for the circumstances of the particular case. In other words, the appropriateness of applying a policy to a particular case should always be kept in question. The TOPP is framed in a way which is inconsistent with this position. As drafted, it is an ADS document, not one to be issued by the Secretary.	Letter
It also states policy positions in a categorical way, as if there is no room whatsoever for departure from the policy - e.g. section 8.6 on Methadone takeaway doses - whatever the particular circumstances might reasonably require. There will be inevitably be situations where it is not appropriate to follow the policy, because of the circumstances of the individual case. These observations may be thought to require adjustment to many elements within the draft document, but at the very least the legal and administrative bases upon which adherence to the policy is expected should be made manifest in the Foreword and also in the body of the document.	Letter
We welcome the release of the Draft Tasmanian Opioid Pharmacotherapy Policy (TOPP) and Clinical Practice Standards (2011). We commend the Alcohol and Drug Service (ADS) for its commitment to the provision of a safe opioid substitution therapy program and for its leadership in the development of real time reporting of prescribing.	Word Doc

<p>How will the Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards work in practice?</p> <p>The implementation of the TOPP will need to be a staged process due to the limitations in Tasmania in relation to reasonable access to pharmacotherapy prescribers, dispensers and case managers. It is well known that current demand for service outstrips the capacity to deliver, with waiting lists in all regions of the State.</p> <p>The development of an appropriate implementation plan will be critical to avoid risk to creating an unsustainable pharmacotherapy program.</p>	Word Doc
<p>Our concerns in relation to the decision by ADS not to conduct a broad and traditional consultation process were raised through correspondence in August 2011 when ATDC advised the ADS that we did not support the decision to abstain from consultation with the community sector on the development of the TOPP. Although the rationale for this decision has been framed in terms of a required level of clinical knowledge or personal experience, it remains our view that ADS should now demonstrate that there has been adequate appraisal of this document by a broad range of stakeholders with the required expertise.</p>	Word Doc
<p>We appreciate the efforts undertaken by the ADS in conducting community feedback forums. However a reported and observed lack of diversity among attendees at these events suggests this mechanism for feedback has limitations. (For example in Hobart, only one prescriber, three community pharmacists and no consumer/carers attended).</p>	Word Doc
<p>We are hopeful the provision for written and online feedback has penetrated the stakeholder group more effectively, but again the relatively short timeframe poses limitations. (On this matter the ATDC would note its appreciation for the extension of time allowed for submission of our own feedback.)</p>	Word Doc
<p>As already acknowledged by the ADS the “...document will need to stand up to intense scrutiny from within Tasmania and across Australia.” If the TOPP is to be implemented in its current form, it clearly demands a change in practice not only within the ADS, but also across the private and community service providers. It would be disappointing if the TOPP is only appraised by a small sub-set of those individuals to whom it is relevant.</p>	Word Doc
<p>In light of these comments, we strongly support the proposal to engage a Peer Review process for the TOPP that involves both Tasmanian and Australian Addiction Medicine Specialists. The ATDC recommends that the document is reviewed from the Chapter of Addiction Medicine http://www.racp.edu.au/page/australasian-chapter-of-addiction-medicine/.</p>	Word Doc
<p>Further, since the TOPP has taken into account the local circumstances and needs of Tasmania, and varies in some instances from National policy, we would consider it highly appropriate that a local private AOD medical practitioner be invited to be one such peer reviewer. We are able to recommend a practitioner who has a long history of working with opioid substitution programs in Tasmania, and as an Addiction Medicine Specialist is highly respected</p>	Word Doc

<p>within the field. As a reviewer, this would bring local knowledge and context essential to understanding how the TOPP will work in practice.</p>	
<p>Key Points</p> <ol style="list-style-type: none"> 1. The appraisal process should demonstrate adequate representation of the views of key stakeholders. 2. We strongly support the proposal to engage a Peer Review process for the TOPP that involves both Tasmanian and Australian Addiction Medicine Specialists drawn from the Chapter of Addiction Medicine. 3. The implementation of the TOPP will need to be a staged process. 4. The development of an appropriate implementation plan will be critical to avoid risk to creating an unsustainable pharmacotherapy program. 5. To include acknowledgment and respect of the consumers perspective towards the principles for effective treatment does not undermine sound clinical risk assessment. 6. A workforce strategy to address the capacity within ADS will need to be in place if shared care, case management and access to service are to be enhanced. 7. More extensive discussion in relation to the clinical discretion in managing risk should be included. 8. This issue of a second opinion or advice could be more clearly defined in the document. 9. Inconsistencies within the TOPP's approach to harm reduction, abstinence and consumer self-determination should be addressed. 10. Implementation of the TOPP should not lead to a reduction to individuals seeking treatment. 11. Processes such as referral, case conferencing, joint treatment planning, and professional development are included. 12. Psychosocial approaches cannot be broadened without inclusion of the community sector 	<p>Word Doc</p>
<p>We see different side of clients to what pharmacists see. They didn't take pharmacotherapy clients on from the start but then realised they need a stable place to live away from bad influences.</p>	<p>Forum</p>
<p>Kids need alcohol drug education, printed matter, modelling mentoring.</p>	<p>Forum</p>
<p>Have consumers been engaged with this process outside of Advocacy Tas contact.</p>	<p>Forum</p>

External Appraisal and Feedback Report

Process Evaluation

Although a formal process evaluation was not undertaken Evaluation Forms were completed for each of the regional feedback forums. A total of 14 evaluation surveys were completed. In general, most participants reported that the forums were useful and felt that they were able to have open discussions. The Figures below provide a brief summary of the evaluation outcomes.

Figure 1 Style of Presentation

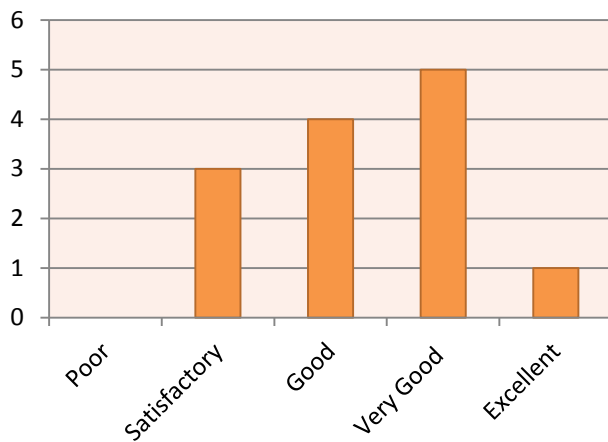


Figure 2 Usefulness of the Forum

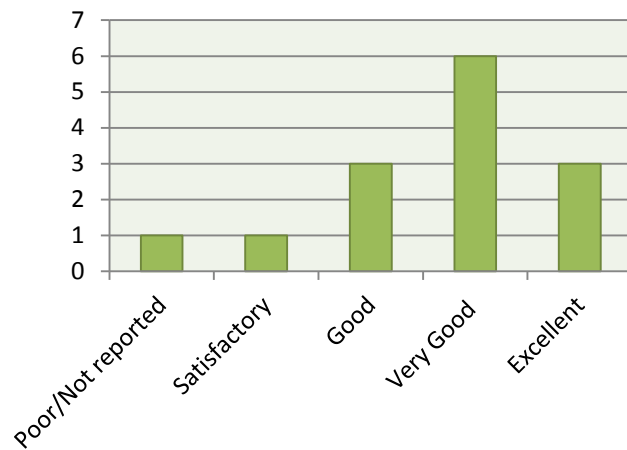


Figure 3 Participant Interaction

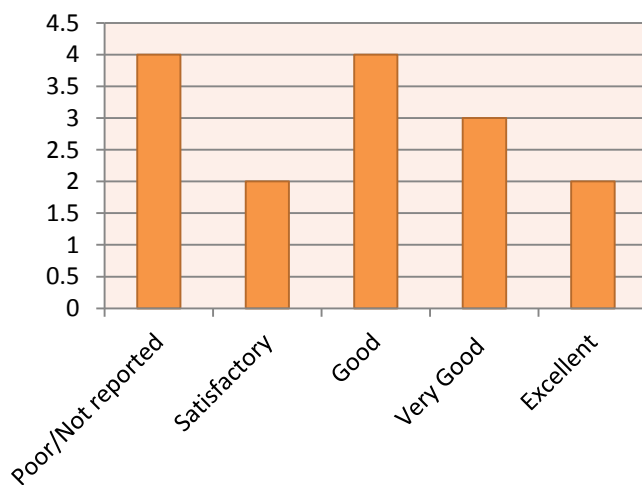


Figure 4 Opportunity to make comment and provide feedback

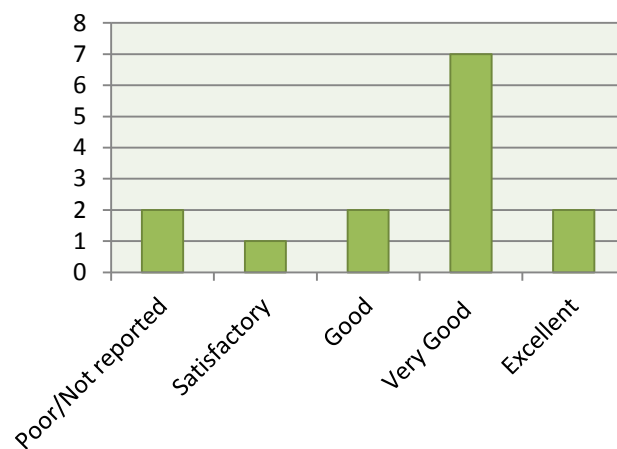


Figure 5 Clarity of Information

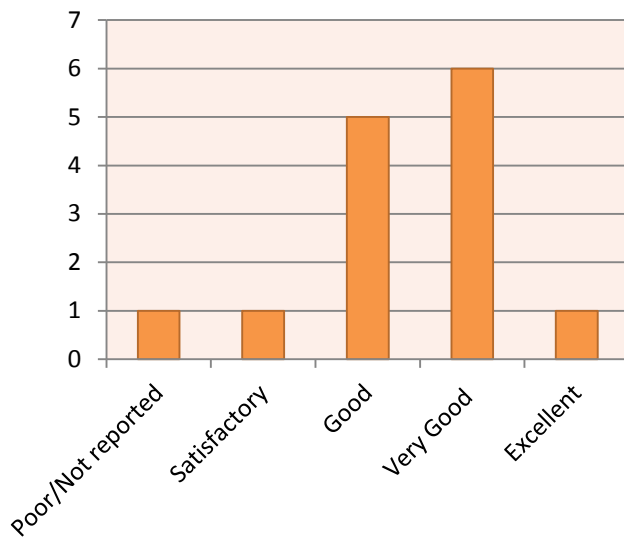
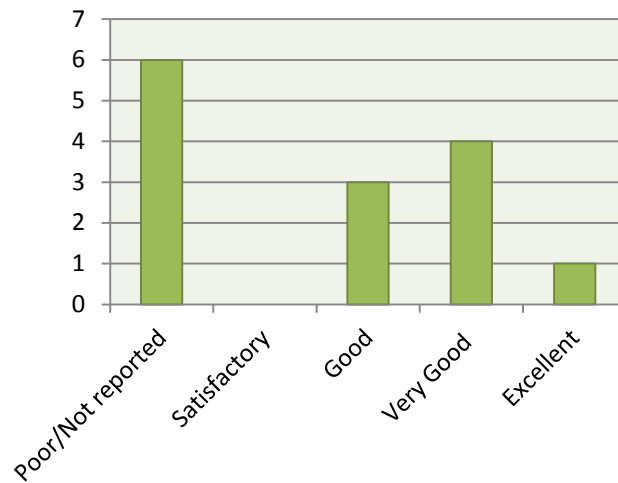


Figure 6 Resources Provided



In addition, the forum feedback evaluation yielded information about the resources required to implement the TOPP. This will inform the development of the TOPP Implementation Plan.

Throughout the TOPP External Appraisal and Feedback process comments and issues relating to the process (that were provided as part of individual or agency feedback) were identified and have been included in the “General Comments” section of the TOPP External Appraisal and Feedback Summary (see Table I).

Key issues identified relating to the TOPP External Appraisal and Feedback process included:

- The very short period of time (4 weeks) allowed for the feedback period;
- A number of agencies requested and received considerable additional time to prepare and provide responses;
- The restricted scope of the appraisal and feedback process and the absence of a full community consultation process;
- The limited extent of consumer and community sector involvement in the process were raised by some organisations;
- Strategies to ensure and facilitate consumer feedback (including payment); and
- The lack of involvement of these groups in the development of the TOPP as a critical issue.

External Appraisal and Feedback Report

Timeframes

The project timeframe for the development and implementation of the TOPP is lengthy. This reflects the significance of this policy document. The TOPP Project Timeline (see Attachment D) shows the key actions, milestones and completion dates for the project.

It is anticipated that the TOPP External Appraisal and Feedback Summary of Recommendations will be completed and distributed to key stakeholders in January 2012.

Conclusion

In summary the majority of the feedback received through the TOPP External Appraisal and Feedback process was positive. A number of key issues and gaps were identified that will require some additions and modifications to the document. These include access to second opinions; complaints mechanisms; restrictions on unsupervised dosing (takeaway doses); and the need for further consideration on the provision of opioid pharmacotherapy to older persons.

It is clear from the feedback that there will need to be a lengthy implementation period. This will ensure and facilitate effective communication; provision of training; and support the review and transition of care.

External Appraisal and Feedback Report

Attachments

Attachment A: Key Stakeholders

Table 2: Key Stakeholders: TOPP External Appraisal and Feedback
Alcohol, Tobacco and Other Drugs Council Inc.
Pharmacy Guild
Pharmacy Guild - Tasmania
Pharmaceutical Society of Australia - Branch Committee - Tasmania
Pharmaceutical Society of Australia - Tasmania
DHHS, Alcohol & Drugs Services
Advocacy Tasmania Inc.
Dept. of Justice - The Office of the Ombudsman
Coroner's Office
Australian General Practice Network
Australian Medical Association - Tasmania - Committees of AMA Tasmania
General Practice Tasmania
GP Divisions - South
GP Divisions - North
GP Divisions - North West
Forensic Science Service Tasmania, Department of Police & Emergency Services
Forensic Science Service Tasmania, Department of Police & Emergency Services
DHHS - Dept of Anaesthesia, Royal Hobart Hospital
Pain Management - Primary Health South, Whittle Ward Palliative Care South
Calvary Health Care Tasmania - Pain Medicine
Department of Health and Human Services, Population Health
Dept. Health and Human Services
DHHS Prescriber
Director Medical Integration Primary & Rural Health, Office of the Chief Health Officer.
Prescriber
DHHS - Primary Health Care Correctional
North Hobart Amcal Pharmacy
Amcal MAX Moonah
Wilkinson's Chemmart Pharmacy
Mowbray Capital Chemist
DHHS - Alcohol and Drug Services - Pharmacy

Table 2: Key Stakeholders: TOPP External Appraisal and Feedback

DHHS - Pharmaceutical Services Branch
Pharmaceutical Services Branch
Medication Strategy and Reform
DHHS - Alcohol & Drug Services - Manager, Clinical Practice Development and Performance
DHHS - Alcohol & Drug Services - Team Leader South
Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD) - Chief Executive Officer
The Link Youth Health Service - Team Leader
DHHS - Alcohol & Drug Services - Nurse Unit Manager - Pharmacotherapy Program
DHHS - Population Health - Coordinator Needle and Syringe Program
DHHS - Statewide and Mental Health Services -Statewide Clinical Director
Department of Police & Emergency Management - Southern District - Drug Investigations Services
Department of Police & Emergency Management - Commander of the Eastern District
Department of Police & Emergency Management - Executive Officer
Department of Police & Emergency Management - Northern District - Criminal Investigations Services - Inspector
Department of Police & Emergency Management - Devonport Division - Detective Inspector
Motor Accidents Insurance Board (MAIB)
University of Tasmania - School of Psychology
University of Tasmania - School of Medicine - Hobart Clinical School - Associate Head
Professor of Pharmacy and Head of School
University of Tasmania - School of Pharmacy - Senior Lecturer in Pharmacy Practice
DHHS - Department of Emergency Medicine Medical Staff Royal Hobart Hospital - Staff Specialist
DHHS - VMO's North West Regional Hospital - Specialist Anaesthetist
DHHS - Medicine Launceston General Hospital - Staff Specialist Director DEM
Live Free Tassie (Teen Challenge Tasmania Inc.)
Drug Education Network Inc.
Brain Injury Association of Tasmania
Wyndarra Centre
OZHELP Foundation
Salvation Army
Community Connections Inc.
Aboriginal Centre Tasmania
Advocacy Tasmania
General Practice North West
Cornerstone Youth Services
Quit Tasmania
Red Cross Tasmania
Mission Australia
Circular Head Aboriginal Corporation
Hobart City Council
Youth and Family Focus
Holyoake Tasmania
Family Drug Support
Launceston City Mission (Missiondale)
Anglicare Tasmania Inc.

Table 2: Key Stakeholders: TOPP External Appraisal and Feedback

Karinya Young Women's Service

Colony 47

Tasmanian Council of Social Service

Rural Alive and Well Inc.

Bicheno Pharmacy

Centre Healthwise Pharmacy

City Capital Chemist

Galloways Pharmacy

Invermay Pharmacy

Kings Meadows Healthwise Pharmacy

Launceston Remand Centre

Legana Pharmacy

Launceston General Hospital Pharmacy

Longford Pharmacy

Mike Moss Pharmacy

Mowbray Capital Chemist

Newstead Capital Chemist

Olde Tudor Pharmacy

Perth Pharmacy

Prospect Vale Pharmacy

Rossetto Pharmacy

Scottsdale Pharmacy

St. Helen's District Hospital

Targett Pharmacy

West Tamar Pharmacy

Westbury Pharmacy

Woodroffe Pharmacy

Price line Plaza

Your pharmacy George Town

Coventry's Pharmacy

Elshafie Pharmacy

Penquin Pharmacy

Mersey Pharmacy

NW Regional Hospital

Rosebery Community Hospital

Somerset Pharmacy

Smithton Pharmacy

Strahan Clinic

Thompson Pharmacy

Tony Davies Pharmacy

Turnbills Pharmacy

Wells Pharmacy

Wilkinson's Pharmacy

Mersey Hospital Pharmacy

Table 2: Key Stakeholders: TOPP External Appraisal and Feedback

Priceline Pharmacy
Goodprice Pharmacy
HealthPoint Pharmacy
ALL ADS STAFF
Notice put on wall in waiting areas - STATEWIDE
Albert Ng Amcal Pharmacy
Brighton Pharmacy
Bruny Island Pharmacy
Chemist Outlet Kingston
Dodges Ferry Pharmacy
Elizabeth Hope Bridgewater Phcy
Elizabeth Hope Priceline Pharmacy
Eastlands Amcal Pharmacy
Friendly Care Chemmart Hobart Pharmacy
Geeveston Pharmacy
Glenorchy Central TW Pharmacy
Huonville ChemMart
Lauderdale Pharmacy
Lenah Valley Amcal
Magnet Court Chemmart
Mt Nelson Pharmacy
New Norfolk Guardian Pharmacy
New Norfolk Terry White Chemists (formerly Derwent Valley)
New Town Pharmacy
HPS Hobart Pharmacy
North Hobart Amcal Pharmacy
Oatlands Pharmacy
Risdon Vale Pharmacy
Rokeby Discount Drug Store
Rosetta Guardian Pharmacy
Sandy Bay Amcal
Sorell Chem Mart
South Arm Pharmacy
Tasman Pharmacy
Terry White Chemists - Kingston
West Hobart Amcal Pharmacy
NDARC
AVIL
Chpater of Addiction Medicine
Private Prescribers- North, South & North West

Attachment B: Client Journeys

Brett:

Brett is a 32 year old male who has presented for review of treatment, after missing one previous review appointment. The pharmacist has contacted advising that Brett has missed the last 3 consecutive days' doses.

Brett has been on 80 mg methadone for the past 5 months, and over the last month he has been receiving a Sunday takeaway. Brett tells you that he is doing really well and using no other drugs and this was confirmed by his last few urine drug screens. However, on examination fresh track marks are evident on both arms and he admits to injecting his methadone on several occasions over the past 2 weeks. He also smells of alcohol and when breathalysed his BAL is 0.08g%. Since stabilising on 80mg of methadone Brett's progress has been good, he has ceased regular use of other drugs. He continued to use cannabis everyday but there had been no recent benzodiazepine or heavy alcohol use. In the past Brett has used both benzodiazepines and alcohol in 3-4 day binges.

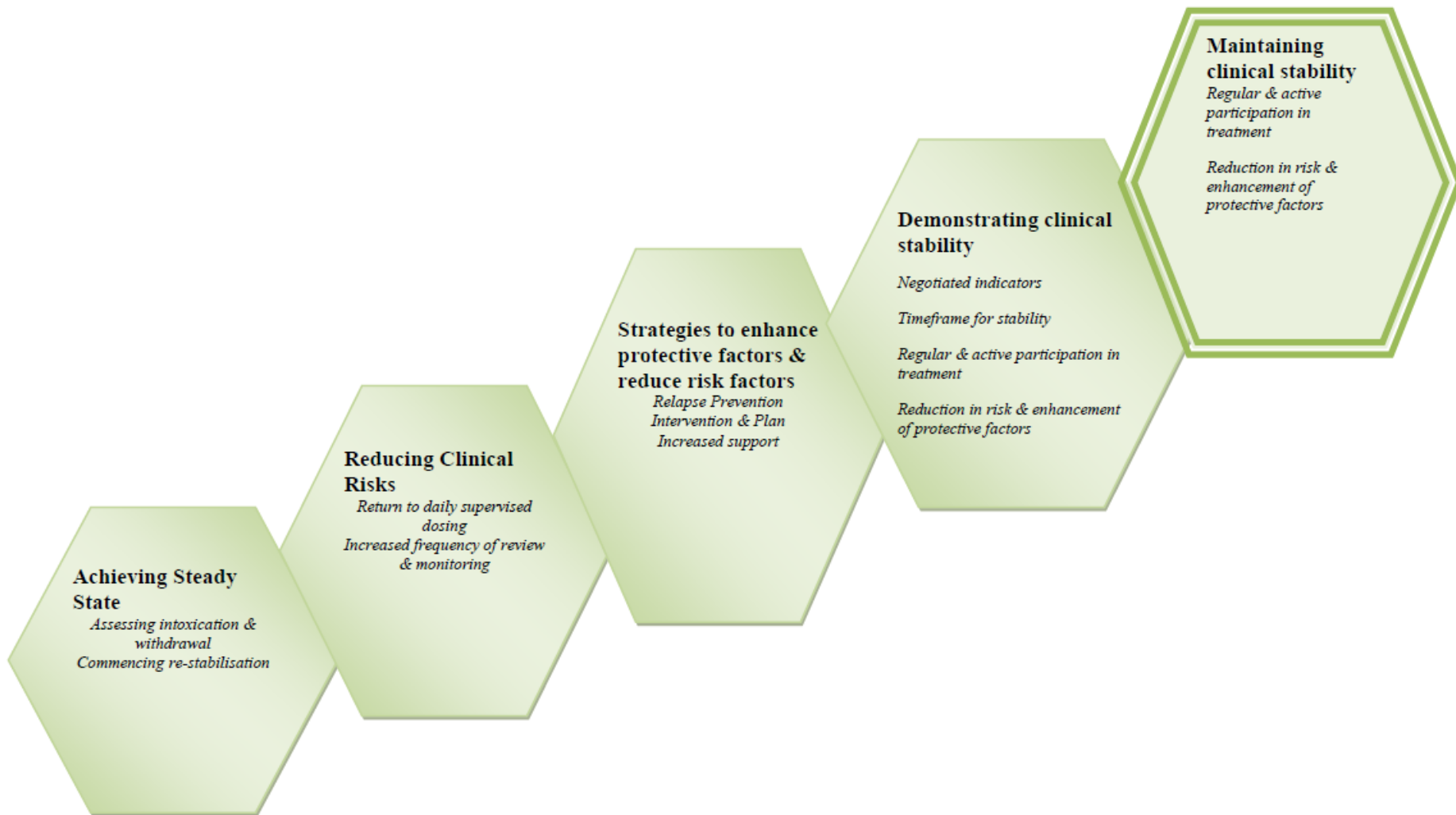
Until four weeks ago he had regularly attended his case management and medical review appointments. During his time on the program he has also been picking up some regular labouring work and has finally been able to pay off some outstanding debts. He admits to 'not turning up' for work lately and says that he has not worked for the past four days. His partner had previously reported an improvement in their relationship and his involvement in caring for their two children. However, during the interview she describes feeling worried that Brett is slipping back into 'his old habits' and is concerned about his ability to stop using drugs.

It is clear that Brett has lapsed in recent weeks and there is concern that his treatment is not progressing well. The consecutive missed doses, recent history of diversion of his takeaway for injection and his significant recent and past history of both alcohol and benzodiazepine use are all indicators of risk. It is also concerning that this loss of stability has occurred around the same time he began to receive takeaway doses.

It is clear that Brett has many strengths and protective factors. To this point Brett has been committed to his treatment and to making changes in his life, he does not appear to be very concerned about his current situation. Given the current situation Brett's care plan needs to be revised. The up-dated care plan should not only include re-stabilisation, but also a range of strategies to manage current clinical risks; identification of triggers and cues for relapse and increased support. The negotiated care plan also needs to include timeframes, requirements and markers of improved clinical stability.

The TOPP describes the required clinical practice standards for managing missed doses, re-stabilisation and for delivery opioid pharmacotherapy using a risk and protective framework. The client journey (flowchart) below demonstrates the application of these standards to this clinical scenario.

Brett's Journey: Achieving Clinical Stability and Managing Missed Doses



Gary:

Gary is a 43 year old man who has been referred by the prison health service. He was released from prison 12 weeks ago and was referred by the prison service but failed to attend his appointment. He is living with his de-facto partner of 6 years after an 18 month sentence in prison for dealing. He is currently receiving the invalid pension for a back injury sustained 25 years ago in a work accident. He experiences pain daily as a result of this injury.

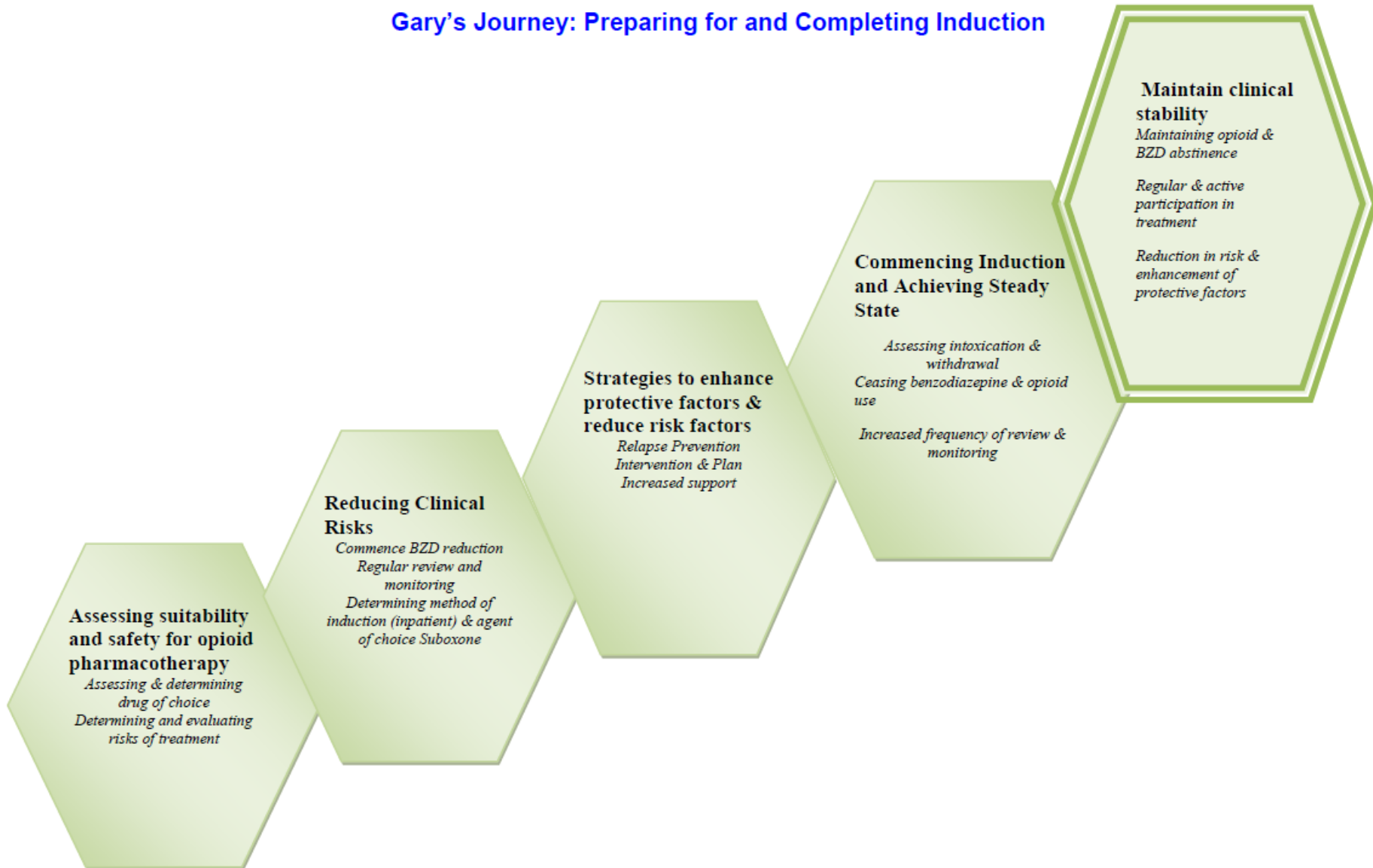
Gary is requesting substitute pharmacotherapy. He has been on a 'bender' since his release from prison and has attended with his partner after falling down a flight of stairs while he was intoxicated on a cocktail of alprazolam and morphine that he scored through a friend. He has substantial bruising on the left side of his face. Gary is quite shaken up by what has occurred. He says that he wants to avoid returning to previous patterns of opiate and benzodiazepine use. He does not want to go back to prison- this is the basis of him seeking pharmacotherapy. He believes that this will stop him from going back to jail as it will stop him from returning to previous patterns of problematic drug use and crime. Gary has a very lengthy criminal record and has served two previous prison sentences for assault and robbery.

Gary has previously been on the pharmacotherapy program 6 years ago for almost 2 years and was stabilised on methadone 100mg. He describes this as a good period of his life. In reviewing his previous history you notice that there were some difficulties for Gary during his time on the program, including presenting a stolen script for alprazolam to the pharmacy and threatening the pharmacist who refused to dose him when he presented intoxicated on benzodiazepines.

He has a lengthy and significant drug use history. Gary first used drugs at age 15/16 and quickly developed a preference for opiates. Gary has a history of poly substance use however his drugs of choice are opiates and benzodiazepines. He prefers alprazolam and takes approximately 8 mg alprazolam three times a day in addition to 60 mg Ms Contin twice a day intravenously. He last used this morning and has used several times a day since his release from prison. He states that he only uses benzodiazepines orally, in the past he has tried injecting them but did not enjoy it. He has had two previous overdoses, the last 6 years ago, this was one of the reasons he went on the methadone program. He describes the overdoses as 'not intentional'. Both Gary's parents drank alcohol to excess. Gary says that he 'never touches the stuff'. He likes the feeling of sedation and says that it assists in managing feelings of anger and helps him to sleep. He denies any previous or current cannabis or amphetamine use, although he has used these in the past. He is insisting that stabilisation on the program will help him but you are concerned about his use and preference for benzodiazepines.

The TOPP describes the required clinical practice standards for assessing suitability for opioid pharmacotherapy, managing existing benzodiazepine dependence and identifying and managing risks associated with the delivery opioid pharmacotherapy. The client journey (flowchart) below demonstrates the application of these standards to this clinical scenario.

Gary's Journey: Preparing for and Completing Induction



Nancy:

Nancy is 44 years old, mother of two children (12 & 10) who wants to return to live in Tasmania after 8 years living on the mainland. She has contacted the Tasmanian Alcohol and Drug Services requesting ongoing care in Launceston. A referral has been received from her GP Prescriber in NSW. Currently Nancy receives 3 takeaway doses a week. She has not used any drugs for nearly 4 years and has recently completed a vocational training program in hospitality.

In the referral letter her GP indicates that Nancy has been consistently drug free during the period of her treatment and that she had completed a 6 month family residential program that has assisted her to maintain her abstinence and develop her parenting and life skills. She is stabilised on 80mg methadone and there has been no history of diversion or missed doses.

Initially Nancy's GP wanted to continue prescribing for her from NSW. He felt that there was no reason for her current management to change and was unable to identify any risks to her ongoing clinical stability with this arrangement. She has never attended a public pharmacotherapy program and has always received her treatment from a GP prescriber. After contact with the Alcohol and Drug Service and receiving advice in relation to the prescribing of opioid pharmacotherapy in Tasmania he has agreed to provide and support a referral for her ongoing management.

Nancy has been diagnosed with bipolar disorder that is now well managed. Her last admission to a psychiatric unit was nearly 7 years ago with a severe depressive episode. Since this time she has been well, her medication and ongoing mental health are also managed by her GP. Nancy regularly takes her medication and has good insight into her mental health issues. She has undertaken several years of long term therapy to deal with a past history of abuse.

Nancy will live in a small house on her parent's farm and has her own transport (car). Her parents are very supportive and eager for her to return to Tasmania. She plans to work fulltime in Tasmania. Her relationship with her parents and her siblings was very strained as a result of her previous drug use however this has improved over the past two years. The father of Nancy's children also lives in Tasmania. Nancy became involved in drug use through her former partner. She left him and moved to the mainland as a result of family violence.

The TOPP describes the required clinical practice standards for the prescribing of opioid pharmacotherapy in Tasmania and the management of opioid pharmacotherapy transfers. This includes determining suitability and capacity for interstate and intrastate transfers. The client journey (flowchart) below demonstrates the application of these standards to this clinical scenario.

Nancy's Journey: Interstate Transfer

Capacity for opioid pharmacotherapy transfer

*Availability of position on program
Availability of dosing location*

Receiving & Providing Information

*Obtain & review interstate transfer referral
Reviewing records for previous treatment episodes
Provide Program Information
Complete treatment agreement and Consent*

Reviewing the Transfer & Determining Clinical Risk and Capacity for Treatment

*Clinical team review
Identification & management of clinical risks
Treatment Plan requirements & capacity to implement
Availability of safe dosing location; prescriber & case manager*

Accepting or declining the transfer

*Communicate with referring prescriber
Provide written confirmation of transfer outcome
Secure dosing location; medical appointment; case manager
Contact client to discuss program requirements and confirm acceptance of these conditions*

Initiating the Transfer

Confirm dosing arrangement prior to departure

Regular review & monitoring during first 6-8 weeks

Identify risk factors; protective factors; timeframes for access to unsupervised dosing

Jenna:

Jenna is a 29 year old married lady who has recently been admitted to the Royal Hobart Hospital following emergency surgery for abdominal injuries following a motor vehicle accident. She is currently a client of the pharmacotherapy program and has been stabilised on 24mg Buprenorphine. She was commenced on pharmacotherapy two years ago after her doctor 'cut her off'. She has a significant history of using prescribed medication and doctor-shopping. She also uses large amounts of over the counter medicines such as Nurofen.

The hospital has contacted requesting advice as they have found Jenna challenging to manage on the ward since her admission two days ago. She says she experiencing withdrawal and has not been dosed for two days. She is also requesting pain relief and valium to help her sleep. The ward doctor has been reluctant to provide pain relief for her but has prescribed PRN valium. Jenna advised the hospital staff that she is receiving opioid pharmacotherapy and has brought with her to hospital one takeaway dose that is in her bedside table. Her pharmacist has also contacted you advising that she has now missed three supervised doses.

Jenna has tried cannabis and alcohol in her early 20's but does not use them regularly. She has previously injected amphetamines and used these in binge/run pattern for 3 years. She stopped using these 6 years ago after she had a miscarriage. She is trying to cut down her cigarette smoking and has reduced from 40 a day to 10 in the past 2 years. She finds it very hard to stop smoking. She has responded well to opioid pharmacotherapy, regularly attends her appointments and the pharmacist reports that there are never any difficulties. There has never been any evidence of diversion or concurrent opioid use.

Jenna lives with her husband Archie (non-user) who works fulltime as a gardener. She works part time in a bakery. She has no children but is close to a number of her nieces and a sister who visits regularly. Her husband is very supportive and has been visiting her daily in the hospital. After a recent visit by her husband hospital staff noticed that Nancy was quite vague and she complained of feeling faint. After further investigation it was revealed that she had been taking handfuls of Nurofen Plus. Her husband had brought her in two large boxes of Nurofen at Nancy's request to help her with her pain.

The TOPP describes the required clinical practice standards for the provision of opioid pharmacotherapy for patients admitted to hospital. This includes arrangements for inpatient hospital dosing, provision of analgesia and discharge planning. The client journey (flowchart) below demonstrates the application of these standards to this clinical scenario.

Jenna's Journey: Inpatient Admission & Management of Acute Pain

Reviewing Opioid Pharmacotherapy Management

*Determine date of last dose/cancel community dosing & cancel OPP script.
Secure and remove takeaway doses & check for any other medications
Assess for signs of intoxication & withdrawal*

Managing Dependence & Pain during Inpatient Admission

*Review recent inpatient medications
Re-establish inpatient opioid pharmacotherapy dosing
Re-stabilise if necessary
Discuss with hospital doctor provision of effective and safe analgesia*

Safe Dosing and Monitoring Treatment during inpatient Admission

*Arrange for hospital pharmacy dosing
Ensure regular review & monitoring of intoxication & withdrawal by inpatient treating team
Ensure treatment plan for analgesia includes a reduction regimen prior to discharge that is clearly communicated to the patient & in writing to the GP and patient*

Preparing for Discharge

*Confirm date of discharge & final dosing
Confirm treatment plan & discharge medications/reduction regimens
Arrange prompt pharmacotherapy review
Advise community pharmacy of date for recommencement of dosing & ensure new script is issued*

Resuming Community Opioid Pharmacotherapy

*Confirm dosing attendance with pharmacy
Increase review & monitoring during first 6-8 weeks post discharge
Liaise with GP and monitor use of medications*

Attachment C: On-line Survey

Introduction

The new draft Tasmania Opioid Pharmacotherapy Policy and Clinical Practice Standards (TOPP) has now been released.

The TOPP External Appraisal and Review Process is now underway. We are seeking feedback from key stakeholders including individuals receiving treatment (and their families), health care professional, services, advocacy groups and independent oversight bodies involved in the delivery of this program.

TOPP External Appraisal and Review Process aims to:

- Obtain feedback on the content and breadth of the TOPP and identify gaps.
- Obtain feedback on the impact of the TOPP for clients receiving treatment (and their families).
- Obtain feedback on the impact of the TOPP for General Practitioners; health professionals and services directly and indirectly involved in the delivery of opioid pharmacotherapy.
- Obtain feedback on the practical application of the TOPP.
- Identify training and resource implications associated with the implementation of the TOPP.

The following survey has been developed to allow key stakeholders to quickly and effectively provide feedback in relation to this new policy.

This new policy presents significant changes in the way that opioid pharmacotherapy is delivered in Tasmania. Your feedback is important to ensuring the TOPP will work in practice.

RESPONDENT INFORMATION

*1. In completing this survey are you responding on behalf of:

- Yourself
- A service/agency

2. Are you a

- Individual receiving opioid treatment
- Individual who has previously received opioid treatment
- Carer/family member
- General Practitioner
- General Practitioner- Private Prescriber
- Pharmacist
- Allied Health Professional
- Nurse
- Medical Officer
- Policy Officer
- Community & Welfare Worker
- Consumer Advocate
- Community Sector Worker
- Researcher

3. Do you work in or represent

- General Practice
- Allied Health: Private Practice
- Community Pharmacy
- Hospital Pharmacy
- Advocacy
- Consumer Organisation
- Peer Support/Self Help Group
- Peak body (e.g. Alcohol Tobacco Drug Council Tasmania)
- Professional Body (e.g. Australian Medical Association)
- Alcohol and Drug Service: Community Sector Organisation
- Alcohol and Drug Service: DHHS
- Alcohol and Drug Service: Private Sector (i.e hospital)
- DHHS
- Other Government Department
- Health Care Private Sector
- Community Sector Organisation
- Research Facility
- Not Applicable

Instructions

The following questions have been developed to assist you in providing feedback in relation to the new draft Opioid Pharmacotherapy Policy and Clinical Practice Standards.

There are no right or wrong answers. In order to complete the survey you will need to provide a response for all of the survey questions.

Your responses to these questions will assist us in finalising this important policy document and ensuring the TOPP will work in practice.

Survey Questions

*4. The aim of the TOPP is to describe the policy and regulatory requirements for the delivery of Opioid Pharmacotherapy in Tasmania including clinical practice standards.

Has the document achieved this?

Yes

No

*5. The TOPP also aims to provide clear and detailed clinical practice standards for the delivery of Opioid Pharmacotherapy in Tasmania.

Has the document achieved this?

Yes

No

*6. An important aim of the TOPP is to reduce the clinical risks associated with the delivery of pharmacotherapy.

Do the policy and clinical practice standards set out in the TOPP reduce the clinical risk associated with the delivery of opioid pharmacotherapy?

Yes

No

*7. Another important aim of the TOPP is to improve the clinical safety of clients receiving opioid pharmacotherapy.

Does the introduction of the risk assessment framework improve the clinical safety for clients receiving opioid pharmacotherapy?

Yes

No

*8. The TOPP also seeks to broaden the current treatment approaches to include a focus on psychosocial interventions.

Has the document achieved this?

Yes

No

*9. In reviewing the TOPP what do you think are the implications for clients receiving opioid pharmacotherapy?

5



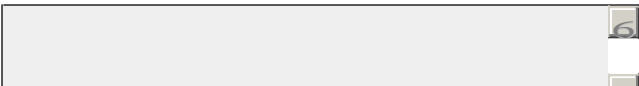
*10. In reviewing the TOPP what do you think are the implications for General Practitioners involved in the delivery of opioid pharmacotherapy?

5



*11. In reviewing the TOPP what do you think are the implications for pharmacists involved in the delivery of opioid pharmacotherapy?

5



*12. In reviewing the TOPP what do you think are the implications for alcohol and drug and other services providers?

5



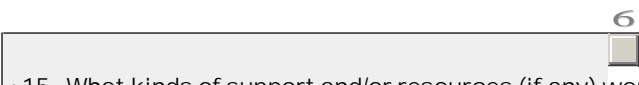
*13. What are the barriers or challenges for you in implementing and adhering to the clinical practice standards described in the TOPP?

5



*14. What kind of training do you think would be helpful to assist in the implementation of the TOPP?

5



*15. What kinds of support and/or resources (if any) would you require in order to implement the clinical practice standards in the TOPP?

5



*16. Are there any sections or clinical practice standards in the TOPP that you think are unclear or require further explanation?

Yes

No

If so, what are they?

*17. Are there any gaps or important issues that have not been covered in the TOPP?

Yes

No

If so, what are they?

*18. Will these clinical practice standards assist you in your clinical practice?

Yes

No

In what way?

*19. What are the positive aspects of the draft TOPP?

*20. How do you think that the draft TOPP could be improved?

21. Are there any other comments or feedback that you would like to make about the TOPP?

If so what are they?

Thank you for taking the time to complete this survey. We value your feedback.

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.

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 Service, on (03) 6336 5577.

Attachment D: TOPP Project Timeline

