## PURPOSE

This document is intended to describe and guide the pathway or tāngata whai ora / service user journey that each person takes as they engage with Bay of Plenty Addiction Services (BOPAS) Opioid Substitution Treatment (OST) team.

Note: The protocols contained in this pathway are designed to be flexible to accommodate and integrate national and international developments in opioid treatment. This document is guided by the NZ OST Practice Guidelines, and will be appropriately reviewed in line with these guidelines to reflect best practice. When situations arise which are not addressed in this pathway, decisions will be made in consultation with BOPAS staff and other opioid substitution specialists and will be based on BOPAS philosophy and the best available research.

## STANDARDS TO BE MET

**1. The OST Service Delivery Model**

BOPAS OST service delivery model provides a tāngata whai ora / service user pathway which the person moves at their own pace with support of the OST service multidisciplinary team (MDT) which includes the community Pharmacist.

Treatment provided by the OST service is essentially pragmatic in its approach, focusing on and giving priority to realisable goals.

The level of intervention needed from the service will vary according to individual needs. The OST service recognises that change takes time; what the change looks like and how it happens will be different for every . Some tāngata whai ora / service users will require more support and input than others. Some tāngata whai ora / service users will aim for abstinence and some will not.

1.1. <u>Access to OST</u>

a) The OST service provides a specialist service to adults aged from 18 years, and in exceptional circumstances young people under the age of 18, who present with opioid dependence.

b) Entry is usually via self-referral though referrals may also be accepted from other healthcare providers or agencies including:
   i. Other BOPAS services
   ii. GPs
   iii. Hospital specialists
   iv. Pharmacists
   v. Medical Officer of Health
   vi. Other healthcare professionals

c) These referrals will be accepted in written form (letter, email, fax). Referrals are triaged by the Mental Health & Addiction Services (MH&AS) triage team, where the tāngata whai ora / service user referred is advised their referral will be sent to the OST service, and their consent gained to do so.

d) **Prioritisation:**
   i. Under some circumstances there may be a wait period before admission and should delays be unavoidable, some tāngata whai ora / service users may be eligible for priority access based upon risk. Those who may be eligible for priority access include:
      - pregnant women

- tāngata whai ora / service users with serious co-existing medical and mental health problems
- tāngata whai ora / service users arriving in New Zealand already established on OST programmes overseas

1.2. Stages of Treatment

The pathway through treatment is outlined with the following stages and actions (though the tāngata whai ora / service user journey is not necessarily linear):

a) *Assessment*:
   i. After the initial triage, the referral is discussed within the MDT, and a suitably trained and qualified clinician is allocated to organise and conduct the initial assessment.
   ii. The tāngata whai ora / service user is asked about their health, drug use and other personal circumstances relevant to OST, and is required to complete blood and / or urine tests.
   iii. The tāngata whai ora / service user receives information about informed consent and treatment including resources such as the tāngata whai ora / service user guide OST and You (see National Guidelines 2014, page 11).

b) *Stabilisation*:
   i. After being inducted onto methadone or buprenorphine the goal is to get the tāngata whai ora / service user to a point of feeling comfortable on a consistent dose, not oscillating between intoxication and withdrawal.
   ii. Time spent in this phase will vary between tāngata whai ora / service users. Until a stable dose is reached it can be expected a tāngata whai ora / service user will be seen by a nurse or key worker at least once a week, moving to fortnightly or monthly for at least the next six months.

c) *Ongoing OST*:
   i. The continuation of treatment with the specialist service or in shared care.
   ii. Appointments with the key worker are 4 - 6 weekly or more frequently depending on the needs of the tāngata whai ora / service user but should occur no less than every 8 weeks for the duration of treatment within the specialist service.
   iii. During ongoing OST the service supports the to transition to shared care with their GP. Where the tāngata whai ora / service user is unable to find a GP to offer OST services the OST service will assist as far as possible. For details see the National Guidelines 2014 page 60
   iv. There may be times when a tāngata whai ora / service user may need to return from GP shared care for a period of re-stabilisation.

d) *Completing OST*:
   i. Tāngata whai ora / service users are not pressured to withdraw from OST, but withdrawing off may be part of their treatment goal. They may choose to complete treatment for a number of reasons.
   ii. Where a tāngata whai ora / service user expresses an intention or a desire to withdraw from OST, it is important to ascertain and discuss the tāngata whai ora / service user's reasoning for choosing to leave treatment. The key worker and clinician identify the tāngata whai ora / service user's supports and provide information and advice regarding other relevant support services in the community.

iii. The tāngata whai ora / service user is given information about the rate of reduction and possible withdrawal methods including fixed, flexible, or blind withdrawal and the use of buprenorphine where appropriate. BOPAS OST service support "reduction at request", to encourage autonomy and empowerment in treatment.

iv. When the tāngata whai ora / service user has made their decision the key worker and clinician assist the  to achieve this goal safely and effectively. Treatment planning focuses on planning for treatment completion / discharge and includes:

- Identifying early warning signs
- Advice to tāngata whai ora / service users about relapse, reduced tolerance and risk of overdose as a result.
- Identifying other community supports
- Liaison with any other agencies involved
- Information about possible re-entry to the OST service.

*e) Treatment completion / discharge / transition:*

i. Tāngata whai ora / service users can complete their engagement with the OST service by:

- undertaking a planned withdrawal from OST (planned discharge)
- leaving against the advice of the OST service (unplanned discharge)
- being withdrawn involuntarily (involuntary discharge)
- transferring to another service (as is stated).

ii. Planned withdrawal

- The keyworker follows up on action steps toward treatment completion with the tāngata whai ora / service user and closes the tāngata whai ora / service user's file in the negotiated timeframe (up to 8 weeks after the tāngata whai ora / service user's last dose).
- A discharge summary is completed, and a copy sent to the tāngata whai ora / service user and their GP. The discharge process follows standard BOPAS discharge procedures, including formulating a wellness / transition plan with the tāngata whai ora / service user prior to discharge.
- Thereafter, the tāngata whai ora / service user may re-engage at any time via the usual referral or self-referral options.

iii. Involuntary withdrawal

- Involuntary withdrawal is undertaken as a last resort, only after input from the MDT and all attempts have been made with the tāngata whai ora / service user to solve the relevant issues.

iv. Discharge / transition to another service

- The OST service assists tāngata whai ora / service users who are relocating to a geographical area that is outside its boundaries.
- As soon as possible, the OST service will refer the tāngata whai ora / service user to the local specialist service, informing them of the tāngata whai ora / service user's move, and requested a transfer of care is actioned as soon as possible.
- Once a tāngata whai ora / service user has moved to a new service, they are discharged from BOPAS.

- It is possible that a tāngata whai ora / service user might need to return to the Te Whatu Ora – Health New Zealand Hauora a Toi Bay of Plenty to be reviewed, if the transfer takes longer than anticipated, or there are serious concerns.

f) Continuing care

i. To support recovery the OST service plans to engage in continuing care activities including recovery check-ups. Evidence shows post-treatment completion recovery contact is associated with positive trends regarding drug avoidance activities, promotes self-management, a return to treatment sooner and people subsequently spend more time in treatment.[3]

## 2. General Treatment Issues

2.1. Adhering to the OST service requirements

a) The safety of tāngata whai ora / service users and those with whom they come into contact is of primary concern. As a result the service has expectations for behaviour, attendance at appointments and attendance at pharmacies for collection of medication. Tāngata whai ora / service users are informed of these expectations at admission to BOPAS. Where expectations are not met, a MDT review of treatment is undertaken with the tāngata whai ora / service user wherever possible.

2.2. Alcohol use

a) Concurrent use of alcohol and OST particularly methadone can cause overdose and death, especially when combined with other respiratory depressants such as benzodiazepines. For tāngata whai ora / service users believed to be abusing alcohol, or dependent on alcohol according to the relevant DSM criteria, an intervention involving use of a breathalyser may offer an opportunity for the tāngata whai ora / service user to address their drinking. Where needed, tāngata whai ora / service users will be referred for a supported alcohol withdrawal assessment, and supported alcohol withdrawal treatment can be explored. As part of their ongoing recovery, OST tāngata whai ora / service user who receive withdrawal treatment, will receive relapse prevention support from the OST team.

b) Where severe alcohol use is identified on admission, provision of OST might be delayed, in order to address the issue first, and buprenorphine might be offered instead of methadone (irrespective) of tāngata whai ora / service user choice. Involuntary reduction of the OST dose by the OST prescriber might be considered if there is a risk concern when someone is already established on OST, and there is significant ongoing alcohol use – this would be to reduce the sedative load, and ultimately reduce the risk of overdose and death due to respiratory depression. Alternatively the option of transferring to buprenorphine / naloxone can be explored as well.

2.3. Concurrent medical conditions

a) When appropriate, the OST service liaises with the health professionals monitoring a tāngata whai ora / service user's medical condition. If a tāngata whai ora / service user is found by the OST service to have a condition that requires further investigation or management, the tāngata whai ora / service user is asked to attend their GP. If it is considered that the tāngata whai ora / service user is unlikely to attend their GP, the service may make a direct referral to a specialist.

b) The OST service does not usually provide general medical services, including prescriptions for on-going medical conditions and sickness certificates, which should be obtained by a tāngata whai ora / service user from their GP.

c) Occasionally the OST service will provide prescriptions for medications co-prescribed alongside methadone or buprenorphine relating to conditions that will impact OST, or to aid oversight of dispensing.

d) Where a tāngata whai ora / service user requires opioids for palliative care in terminal illness the OST service liaises with the Palliative Care Team and the tāngata whai ora / service user's Primary Care Team. The opioid prescribing is undertaken by the team most appropriate to the tāngata whai ora / service user's circumstances. If the Palliative or Primary Care Team takes over prescribing, the tāngata whai ora / service user's OST file remains open for a period of 1 month following transfer of prescribing. OST service clinicians continue to be available for consultation and advice regarding opioid prescribing issues even when the tāngata whai ora / service user has been discharged from the service.

2.4. Driving

a) Tāngata whai ora / service users are advised about the risks of driving whilst on OST and other prescribed or non-prescribed medications / substances. A tāngata whai ora / service user who is known to be driving against medical advice will be notified by the OST service to the NZTA. See National Guidelines 2014, page 31.

b) Specific information about driving is in the OST and You booklet.

2.5. Drug interactions with opioids

a) It may be hazardous to take opioids with other drugs without careful consideration. Information on using other drugs is included in the OST and You Booklet.

2.6. Enrolling in primary care

a) The OST service expects all tāngata whai ora / service users to have their own GP by the end of the stabilisation phase of treatment. If the tāngata whai ora / service user does not have a GP, the service should assist them to find a GP. The OST service might hold off on commencing TA doses until such time a tāngata whai ora / service user is registered with a suitable GP, especially of it is felt there are significant health issues that also need monitoring.

2.7. Formal reviews and case conferences

a) Formal reviews and case conferences are used from time to time to evaluate treatment and treatment decisions or to assist or improve the overall co-ordination of treatment. This will be especially relevant where treatment might fall outside of the recommendations of the National guidelines.

2.8. Fraudulent behaviour

a) Tāngata whai ora / service users who act fraudulently in relation to obtaining treatment or medication from the OST service or a service to whom they are referred by the OST service will have the circumstances of their fraudulent act reviewed which may lead to involuntary discharge from OST and maybe referred to the Police.

2.9. Gambling

a) Tāngata whai ora / service users are screened for problem gambling at initial assessment. At the tāngata whai ora / service user's request a referral can be made to a problem gambling service.

2.10. Holding doses

a) Occasionally there might be a need for a random blood or urine test to be completed. This will usually be to inform safe clinical practice and / or ongoing prescribing. Due to the random nature of these tests, the OST service will not be able to inform the tāngata whai ora / service user in advance. To ensure the test is done within the timeframe required (for example a pre-dose serum methadone level), the tāngata whai ora / service user's dose might be held at the Pharmacy until such time the test has been completed, and thereafter released by the Pharmacist.

b) On occasion a tāngata whai ora / service user's dose might also be held to facilitate attendance at appointments. There is a statutory requirement on the service to review a tāngata whai ora / service user with regular intervals, and on occasion it might be required to hold a tāngata whai ora / service user's dose to facilitate attendance at such review appointments if previous offered appointments have been missed. Equally, a dose might also need to be held to facilitate attendance at a case manager or clinician's appointment to inform ongoing safe prescribing, for example where information has been received that a tāngata whai ora / service user is presenting intoxicated or there are concerns for their safety.

2.11. Liaison with GP and other healthcare professionals

a) The OST service considers that the wellbeing of a tāngata whai ora / service user is at risk if their GP is not aware that they are receiving OST so communicates with tāngata whai ora / service user's GP. The service also communicates on occasions with other health professionals involved in the care of the tāngata whai ora / service user .

b) If a tāngata whai ora / service user is refusing consent for the service to communicate with their GP, their suitability for treatment might need review. The service will do its utmost to work with the tāngata whai ora / service user in addressing the barriers that are in place, for example assist the tāngata whai ora / service user in changing GP practice if possible. Individual cases should be discussed in the MDT, and with the service Clinical Director where appropriate.

c) In the event that the tāngata whai ora / service user or public safety is at serious and imminent risk and the tāngata whai ora / service user does not consent to the service liaising with others, OST staff may communicate relevant information to the GP or healthcare professionals.

d) Due to the risks involved with OST prescribing and the importance of knowledge of other prescribed medications and their interactions with OST, tāngata whai ora / service users cannot opt out of Testsafe dispensing recording. If a tāngata whai ora / service user chooses to do so, they need to be informed of this requirement, and if they continue to opt out, suitability for ongoing OST to be discussed within the MDT, and / or the service Clinical Director as appropriate

2.12. Mental health issues

a) For tāngata whai ora / service users who present with co-existing mental health issues the key worker and / or clinician liaises with the current provider of mental health services if any, and supports the tāngata whai ora / service user and the mental health services provider where appropriate. For more information see Medical conditions and End Of Life Care policy)

2.13. Outcome measures

a) Outcome measures are indicators of change and improvements in tāngata whai ora / service users' functioning. The Alcohol and Drug Outcome Measure (ADOM) will be completed at the start of treatment and then periodically with the tāngata whai ora / service user to assist in assessing achievement of tāngata whai ora / service user goals and to support treatment and recovery planning.

2.14. Pain management

a) Tāngata whai ora / service users with pain management issues who present to the OST service are thoroughly assessed to establish whether they are opioid dependent as per the relevant DSM criteria. This assessment involves liaison between the OST service and the clinician managing the tāngata whai ora / service user's pain issues, and may involve consultation with the Clinical Pain Service. Tāngata whai ora / service users with chronic pain who are found following assessment not to have addiction issues are referred back to the referring clinician for on-going management.

b) Tāngata whai ora / service users with pain appearing to use opioids for addiction cannot legally continue to obtain opioids from a GP or other unauthorised clinicians. Where a tāngata whai ora / service user has both addiction and chronic pain issues the service works together with the tāngata whai ora / service user, the tāngata whai ora / service user's GP and the Clinical Pain Service where relevant to ensure that the tāngata whai ora / service user receives adequate pain management.

c) When tāngata whai ora / service users are admitted to hospital, and need prescribing for pain, the OST service will liaise with the hospital Physicians and Clinical Pain Team as required to support safe and adequate pain prescribing to the tāngata whai ora / service user.

2.15. Split doses

a) Split dosing may be considered for tāngata whai ora / service users who are fast metabolisers of methadone as demonstrated by serum methadone levels and clinical review, and for pregnant tāngata whai ora / service user who may temporarily become fast metabolisers of methadone. Split dosing for any other reason (such as in supporting a  with CNMP) must only be done in agreement with the MDT, and with the support of other clinicians involved in the tāngata whai ora / service user's care, such as the Clinical Pain Team. A rationale must clearly be established and documented, and should be reviewed within the MDT periodically.

b) Initially when commencing split dosing, the tāngata whai ora / service user might be expected to consume all doses observed in the Pharmacy, until such time the service feels the tāngata whai ora / service user is stable enough to have the evening doses as a takeaway. All tāngata whai ora / service users on split dosing in specialist service prescribing must consume both doses observed in the Pharmacy at least once a week. The bigger part (2/3) of the split will be consumed in the morning in the Pharmacy observed. Split doses should be consumed more than 4 hours apart, and on observed days, the prescription should specify this requirement.

2.16. Taking over prescribing of other medications

a) When a tāngata whai ora / service user is prescribed medication by a non-OST prescriber such as the 's GP which may affect the safety or efficacy of a tāngata whai ora / service user's OST, the OST service may consider taking over the prescribing of the medication. This will be especially relevant where benzodiazepines and other sedatives are prescribed.

2.17. Violent or threatening behaviour

a) Violence or threatening behaviour is not tolerated by BOPAS.

b) If a tāngata whai ora / service user is physically aggressive towards staff or other tāngata whai ora / service users policy 5.4.7 Safe and Respectful Workplace is followed.

c) If a tāngata whai ora / service user threatens or is verbally or physically violent towards staff, other tāngata whai ora / service users or community pharmacists the circumstances of the threatening behaviour are reviewed and may lead to involuntary discharge from OST.

## 3. Shared Care

3.1. Shared care is the continuation of OST with the tāngata whai ora / service user's GP. This occurs after the stabilisation phase, once it is felt the tāngata whai ora / service user is fully engaged in their own recovery. The suitability for shared care is usually assessed within a formal review by the prescriber and case manager, and discussed with the tāngata whai ora / service user. Thereafter it is discussed in the MDT, and if the MDT is in agreement with the suitability for transfer to GP Shared care, the relevant GP is approached.

3.2. Within BOPAS OST service, all shared care provision is funded via the PHO. Once the transfer to GP Shared care prescribing has been agreed, the Addiction Liaison Clinician will advise the PHO so that the funding is released to the practice.

3.3. Prior to the transfer appointment, the tāngata whai ora / service user's regular case manager will arrange an appointment with the tāngata whai ora / service user and the Addiction Liaison Clinician to introduce them to each other. The tāngata whai ora / service user will then be transferred to the GP Liaison Nurse for ongoing case management.

3.4. The initial transfer appointment with the GP is arranged with the Addiction Liaison Clinician in attendance, and is usually a double appointment. At this appointment the Clinician will hand over the relevant paper work to the GP, get the GP Shared care agreement signed by the tāngata whai ora / service user and GP and ensure the tāngata whai ora / service user and GP is each aware of their role and responsibilities, as well as the role and responsibilities of the specialist service.

3.5. Authorising GP's:

a) It is the responsibility of the lead clinician of the OST service to authorise GP's to prescribe controlled drugs for dependence. The lead clinician can also authorise other clinicians within the specialist service to authorise GP's on their behalf.

b) A GP authorisation is limited to three months, although this period can be extended with the agreement of the Medical Officer of Health within the Ministry of Health's Medicines Control team on request of a lead clinician. A copy of this authorisation is also forwarded to the pharmacy, the GP, and Medicines Control. This authorisation is specific for each individual tāngata whai ora / service user.

3.6. Responsibilities of GPs:

a) The GP must prescribe medication in accordance with written terms and conditions defined by the specialist service in relation to the specified tāngata whai ora / service users. The GP is expected to review the tāngata whai ora / service user face to face every three months. Any changes to takeaway arrangements or doses (i.e. increases or splitting doses) should be discussed with the specialist service, as this is likely to require a new authorisation to be issued.

3.7. Responsibility of specialist service:

a) The specialist service will provide ongoing support to the tāngata whai ora / service user and GP. Once a GP has agreed to prescribe, the Addiction Liaison Clinician will meet with the GP and provide written and verbal information on prescribing OST, and how to contact the service.

b) The Addiction Liaison Clinician will meet face to face with the tāngata whai ora / service user at least annually to review their progress in shared care, and discuss the outcome of the review within the MDT. This review will also include feedback from the Pharmacist and GP. If the MDT deems this necessary, a medical review will be organised with a specialist service clinician.

c) Every 6 months, the Addiction Liaison Clinician will also do a telephone review of the tāngata whai ora / service user, including obtaining feedback from the Pharmacist and GP.

d) If at any stage the GP feels the tāngata whai ora / service user needs to return to the specialist service for ongoing care, the service will arrange for this to occur without hesitation.

## REFERENCES


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- McKay, J. et al. 2005. The Effectiveness of Telephone-Based Continuing Care for Alcohol and Cocaine Dependence. Archives of General Psychiatry 62: 199-207
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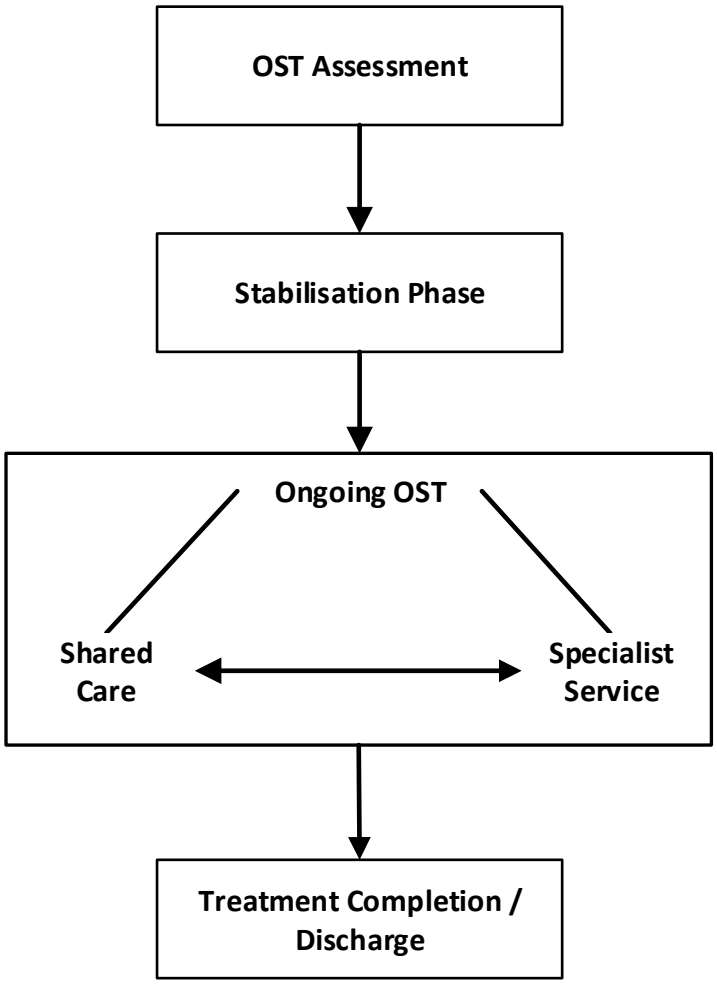
- Rollnick S. & Miller W.R. 1995. What is motivational interviewing? Behavioural and Cognitive Psychotherapy 23: 325-334
- Single, E. 1995. Defining harm reduction. Drug & Alcohol Review 14 (3): 287 - 90
- Ministry of Health. 2014. New Zealand Practice Guidelines for Opioid Substitution Treatment. Wellington: Ministry of Health


## ASSOCIATED DOCUMENTS

- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.1.1 Informed Consent
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.2 Health Records Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 4.1.0 Infection Prevention and Control Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 5.4.7 Safe and Respectful Workplace

- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.2 Pharmacist Dispensing Opioid Substitution Treatment (OST)
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.3 Admission to Opioid Substitution Treatment (OST)
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.4 Opioid Substitution Treatment (OST) Pathway
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.5 Opioid Substitution Treatment (OST) Managing Co-existing Conditions
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.6 Opioid Substitution Treatment (OST) Prescribing and Dispensing
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services OST Overseas Travel Letter template

**Appendix 1: OST Admission to Treatment Completion flowchart**



## Appendix 2: OST Admission and Assessment Phase flowchart