

**A. Winstock, J. Molan & T. Lea**

**Survey of NSW Opioid Treatment Program  
Public Clinics  
SWAT Report 3**

**NDARC Technical Report No. 298**



**SURVEY OF NEW SOUTH WALES  
OPIOID TREATMENT PROGRAM  
PUBLIC CLINICS  
SWAT REPORT 3**

**Adam Winstock, Jill Molan and Toby Lea**

**Technical Report Number 298**

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## Abbreviations

<b>ACT</b>	Australian Capital Territory
<b>ADIS</b>	Alcohol and Drug Information Service
<b>AHS</b>	Area Health Service(s)
<b>CNC</b>	Clinical Nurse Consultant
<b>FTE</b>	Full-time equivalent
<b>EPC</b>	Enhanced Primary Care
<b>GP</b>	General Practitioner
<b>GPET</b>	General Practice Education and Training
<b>HIV</b>	Human Immunodeficiency Virus
<b>IDU</b>	Injecting drug user(s)
<b>MHDAO</b>	Mental Health and Drug & Alcohol Office, NSW Health (formerly Centre for Drug and Alcohol)
<b>NGO</b>	Non-government organisation
<b>NSP</b>	Needle and Syringe Program
<b>NSW</b>	New South Wales
<b>NUM</b>	Nursing Unit Manager
<b>OTP</b>	Opioid Treatment Program
<b>PBS</b>	Pharmaceutical Benefits Scheme
<b>PSA</b>	Pharmaceutical Society of Australia
<b>PSB</b>	Pharmaceutical Services Branch, NSW Health
<b>SD</b>	Standard deviation
<b>SSC</b>	Streamed Shared Care
<b>SWAT</b>	State-Wide Advisory Team: Drug Health Streamed Shared Care
<b>TCA</b>	Team Care Arrangement
<b>NSW Area Health Services</b>	
<b>GSAHS</b>	Greater Southern Area Health Service
<b>GWAHS</b>	Greater Western Area Health Service
<b>NSCCAHS</b>	Northern Sydney/Central Coast Area Health Service
<b>HNEAHS</b>	Hunter/New England Area Health Service
<b>NCAHS</b>	North Coast Area Health Service
<b>SESAHS</b>	South East Sydney/Illawarra Area Health Service
<b>SSWAHS</b>	Sydney South West Area Health Service
<b>SWAHS</b>	Sydney West Area Health Service

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## Summary

The State-Wide Advisory Team (SWAT): Drug Health Streamed Shared Care was established in 2005 by NSW Health and Drug Health Services, Sydney South West Area Health Service for the purpose of mapping, consulting and supporting opioid pharmacotherapy services across NSW. Specifically SWAT had the objective of building capacity within existing specialist and community facilities for the management of those with drug and alcohol problems, with an initial focus on those with opioid dependence.

To assist in the attainment of the goals of the SWAT project, it was decided to undertake a study to identify the range of work practices, clinical referral pathways and supporting policies currently in place in public clinics providing treatment for opioid dependence across NSW. In addition, the possible utility of benchmarks for staffing, capacity and service delivery was investigated. This report presents the findings of the *Survey of NSW Opioid Treatment Program Public Clinics* conducted by SWAT.

Initial consultations with Area Health Services (AHS) revealed wide variation in culture and priorities as well as in staffing levels, resources, and operational practices at public clinics across NSW. However, one of the few consistencies across the state was that many public clinics had a limited capacity to take on new-to-treatment clients and there appeared to be an under-utilisation of available community pharmacy dosing places.

Between April and September 2006 a questionnaire was sent to all public clinic Nursing Unit Managers (NUMs) across NSW. A response rate of 100% was achieved. Data was collected on a range of clinical and resource variables including staffing levels, client numbers, provision of takeaway doses, and the utilisation of community service providers such as community pharmacies and GP prescribers, and relationships with these service providers. Where appropriate, results have informed the development of recommendations for clinical practice and in some areas suggestions are made for benchmarking clinical activity and staffing to client ratios. Associated rationales and suggested ways of achieving these recommendations have also been developed. A full list of recommendations is provided in the section following this summary.

### **Clinic characteristics**

Thirty-five public clinics across NSW participated in the survey. The number of clinics in each AHS, as defined by the AHS, varied between one and seven. The majority were located on

hospital grounds. Fourteen clinics reported having a private clinic in their local area (none of which were rural). All clinics except one provided both methadone (74% Methadone Syrup, 50% Biodone Forte, 24% both) and buprenorphine, with most not reporting either separate dosing times or areas. On average, 80% of those dosed at public clinics were on methadone. Forty-one percent of clinics (n=14) provided takeaways, of which eight clinics provided these at no charge.

All clinics provided case management and in all but three clinics this was delivered onsite. In terms of other on-site services, half the clinics reported providing other medications and approximately 40% providing services for other drug or alcohol problems. There was limited access to other on-site services, notably only 29% having a hepatology service, 23% a dental service, and 11% an on-site psychiatrist.

### **Client numbers, opening hours, clinic capacity**

The mean number of clients managed at each clinic was 159 (range: 18-364). Only 21 clinics had a defined maximum capacity (with determinants including clients per full-time equivalent (FTE) case manager, FTE prescribers, number of medical session and dosing hours available).

In terms of opening hours, generally, the bigger the clinic the longer the opening hours. However, there was wide variation in dosing hours between clinics (two to eight hours/day) and there was generally very limited availability of early and late dosing. All but three clinics were open seven days a week. The majority of clients managed by a public clinic (59%) received their doses at a public clinic. The overall split between public clinic dosing and community dosing, however, varied widely between individual services. For example, the proportion of clinic-managed clients dosed at community pharmacies varied from 22% to 63% across the different AHS. The majority (80%) of clients managed by a public clinic had a public prescriber, regardless of where they were dosed (range: 57-100% across the AHS).

### **Staffing (nursing, medical, other) and clinical activity (including prescribing and case management)**

Thirty-three clinics had a dedicated NUM position, and three-quarters had a dedicated administrative support position. The mean number of FTE clinical staff at each clinic was four. Just under half of the clinics reported having at least some non-nursing clinical staff. Taking into account case management activity, the mean number of clients per FTE case manager was 28 (range: 10-50).

Ninety-four percent of clinics reported having on-site medical officers, with 54% having staff specialist medical cover. The mean number of four-hour medical sessions was 4.3 per week (range: 0.25-12). The mean number of clients seen per four-hour medical session varied between four and 25. Three-quarters of clinics reported having minimum periods for prescriber reviews, with only 50% setting this at three months or less.

### **Waiting lists**

Nine clinics reported having a waiting list (although interpretation of this term was inconsistent). These findings should not be interpreted as meaning that the remaining clinics had available capacity. The findings only suggest that the majority of clinics do not keep a formal record of their inability to provide treatment to all those who present for treatment.

### **Shared care activities**

The vast majority of clinics reported routine transfer of stable clients to pharmacies and 75% reported that they monitored available capacity within their local pharmacies. Two thirds of clinics reported the use of standard assessment tools for identifying stable clients for transfer. Less than half reported the transfer of stable clients to GPs and only two-thirds reported they had contact with any of their local GP divisions. Although many clinics recognised the utility of transferring patients to community providers, many AHS, particularly those located in rural areas, reported difficulty in accessing both GP prescribers and dosing community pharmacies.



## Recommendations

### Recommendation 1.1

A clear definition is required as to what is meant by the term ‘public clinic’.

### Recommendation 1.2

There should be a uniform database of public clinics across NSW agreed by both NSW Health and the Directors of Drug and Alcohol in each AHS.

### Recommendation 2.1

That local specialist drug and alcohol services proactively engage public hospitals (especially small rural facilities) to permit a reasonable provision of access to opioid treatment at every public hospital in NSW. In addition to the requirements of NSW Health Policy Directive PD2006\_052: *Dosing Facilities in Public Hospitals for Patients on Opioid Treatments* (NSW Department of Health, 2006b), every public hospital in NSW, in consultation with its local specialist services, should be required to make advanced provision for dosing a pre-determined number of clients. Options such as funding additional hospital pharmacists and nursing staff (whether specialist or generalist) to support on-site dose administration should be considered and supported by NSW Health. Such staff may administer opioid treatment but also engage in other activities at the hospital.

### Recommendation 2.2

SWAT recommends that NSW Health facilitate specialist services, especially in rural areas, in the effective recruitment of local public hospitals to dose clients on opioid treatment.

### Recommendation 3: Additional on-site services

While services provided by clinics in addition to opioid treatment vary widely across the state, SWAT recommends that all public clinics should provide, in addition to care planning, as a minimum, on-site specialist services in mental health, dental health, and hepatology. Additional funding may be required to support implementation of this.

### Recommendation 4.1

All public clinics should have a fully funded, full-time equivalent permanent NUM position. In smaller clinics a part-time NUM may be more appropriate.

### Recommendation 4.2

All public clinics should have at least one fully funded, full-time or part-time permanent administration position.

### **Recommendation 5**

Consideration should be given to the impact of providing buprenorphine-naloxone from public clinics with the objective of encouraging the transfer of stable clients from public clinics to community pharmacies. Since buprenorphine-naloxone is the preparation of buprenorphine recommended for clients identified as stable enough to be in receipt of regular unsupervised doses, and clients as stable as this would generally be managed at a community pharmacy, it seems that the regular provision of buprenorphine-naloxone from public clinics should not be encouraged. Exceptions may be made for rural areas and for clients returning to a public clinic due to destabilisation.

### **Recommendation 6.1**

It is recommended that public clinics do not routinely provide takeaway doses of methadone, buprenorphine, or buprenorphine-naloxone. Where geographical distances or absence of community pharmacy dosing places make daily attendance difficult to the extent that it threatens retention in treatment, it may be acceptable to provide the minimum number of takeaway doses necessary to maintain the client in treatment.

### **Recommendation 6.2**

Where methadone takeaways are provided, these should not be provided free of charge. Consideration may be given to means of payment that do not involve cash handling or increased risk to staff.

### **Recommendation 6.3**

An annual methadone takeaway audit should be conducted that includes an assessment of the documentation within the notes that supports the suitability for takeaway methadone doses in those clients receiving two or more unsupervised doses per week. The *Stability Assessment Flowchart* may assist in this documentation (see Appendix C). All clients in receipt of any takeaways must be informed of appropriate safe methadone takeaway storage practice.

### **Recommendation 7.1**

NSW Health should consider providing a benchmark for the flowthrough of clients in public clinics.



### **Recommendation 7.2**

SWAT recommends that public clinics aim to have the majority of their managed clients dosed at a community pharmacy.

- For metropolitan areas, it is recommended that for public clinic managed clients, one-third be dosed at the clinic and two-thirds at non-public clinic dosing sites.
- For regional and rural areas, it is recommended that 50% of public clinic managed clients be dosed at the clinic and 50% at non-public clinic dosing sites.

In determining these benchmarks, consideration must be given to the particular circumstances affecting individual clinics in regional and rural areas where limited community pharmacy places may be available and travel access and costs to clients may be prohibitive. In regional and rural areas, it is recommended that public hospital dosing be actively engaged to compensate for the relative paucity of dosing community pharmacies (see Recommendations 2.1 and 2.2).

### **Recommendation 8.1 – GP prescribing**

Public clinics should increase the direct involvement of GP prescribers in the management of clients dosed and stabilised at a public clinic. Consideration could be given to offering GPs the opportunity to prescribe to their opioid dependent clients within the public clinic. Further information regarding GP management of opioid dependent clients will be found in the *Patient Journey Kits* (SWAT, 2007a).

### **Recommendation 8.2 – GP prescribers working to clinic policies**

Where a GP prescriber requests that a public clinic provide dosing and/or case management to a client, it is advisable that there is a formally negotiated agreement between the clinic and the GP. This may include a written agreement that the GP will comply with the policies of the clinic. Most importantly, GPs should agree to the principle of transferring stable clients to community pharmacies, and should work closely with clinic staff in identifying stable clients. Please refer to Appendix E for sample letter/agreement.

### **Recommendation 8.3 – GP primary care provision**

Clinics should aim to have all clients on the books of a named GP for primary care provision within six months of commencing treatment. It is recommended that clinics ask all clients if they have a GP and if they do not, they should be strongly encouraged to obtain one for their primary health care needs. Primary care is not a service routinely delivered within the public clinic system.

Where clients do not have a GP but have indicated they would like one, clinics should assist the client in obtaining a regular GP.

### **Recommendation 9**

It is recommended that a benchmark be set to standardise the ratio of clients to staff in public clinics across NSW. The ratio should be the minimum required to coordinate care and support movement to pharmacy. The figure may vary depending on the complexity of the client group, which should be comprised of a combination of stable and unstable clients. SWAT recommends that this ratio be 30 clients (case managed) per FTE clinic staff (not including administration staff and medical officers). Please refer to Appendix D for an example of benchmarking.

### **Recommendation 10**

To assist clinics in estimating required opening hours for dose administration, it is suggested that benchmarks be established across NSW in regard to time allocated for dosing clients. SWAT recommends these benchmarks are:

Methadone: Two minutes per client. This is consistent with existing NSW Health guidelines (NSW Department of Health, 2000). This should include a compliance check such as initiating a conversation with clients after they have taken their doses to ensure that they have been swallowed.

Buprenorphine: Five to 10 minutes per client. If more than one client is dosed at one time, 10 to 20 clients may be dosed per hour. Variations in dosing benchmarks for buprenorphine are necessary because of differences between clinics in the size of the dosing area, supervised administration practices, and the way buprenorphine is prepared (e.g., whole tablets, broken into pieces, crushed).

### **Recommendation 11.1**

It is recommended that benchmark times be established across NSW for medical services offered in public clinics. The SWAT recommended benchmark is for every 30 clients managed by the clinic, a four-hour medical session should be available each week. For example, a clinic that manages 240 clients will require eight four-hour medical sessions per week.

### **Recommendation 11.2**

A clear definition is needed as to what is required of a medical officer during a clinical review of a client. Please refer to Appendix G for an example of benchmarking medical sessions.

### **Recommendation 11.3**

In each four-hour medical session, between eight and 10 clients should be reviewed by the medical officer.

- A standard review: between 20 and 30 minutes;
- New clients: one hour (no more than one new client per four-hour medical session in most cases); and
- New Justice Health transfers: between 30 minutes and one hour (depending on the quality of information accompanying the client).

Please refer to Appendix G.

### **Recommendation 12.1**

Consideration should be given to benchmarking the maximum time between client presentation and commencement of assessment, prescribing, or dosing. Currently, this may not be practical because of the lack of spaces in treatment programs across NSW and an absence of consistent data collection, but in time could be a useful indicator of service capacity.

### **Recommendation 12.2**

NSW Health may consider, in discussion with NUMs, monitoring the inability of services to provide timely treatment to people requesting it. Access to treatment may be separated into assessment, prescribing, and commencement of dosing. Standard data collection should be recorded on a monthly basis with other statistics providing each AHS with information on how many treatment-seeking people they were unable to commence on treatment each month. Data to be collected may include age, gender, reason for inability to provide treatment (e.g., assessment, prescriber, case manager, or dosing place), whether other treatment providers had been approached, and whether the client was in a priority or non-priority group.

### **Recommendation 12.3**

That a standardised response be developed by each AHS for when a public clinic is not able to offer an opioid treatment place to a person requesting treatment. This would include a courteous expression of regret, written and/or verbal; a risk assessment; information provision about private clinics, other prescribers, and local drug and alcohol services including harm reduction services, non-government organisations (NGOs), and Alcohol and Drug Information Service (ADIS); encouragement to return to the clinic after a period of time; or referral to counselling services.

#### **Recommendation 12.4**

It is recommended that all clients have a copy of their care plans (signed by client with a copy in the notes) within one month of commencing treatment with at least an annual review.

#### **Recommendation 13**

That a benchmark be established at each clinic for prescriber reviews to occur for every client at a minimum of every three months. One way of ensuring this occurs is for the prescriber to provide prescriptions for no longer than three-month duration. Clients who are demonstrably unstable should be reviewed more frequently.

#### **Recommendation 14.1**

It is essential that community pharmacies are reassured that public clinics will take back clients who become unstable at a community pharmacy. Public clinics should monitor the proportion and number of transferred clients that remain without incident at community pharmacies. Please also refer to the *NSW Community Pharmacy Practice Survey* (SWAT, 2007b).

#### **Recommendation 14.2**

AHS should consider providing financial inducements to community pharmacies either to commence dosing or reduce costs to clients. This may facilitate transfer of clients to community pharmacies and for some public clinics may be economically attractive since community pharmacy dosing costs are considerably lower than dosing at a public clinic (NSW Department of Health, 2005a). Resource and financial implications of developing such a relationship could be explored by the NSW Pharmacy Guild and NSW Health.

#### **Recommendation 14.3**

NSW Health should consider subsidising community pharmacy dispensing fees for clients on opioid treatment. For example, in the Australian Capital Territory (ACT) clients pay 50% of the dispensing fee (\$15 per week). Another approach could be that dispensing fees for supervised doses of opioid pharmacotherapies are included on the Pharmaceutical Benefits Scheme (PBS) so clients can work towards the safety net threshold beyond which the receipt of their medication would be free.

#### **Recommendation 15**

That NSW Health recommend to AHS Directors of Drug and Alcohol that public clinics routinely utilise the *Stability Assessment Flowchart* (Appendix C) for the assessment of client stability and suitability for transfer to community pharmacy dosing.

### **Recommendation 16.1**

NSW Health could provide a training module for all NSW universities offering pharmacy degrees covering all aspects of drug and alcohol relevant to pharmacy practice.

### **Recommendation 16.2**

In order to provide pharmacists-in-training with a better understanding of their important role in the delivery of OTP in NSW, it is recommended that, in collaboration with the NSW Branch of the Pharmacy Guild, the Pharmaceutical Society of Australia (PSA), and relevant universities, all public clinics actively provide access to placements for pharmacy students.

### **Recommendation 17**

Public clinics should consistently and routinely follow up clients transferred to a GP prescriber to provide ongoing support to both. This would maintain a relationship between the clinic and prescriber and provide an opportunity for the early detection of problems experienced by the client or prescriber. In some areas, providing ongoing, on-site case management support for GPs has been found to be an effective strategy to support GP prescribers. Clinics should contact each GP prescriber at a minimum of twice a year and offer to review the client if required.

### **Recommendation 18.1**

It is important that public clinics establish and maintain regular contact with their local Divisions of General Practice. This will facilitate the engagement of local GPs in the care of opioid dependent clients. Both NUMs and staff specialists should be responsible for developing such relationships. In addition, NSW Health should explore opportunities to support these relationships by working closely with the NSW Alliance of Divisions of General Practice.

### **Recommendation 18.2**

Public clinics and their clinical directors should offer clinical placements to interested GPs. This is a way of enhancing the skills of GPs and of engaging more GPs in opioid treatment. It can be undertaken in conjunction with NSW Health (such as when funds are available to support GPs to do this).

### **Recommendation 18.3**

In order to encourage more GPs to engage in the care of opioid dependent clients, the contact details of newly accredited GP prescribers should be provided to their local public clinics so that the NUMs and staff specialists may develop a supportive working relationship. The responsibility for this rests with the Course Coordinator of the Pharmacotherapies Prescriber Accreditation

Course, which is managed by the Coppleson Committee in Continuing Medical Education at the University of Sydney.

# Opioid Treatment Program Public Clinic Survey

## 1. Introduction

Between April and September 2006, the State-Wide Advisory Team (SWAT): Drug Health Streamed Shared Care undertook a survey of all public clinics participating in the New South Wales (NSW) Opioid Treatment Program (OTP). Outcomes of the survey are detailed in this report. The report has also been informed by local consultations with Area Health Service (AHS) Directors of Drug and Alcohol, public OTP clinic Nursing Unit Managers (NUMs), clinical staff, NSW Divisions of General Practice, and the Pharmacy Guild of Australia (NSW Branch).

In this report the terms 'patient' and 'client' are used interchangeably. The term 'patient' is typically used when referring to a relationship with a medical practitioner. The term 'client' is used when referring to a relationship with a case manager, other health care provider, or treatment service.

NSW Health considers private prescribers to include both general practitioner (GP) prescribers working in a primary care setting as well as any other prescriber working in a non-public setting. In this report, GP prescribing will be used only to describe those prescribers in primary care settings while private prescribers will refer exclusively to any prescriber (including GPs) who works in any private setting (e.g., private clinic).

### ***1.1 Context of the survey***

It was recognised at the 1999 NSW Drug Summit that the demand for pharmacotherapy places in NSW was greater than the supply and that the number of public clinic treatment places available for new clients was severely restricted by the absence of movement of stable clients through these clinics to community pharmacy dosing (NSW Government, 1999). Underscoring the importance of timely commencement of treatment, recent research has shown rapid access to pharmacotherapy treatment to be associated with better retention in treatment than access delayed through a waiting list (Schwartz et al., 2006; Schwartz et al., 2007). It is further recognised that retention in treatment is an indicator of better outcomes for clients (Bell, Burrell, Indig, & Gilmour, 2006).

As a result, in the *NSW Drug Treatment Services Plan 2000-2005* (NSW Health Department, 2000), it was proposed that the public opioid treatment sector should provide specialist services with

specific and limited aims that were, in part, to:

- “provide an access point to methadone maintenance treatment;
- initiate and stabilise patients for a limited period of time, of no less than 3 months and no more than 12 months;
- provide continuing services to difficult or complex patients who are unsuitable for community dosing.” (p.37)

To complement this strategy, it was proposed that the ongoing provision of treatment of stable clients should be managed in the community, and public clinics should also:

- “refer stable patients to general practitioners and community pharmacists and co-ordinate the transition of patients across the sectors.” (p.37)

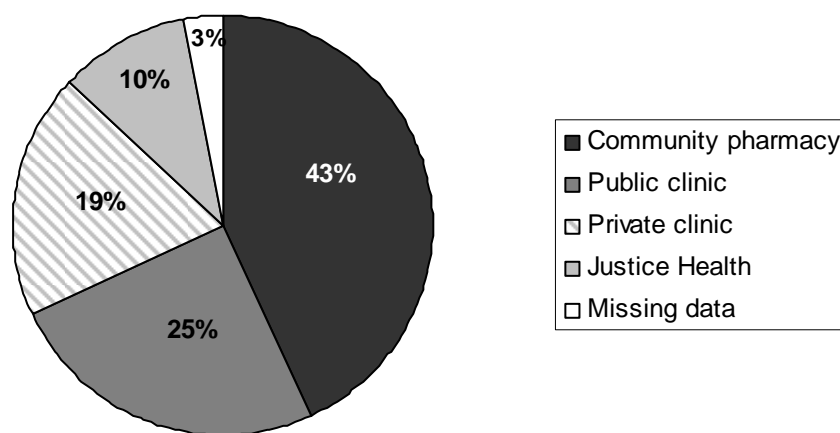
The practical implementation of these policy guidelines has been limited, in part, by a shortage of GPs and wide variations in clinic populations, resources, and the proximity of alternative dosing sites. It was also noted at that time that there was a need to recruit more GPs and community pharmacies into the care of clients on opioid treatment. These aims and strategies remain current in the recently released *NSW Health Drug and Alcohol Plan 2006-2010* (NSW Department of Health, 2007).

## ***1.2 Current opioid treatment provision in NSW***

In 2005, approximately 39,000 people across Australia were registered on opioid treatment programs (AIHW, 2006). Of those, more than 16,000 were registered on opioid treatment in NSW, with 84% on methadone treatment and 16% on buprenorphine treatment (NSW Health, unpublished data, December, 2006). Opioid treatment medications in NSW are provided through public clinics, community pharmacies, private clinics, and correctional facilities (Justice Health). Public clinics dose approximately 25% of those in treatment, community pharmacies dose approximately 43% of those in treatment, and a small number of private clinics dose approximately 19% of those in treatment. Ten percent of clients are in correctional facilities and 3% refers to missing data (NSW Health, unpublished data, December, 2006; see Figure 1). The provision of supervised dosing at public clinics in NSW is delivered in conjunction with case management provided at no cost to clients and the majority of public clinics do not provide takeaway doses for either methadone or buprenorphine.



Seven years on from the 1999 Drug Summit it was unclear to what extent different clinics were addressing the needs of local drug users and getting new-to-treatment persons stabilised in treatment. Clinics were also faced with the challenge of meeting the additional requirements of NSW Health directives such as providing immediate access to prison releases and priority access to people being released from correctional institutions to the community and ensuring priority access to specific groups: pregnant women and their opioid-using partners; people with HIV and their opioid-using partners; hepatitis B carriers and their opioid-using partners; and people on a diversion program from the criminal justice system (NSW Department of Health, 2005b, 2006a).



(Source: NSW Health, 2006)

**Figure 1.** Clients in opioid treatment in NSW by dosing site

Compounding the limitations of finite treatment capacity at public clinics has been the relative lack of community based prescribers and dosing sites. There has therefore been a persistent need to increase the capacity of community treatment services (GP prescribers and dosing community pharmacies). Clients who have been stabilised at a public clinic may then have their treatment transferred to a community pharmacy and subsequently gain access to a GP prescriber.

It is important to note that community pharmacy dosing alone does not open up new treatment places within public clinics. Both case manager and prescriber access may also be limiting factors in the capacity to provide care. Additional barriers to community pharmacy transfer have been the relative diffusion of responsibility between public clinics, clients and prescribers to facilitate and motivate such transfers and the ability for either individual clinics or NSW Health to monitor such throughput.

### ***1.3 State-Wide Advisory Team (SWAT): Drug Health Streamed Shared Care***

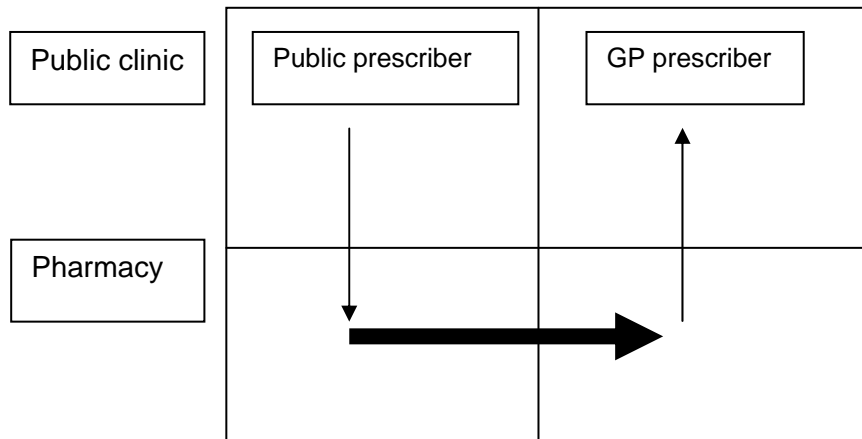
In 2005, the State-Wide Advisory Team (SWAT): Drug Health Streamed Shared Care was established by NSW Health and Drug Health Services, Sydney South West Area Health Service for the purpose of mapping, consulting and supporting opioid pharmacotherapy services across NSW. Initial consultations revealed wide variations in culture and priorities at public OTP clinics across NSW and wide variations in staffing levels, resources, and operational practices between clinics. In many areas, public clinics were full and there appeared to be an under-utilisation of available community pharmacy capacity (there were between 2,500 and 4,000 vacancies across NSW) (*Pharmacy Capacity Survey*, SWAT, 2006). It was clear that there was a need to identify the range of work practices, clinical referral pathways and supporting policies currently in use in public clinics across NSW, as well as to investigate possible ways of increasing consistency across services. The development of appropriate benchmarks for staffing, capacity and service delivery was considered by SWAT to be a useful way of approaching the issue of improving consistency. The practice of benchmarking, as a way of setting standards, requires first the identification of key items which are to be benchmarked, and second, the development of specific targets to be reached. Resourcing and implementation strategies may then be developed. Based on the findings of this survey, SWAT has made recommendations regarding which items are suitable for benchmarking, and what those benchmarks could be. Further discussions involving key stakeholders are needed to reach agreement and to implement these benchmarks.

### ***1.4 Streamed Shared Care***

Streamed Shared Care (SSC) is the cornerstone of the SWAT project. It builds on other medical models of shared care that recognise that both disease severity and professional expertise exist on a spectrum. SSC aims to match clients to practitioners based upon client complexity, practitioner experience and resource availability. The model aims to increase the capacity of existing specialist public clinics to take on new clients in addition to the nominated priority groups (see Section 1.2). This will largely be dependent upon increasing the willingness, ability and capacity of community based service providers (GPs and community pharmacies) to accept and manage stable clients on methadone or buprenorphine.

The foundation of SSC is a common understanding by all service providers and clients of the criteria (that of client stability) for transfer from a public clinic, initially to a community pharmacy and then to a GP prescriber. It also clarifies the benefits for all involved in supporting

the streaming of clients to different providers depending on client complexity, stability, and access to other providers. SSC thus defines the typical transfer pathway of a client commencing treatment on OTP in NSW as *“induction and stabilisation at a public clinic followed by transfer to a community pharmacy once assessed as stable and subsequently, once a period of persistent and effective community dosing has been demonstrated, transfer to a GP for ongoing prescribing”* (see Figure 2).



**Figure 2.** Referral pathways – public clinic, community pharmacy, and GP prescriber

SSC accepts that GPs are not a homogenous group with respect to their interest, skills and experience in managing this patient group. However, there are many stable patients who could effectively be managed by GP prescribers with some additional training and ongoing support from specialist services. Unfortunately, at present across NSW there are a number of AHS that do not have their full complement of drug and alcohol specialists and thus at times there may be limited access to high quality local support for GPs.

Although SSC emphasises the importance of attaining clarity between the roles of specialist and generalist community providers, it also recognises the importance of engaging consumers in accepting that this process is both clinically beneficial and equitable given the limited resources available. For many clients, especially those who have received free treatment at a public clinic for many years, the transfer to community dosing may be seen as punitive since it will incur a cost and clients may also feel that a GP would be unwilling or unable to provide the appropriate level of care they require. Part of the SSC model therefore specifically includes a process that can be adopted by staff to increase clients’ understanding of both the resource limitations on public clinics, but, more importantly, the enormous benefits in having their care transferred away from a public clinic to a community pharmacy and eventually having all their medical health care needs provided by a single medical practitioner. We know from previous research that 80% of

those within the public clinic system would prefer to be dosed at a community pharmacy (Madden, Lea, Bath, & Winstock, in press).

In order to maximise both the engagement and service provision by community pharmacies and GPs to opioid dependent clients, SSC provides a framework within which care providers can work with clients to best utilise existing Medicare items and Home Medicines Reviews (HMR) to ensure optimal treatment access for the patient and optimal financial remuneration for participating health care professionals (see *Patient Journey Kits*, available online at [http://www.health.nsw.gov.au/resources/drugandalcohol/patientjourneykit1\\_pdf.asp](http://www.health.nsw.gov.au/resources/drugandalcohol/patientjourneykit1_pdf.asp) and [http://www.health.nsw.gov.au/resources/drugandalcohol/PatientJourneyKit2\\_pdf.asp](http://www.health.nsw.gov.au/resources/drugandalcohol/PatientJourneyKit2_pdf.asp), SWAT, 2007a).

## 2. Method

### *2.1 Clinic sample*

Available lists of all public OTP clinics in NSW were obtained from the NSW Department of Health Mental Health and Drug & Alcohol Office (MHDAO) and the NSW Opioid Treatment Program Managers Group (“NUMs Network”). In addition, in some cases, some AHS Directors of Drug and Alcohol were asked to follow up in areas where initial response rates were poor.

The SWAT team defined a ‘public clinic’ as a publicly funded and staffed specialist outpatient treatment service which provides on-site access to a prescriber and supervised dosing. Medication provision is delivered as part of structured treatment which is determined through comprehensive assessment and the delivery and review of a ‘care plan’. Public clinics are typically supported by at least some access to specialist staff, medical and psychosocial supports through referral or on-site provision. Public clinics are typically located on the grounds of a public hospital or community health centre. Where there was uncertainty as to whether a dosing site was classified as a public clinic or not between the different lists provided, direct discussions were undertaken with clinical representatives of that service to determine its suitability for inclusion in the survey.

Note: Some AHS currently structure their service provision in ways that make the SWAT definition of public clinics less applicable. For example, in some areas such as Greater Southern Area Health Service (GSAHS) there are a number of fixed public dosing sites staffed by public specialist staff that variously provide case management or prescribing but not both. In Sydney West Area Health Service (SWAHS), dosing, case management and prescribing are not always co-located, with the Centre of Addiction Medicine taking on a central treatment role for many of its public dosing sites.

### *2.2 Measures and procedures*

After extensive consultation with public clinic representatives, prescribers, and drug user organisations, a self-complete survey was developed to be completed by NUMs of 37 publicly funded and managed OTP clinics across NSW. The questionnaire was designed specifically to identify variations in clinical practice between public clinics with the intention of providing clinically meaningful findings to NSW Health as well as public clinics and their AHS. The questionnaire was piloted at four clinics and consent was obtained from the Directors of Drug and Alcohol at each AHS before distributing the questionnaire. Questionnaires were distributed

to clinics via post, email, and fax, between April and September 2006. Non-responding clinics were contacted on two additional occasions to ensure a high response rate. This project was supported by the “NUMs Network” and its chair, Carol Stublely.

Please refer to Appendix A for a copy of the questionnaire. The questionnaire content included:

- location and description of the clinic;
- hours of operation: opening and dosing hours;
- range of services provided;
- dispensing practices including the provision of takeaways and associated costs;
- clinic capacity and determinants;
- prescribers, medical sessions, frequency of prescriber review;
- clinic-managed population breakdown (by prescriber, dosing site, and pharmacotherapy type);
- case management activity and provision;
- relationships with local GPs and pharmacies; and
- stability assessment tools and transfer policies.

### ***2.3 Statistical analysis***

All data were analysed using descriptive statistics. Tests of statistical significance were not conducted to compare the responses of clinics due to the small population size and lack of statistical power. All statistical analyses were performed with SPSS 14.0 for Windows.

### 3. Results and recommendations

#### 3.1 Response rate

Responses were received from 37 public clinics across NSW. The Kirketon Road Centre was excluded from the definition of a public clinic because its core business is the provision of primary care services to many vulnerable groups including sex workers, homeless people, and drug users. The provision of opioid treatment is one of a number of services it provides to a range of different target populations, many of whose lives are unstable. It was considered by SWAT to be atypical as a clinic. Sutherland and Kogarah clinics were also excluded as they were in a process of transition from private to public clinic at the time of the survey. Thus, the total number of clinics eligible to participate in the survey was 35. A 100% response rate was achieved and responses were received from all 35 clinics.

#### 3.2 Clinic descriptors

##### 3.2.1 Number of public clinics in each AHS

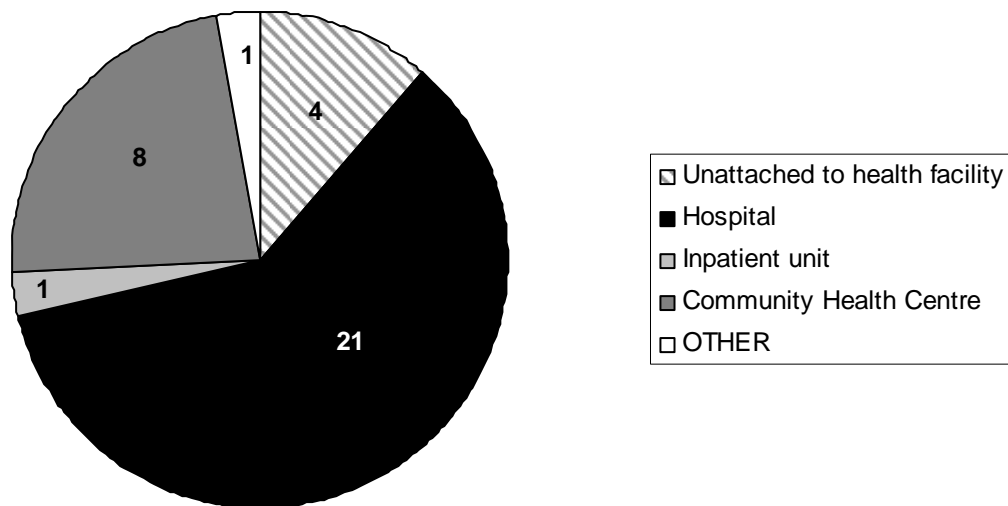
Table 1 displays the number of public clinics in each AHS and the number of clinics that participated in the survey. For a full list of public clinics, their contact details, and their corresponding AHS, please refer to Appendix B.

**Table 1.** Public clinics in each AHS and clinics that participated in the survey

AHS	Total clinics	Participating clinics
Greater Southern Area Health Service (GSAHS)	1	1
Greater Western Area Health Service (GWAHS)	4	4
Hunter/New England Area Health Service (HNEAHS)	4	4
North Coast Area Health Service (NCAHS)	7	7
Northern Sydney/Central Coast Area Health Service (NSCCAHS)	4	4
South Eastern Sydney/Illawarra Area Health Service (SESIAHS)	6	4
Sydney South West Area Health Service (SSWAHS)	5	5
Sydney West Area Health Service (SWAHS)	6	6

##### 3.2.2 Location and description of facilities

The majority of public clinics were located on the premises of a public hospital, with a smaller number of clinics co-located within a community health centre, inpatient unit, or unattached to a health facility (see Figure 3). The single clinic that responded “Other” refers to an OTP service in Hunter/New England Area Health Service (HNEAHS) provided across a variety of locations including a public clinic located within a public hospital.



**Figure 3.** Location of public clinics in NSW

### **Recommendation 1.1**

A clear definition is required as to what is meant by the term ‘public clinic’.

### **Recommendation 1.2**

There should be a uniform database of public clinics across NSW agreed by both NSW Health and the Directors of Drug and Alcohol in each AHS.

### **Rationale and suggested approaches to achieving this:**

Currently there is an inconsistent approach to the way that public clinics are defined. This has implications for future benchmarking and resourcing initiatives.

According to NSW Health Policy Directive PD2006\_052: *Dosing Facilities in Public Hospitals for Patients on Opioid Treatments* there are four categories of dosing sites in NSW (NSW Department of Health, 2006b). These are:

- “1. Public, specialised drug treatment service, often within or on the grounds of public hospitals or community health centres.
2. Private, specialised drug treatment services.
3. Community pharmacies that are authorised to dose.
4. Other locations within public hospitals without special-purpose drug treatment services, for example the use of hospital pharmacies or other appropriate facilities to dose a medium number of patients.”



SWAT recommends that the following definition of ‘public clinic’ be adopted:

“A publicly funded and staffed specialist outpatient treatment service which provides on-site access to a prescriber, case management, and supervised dosing. Medication provision is delivered as part of structured treatment which is determined through comprehensive assessment and the delivery and review of a ‘care plan’. Public clinics are typically supported by access to specialist medical and psychosocial supports through referral or on-site provision. Public clinics are typically located on the premises of a public hospital or community health centre”.

The majority of people on opioid treatment in NSW are dosed at sites other than public clinics. SWAT suggests that the defining characteristic of these dosing sites (other than private clinics) is that they provide supervised dosing in the absence of on-site structured treatment provision. Every public dosing site is connected to and supported by a public clinic. Ongoing client assessment and review, including the provision of other health and psychosocial interventions, delivered as part of a comprehensive care plan, will usually be provided by staff working within the public clinic to which the dosing site is attached. These sites may be located in a public hospital, pharmacy, an accident and emergency department, an outpatients department, a community health centre or other public health service site. There is greater variation in the location of public dosing sites in rural than in metropolitan areas.

### **Recommendation 2.1**

That local specialist drug and alcohol services proactively engage public hospitals (especially small rural facilities) to permit a reasonable provision of access to opioid treatment at every public hospital in NSW. In addition to the requirements of NSW Health Policy Directive PD2006\_052: *Dosing Facilities in Public Hospitals for Patients on Opioid Treatments* (NSW Department of Health, 2006b), every public hospital in NSW, in consultation with their local specialist services, should be required to make advanced provision for dosing a pre-determined number of clients. Options such as funding additional hospital pharmacists and nursing staff (whether specialist or generalist) to support on-site dose administration should be considered and supported by NSW Health. Such staff may administer opioid treatment but also engage in other activities at the hospital.

### **Rationale and suggested approaches to achieving this:**

Engaging public hospitals to provide opioid treatment dosing will in some areas compensate for the limited access to community dosing sites. Utilisation of these places by stable clients may go some way to challenging the concerns voiced by some staff and general hospital services. In

short, it is better that services start to engage hospital sites for routine dosing of clients than approach them at a time of crisis.

In 2006, NSW Health released a policy directive directing all public hospitals to provide on-site supervised dosing facilities for a limited number of clients on opioid treatment where other dosing sites were unavailable (NSW Department of Health, 2006b). The implementation of this directive was not without challenges.

Many public hospitals in rural areas are staffed by health care professionals with little or no experience dealing with people in opioid treatment. It is likely that many of the staff working in these hospitals will have significant misunderstandings and preconceptions as to both the value of treatment and the ability of this client group to behave in what they would regard as a socially acceptable manner. In addition, it is likely that staffing and other resource limitations (such as access to hospital pharmacy time) will result in a reluctance to facilitate dosing even for small numbers on initial approach from local specialist services. At present, in many areas, the utilisation of public hospitals is considered as a last resort for clients who have not been maintained effectively at a community pharmacy. As a result the group of clients who may conform most strongly to the preconceptions of some staff regarding drug users is the group who end up being dosed in such settings. In addition, since public hospitals are often approached at a time of crisis, there is additional stress placed upon the relationship between specialist services and hospitals.

### **Recommendation 2.2**

SWAT recommends that NSW Health facilitate specialist services, especially in rural areas, in the effective recruitment of local public hospitals to dose clients in opioid treatment.

#### **Rationale and suggested approaches to achieving this:**

This may include the development of a marketing approach comprising a presentation to local public hospital clinical staff, management, and hospital pharmacy representatives. Directors of Drug and Alcohol should be consulted in the development and implementation of this recommendation. The processes of policy implementation should be monitored and evaluated, particularly in relation to numbers dosed at each site, aggressive incidents, and staff attitudes.

One suggestion to ensure equity between public hospitals of different sizes is the development and use of a formula that identifies a realistic number of clients for a hospital to dose. Such a

formula could be based, e.g., on bed and staff numbers. See Figure 4 for an example of a formula developed in Greater Western Area Health Service (GWAHS).

The number of beds in the Unit, divided by the number of staff (Registered Nurses & Enrolled Nurses on duty that can be delegated as dosing staff) multiplied by upper management on duty to address critical incidences.

e.g. A Unit of 20 beds, divided by the number of staff on duty (4) with 2 managers on duty (Health Services Manager and Nurse Manager) i.e.  $20 \div 4 = 5 \dots \times 2 = 10$

This means this small facility may dose a MAXIMUM of 10 clients.

20% of this allocated number MUST be utilised for incoming temporary transfers.

In this case 20% of 10:

$20 \div 100 = 0.2 \dots \times 10$  (client places) = 2

This facility may permanently dose 8 clients and hold 2 positions vacant for temporary transfers.

These figures may be varied according to work load and nursing competencies but must not exceed the set number calculated above. This enables the Health Services Manager to decline additional numbers so their core business is not compromised and supports OTP to become "part of" core hospital business.

Source: Wendy Pierpoint, GWAHS

**Figure 4.** Example formula used to calculate number of OTP dosing places at public hospitals

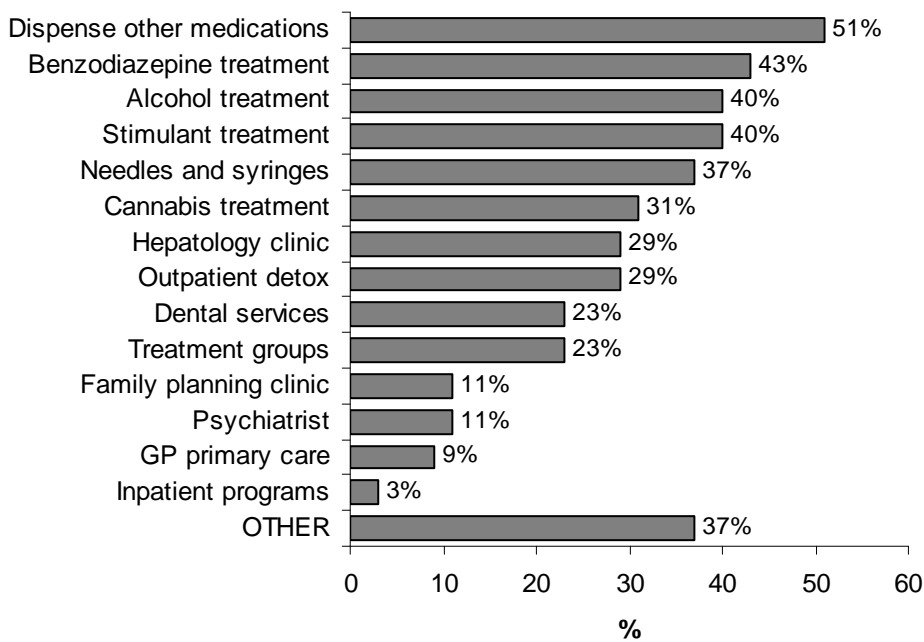
### 3.2.3 Private clinics

Forty percent of clinics (n=14) reported that there were private OTP clinics in their local areas. The median number of private clinics located near each public clinic was one (range: 1-4). No private clinics were identified in GSAHS, GWAHS, HNEAHS, and North Coast Area Health Service (NCAHS). That is to say, all private clinics are located in the Sydney metropolitan area, with the exception of one clinic which is in a regional area (Wollongong). No rural areas have private clinics.

Clinics were provided with an open-response question to share information about their relationship with private clinics in their areas. Of the 14 with private clinics locally, there was evidence of varying levels of co-operation in the support of local client populations. Five clinics reported that they refer clients to a private clinic when the public clinic is full or if the clients are not high priority, four clinics reported that the private clinic used the public clinic for financial respite for some clients, three clinics reported that they had a good relationship with local private clinics, three clinics transferred some unstable clients to private clinics, and two clinics had unstable clients transferred from private clinics to the public clinic. Two public clinics reported minimal contact with local private clinics.

### 3.2.4 Range of on-site services provided

In addition to the provision of opioid pharmacotherapy treatment, clinics were asked to provide information regarding other services provided to clients directly from the clinic. Results are presented in Figure 5. The dispensing of other medications, provision of needles and syringes, and treatment for other classes of drugs were the additional services provided most commonly by clinics. Thirty-seven percent of clinics (n=13) reported providing other services in addition to those specified in the questionnaire. These other services were child and family services (20%, n=7), sexual health services (11%, n=4), a diabetes education service (n=1) and a blood collection service with a visiting phlebotomist (n=1).



**Figure 5.** Proportion of public clinics providing on-site services other than opioid dispensing

#### **Recommendation 3: Additional on-site services**

While services provided by clinics in addition to opioid treatment vary widely across the state, SWAT recommends that all public clinics should provide, in addition to care planning, as a minimum, on-site specialist services in mental health, dental health, and hepatology. Additional funding may be required to support implementation of this.

#### **Rationale and suggested approaches to achieving this:**

##### **Mental health**

The two main initiatives that would enhance the provision of mental health services for clients in opioid treatment would be first, to provide an on-site mental health Clinical Nurse Consultant (CNC) or psychiatrist to provide direct psychiatric interventions, and clinical support for staff

within the clinic (such as clinical supervision). The second initiative is the supervised administration of psychotropic medication. There is a high prevalence of psychiatric disorders among those in opioid treatment (Darke, Ross, & Teesson, 2007; Darke, Swift, & Hall, 1994; Ross et al., 2005; Verthein, Degkwitz, Haasen, & Krausz, 2005). As in the general community, depression and anxiety are the most common co-morbid conditions and will often require the prescribing of psychotropic medication. Compliance with anti-depressants is generally poor in depressed populations and even worse in those with substance use problems (Cameron & Ritter, 2007). Non-compliance is associated with poorer treatment outcomes. The earlier non-compliance can be identified, the earlier interventions to re-engage and monitor clients at risk can be implemented. Although it is recognised that the provision of supervised medication may impact upon the core clinical activity of public OTP clinics and may encroach upon community mental health services, the co-ordinated delivery of medication prescribed by mental health services and administered by the public clinic is likely to result in better client outcomes. In addition, such an arrangement may foster closer working relationships between public clinics and mental health services and will permit early identification of destabilisation in a client's mental health that can be conveyed to the appropriate mental health service. If supervised administration of psychotropic medications was adopted, administration of opioid treatment medications should not be contingent on client compliance with the psychotropic medication. Not all clients prescribed psychotropic medication would require supervised administration. It is acknowledged that should clinics routinely provide psychotropic medications, the required dosing hours for a given number of clients would need to be revised.

### **Dental health**

On-site dental health care may mean on-site screening, with treatment delivered at a site with suitable equipment. Access to basic preventative dental care following dose administration should be available, such as the provision of sugar-free gum, sugar-free lemon drops, and salivary stimulant (e.g., SST<sup>TM</sup> – sugar-free, citric acid, malic acid in a sorbitol base). For buprenorphine clients, this should not be provided until the entire dose has been absorbed. All clients should be encouraged to rinse their mouths out with water following dosing. Such an approach may also help to reduce dose diversion.

Unmet dental health care needs are a significant problem for clients in opioid treatment (Sheridan, Carson, & Aggleton, 2003; Titsas & Ferguson, 2002; Winstock, Lea, & Sheridan, 2008). Dental services could include an on-site dentist or dental hygienist for screening and referral, and a dental educator. Where the waiting list for public dental services is excessive and

clients do not have the resources to afford dental fees, AHS should negotiate with local private dentists to provide access to dental care at a bulk-billed rate funded by the AHS. Additional funding may need to be considered by NSW Health to support this recommendation. In addition, public clinics should contact a client's GP to assess his/her eligibility for referral by the GP for specialist dental treatment. In November 2007, a number of new Medicare item numbers were created to allow GPs to refer clients for a wider range of dental treatments.

### **Hepatology services**

The prevalence of hepatitis C infection among injecting drug users (IDU) in Australia is estimated to be approximately 60% and has ranged from 50-70% since the 1970s (Law et al., 2003; National Centre in HIV Epidemiology and Clinical Research, 2006). Despite this, nationally only one-third of drug and alcohol services provide on-site screening for hepatitis B and hepatitis C, and vaccination for hepatitis B (Winstock, Anderson, & Sheridan, 2006). All clinicians should encourage their clients to consider treatment and should facilitate referral where necessary to specialist services. Given that the uptake of hepatitis C treatment by IDU is very low (National Centre in HIV Epidemiology and Clinical Research, 2006), it is suggested that routine screening, vaccination for hepatitis B, and access to government subsidised \$100 hepatitis C treatment is provided onsite through liaison with specialist services.

Where mental health, dental health and hepatology services cannot be provided onsite (such as where physical space is limited), it is essential that the clinic staff actively support the client to access these services. While this is not intended to disempower clients or diminish their responsibility for their own welfare, it is clear that there are times when additional support is needed by some clients actually to attend appointments. This additional support may include ensuring the client has suitable travel arrangements, or may include accompanying the client to an appointment. Such decisions will always rest on the clinical judgement of the NUM or prescriber.

### **3.2.5 Staffing**

Ninety-four percent of clinics (n=33) had a full-time NUM responsible for the management of the clinic. Two clinics (6%) reported that they did not have a NUM.

The mean number of nurses and case managers at each clinic was 4.0 full-time equivalent (FTE) (SD=2.7, range: 1.0-10.8). One-quarter of clinics (24%, n=8) had no administration staff. The mean number of administration staff was 0.8 FTE (SD=0.2, range: 0-2.5). Forty-five percent of clinics (n=17) reported that they had other staff members, which included psychologists, social

workers, dental workers, in-reach workers, a drugs in pregnancy co-ordinator, a child and family nurse, and pharmacists. The mean number of other staff members was 0.9 FTE (SD=1.9, range: 0-7.8). Two clinics did not provide information about staffing other than the NUM.

#### **Recommendation 4.1**

All public clinics should have a fully-funded, full-time equivalent, permanent NUM position. In smaller clinics, a part-time NUM may be more appropriate.

#### **Rationale and suggested approaches to achieving this:**

A full-time NUM would help ensure adequate clinical support, direct service delivery and the co-ordinated implementation of changes in either NSW guidelines or locally determined clinical practice. This position also supports a consistent management approach with respect to governance within the public clinic system.

#### **Recommendation 4.2**

All public clinics should have at least one fully-funded, full-time or part-time, permanent administration position.

#### **Rationale and suggested approaches to achieving this:**

Administrative support allows clinicians to spend more time with clients.

### **3.2.6 Medical officers**

Ninety-four percent of clinics (n=33) reported that they had on-site medical officers. The AHS that had clinics without on-site medical officers were GWAHS and SWAHS. In GWAHS, there was a shortage of medical officers at the time of the survey. This situation has now changed. In SWAHS, medical officers were available at a site other than the clinics.

The majority of clinics (54%, n=19) had staff specialists (all AHS except GSAHS and GWAHS)<sup>1</sup>, 49% (n=17) had career medical officers (all AHS except GSAHS and NCAHS), 43% (n=15) had visiting medical officers (all AHS except GSAHS and GWAHS), and 17% (n=6) had sessional GPs (GWAHS, NCAHS, Sydney South West Area Health Service (SSWAHS)). Responses to questions regarding medical officers were inconsistently provided, and only a brief summary of responses is presented here. For information about the number of medical sessions offered at clinics please refer to Section 3.4.4.

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<sup>1</sup> Please note that recent move of two staff specialists to GWAHS in April 2007 will now have resulted in a change to the reported results.

### 3.2.7 Number of clients managed by public clinics

Clinics provide three main services to clients: prescribing, dosing, and case management (care planning). These services are provided to a range of clients in a variety of combinations. For the purpose of this analysis, if a clinic provides two or more of these three services to a client, the client is considered to be ‘managed’ by the public clinic. This includes three groups of clients, those who:

- 1) are prescribed their opioid treatment by a prescriber at the public clinic, are dosed at the public clinic and receive case management (care planning) from the public clinic; or
- 2) are prescribed their opioid treatment by a prescriber at the public clinic, dosed at a community pharmacy, and receive case management (care planning) from the public clinic; or
- 3) are prescribed their opioid treatment by a GP prescriber, dosed at the public clinic, and receive case management (care planning) from the public clinic.

By contrast, a client who is prescribed their opioid treatment by a GP prescriber and who is dosed at a community pharmacy is considered to be a fully privately managed client, with the GP as the case manager/care planner. The degree of shared care support provided to GPs by public clinics will vary across these groups (see Table 2).

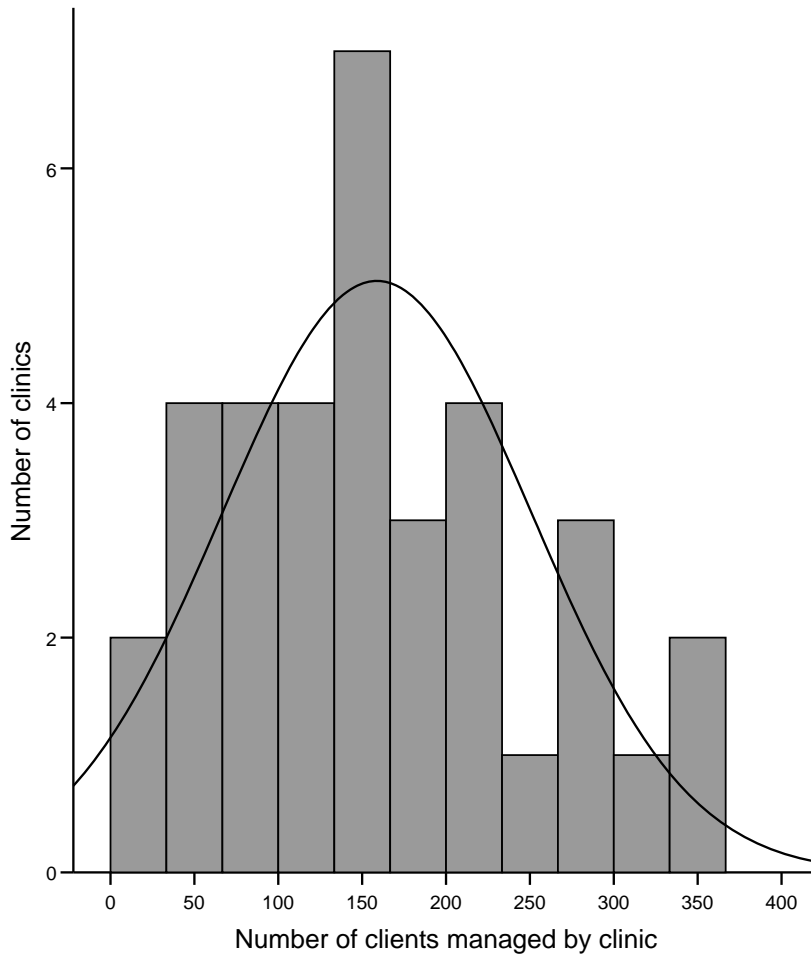
**Table 2.** Clients considered to be ‘managed’ by a public clinic

Dosing site	Public prescriber and public clinic case manager	Private prescriber not providing case management	Private prescriber providing case management
Public clinic	✓	✓	×
Community pharmacy	✓	×	×

✓= managed by a public clinic

The total number of clients managed by each clinic is depicted in Figure 6. The mean number of clients dosed at each clinic was 158.8 (SD=92.3, range: 18-364).





**Figure 6.** Total number of clients managed at public clinics

### 3.2.8 Public clinic capacity

Sixty percent of public clinics (n=21) indicated that they have a defined maximum capacity for the number of clients the clinic can manage (or dose), although four of these clinics did not provide a specific figure. Thus, 17 clinics provided information regarding the maximum number of clients they can manage. The mean maximum capacity was 183.6 clients (SD=98.6, range: 20-345). A more detailed classification of clinics according to their defined maximum capacity is displayed in Table 3.

**Table 3.** Clinics classified according to their defined maximum client capacity

Maximum client capacity	Number of clinics <sup>a</sup>	AHS
Less than 100	3	GWAHS, HNEAHS, SESIAHS
100-200	8	GWAHS, NCAHS, NSCCAHS, SESIAHS, SSWAHS, SWAHS
200-300	4	HNEAHS, NSCCAHS, SSWAHS, SWAHS
More than 300	2	SEZIAHS

<sup>a</sup> 18 clinics did not provide information about their defined maximum capacity

Note: less than half the clinics responded to this question. Using other data provided the largest clinics as assessed by the current number of clients they reported managing were Blacktown, Riverlands, Rankin Court, Jacaranda House, and Newcastle (see Figure 6). In terms of number of clients actually dosed, the top five were Blacktown, Langton Centre, Rankin Court, Fleet Street and Riverlands.

### 3.2.9 Opening and dosing hours

#### 3.2.9.1 Weekday hours

All clinics were open on weekdays. The majority of clinics (66%, n=23) opened at 8am or later. The latest opening time was 9:30am. The remaining 34% (n=12) opened prior to 8am. The earliest opening time was 6:30am. The majority of clinics (63%, n=22) were closed by 5pm. Twenty-nine percent (n=10) closed before 1pm. The earliest closing time was 10am. Three clinics (9%) closed after 5pm. The latest closing time was 8pm. Of note, one clinic was an inpatient facility which by nature is open 24 hours a day. The pharmacotherapy dosing facility at this site was open for operation between the hours of 8am and 8pm.

Weekday dosing times for methadone and buprenorphine categorised according to the number of hours clinics are open for dosing are presented in Table 4. Five clinics had separate dosing times for methadone and buprenorphine. Four clinics had separate dosing areas for methadone and buprenorphine. Separate dosing times for methadone and buprenorphine do not necessarily indicate that there were separate dosing areas for each pharmacotherapy.

**Table 4.** Weekday methadone and buprenorphine dosing hours

Dosing hours per day	Proportion of clinics			
	Methadone (n=34)		Buprenorphine (n=35)	
	n	%	n	%
Less than 2	3	9	7	20
2-4	19	56	19	54
4-6	8	24	5	14
6-8	2	6	2	6
More than 8	2	6	2	6

#### 3.2.9.2 Weekend hours

One clinic was closed all weekend and one was only open on Saturday. These clinics were located in HNEAHS and NCAHS. The majority of clinics had shorter opening hours on weekends (69%, n=24). On weekends, the majority of clinics opened at or after 8am (71%, n=25). The

latest opening time was 10:30am. The remainder opened prior to 8am (29%, n=10) and the earliest opening time was 6:30am. Eighty percent of clinics (n=28) closed before 1pm on weekends. The earliest closing time was 10am. The remaining 20% (n=7) closed at or after 1pm. The latest closing time was 8pm. Weekend dosing times for methadone and buprenorphine according to the number of dosing hours are presented in Table 5.

**Table 5.** Weekend methadone and buprenorphine dosing hours

Dosing hours per day	Proportion of clinics			
	Methadone (n=34)		Buprenorphine (n=35)	
	n	%	n	%
Less than 2	7	21	10	29
2-4	17	52	17	50
4-6	8	24	6	18
6-8	1	3	-	-
More than 8	-	-	1	3

Opening and dosing hours are clearly limited by staffing resources. Available evidence suggests that existing opening hours within the public clinic system are not favourably received by those in treatment. In a 2005 study of 448 clients in opioid treatment at nine public clinics in NSW, clients expressed dissatisfaction with clinic dosing hours, identifying them as one of the worst things about public clinics and the thing they would most like to change about treatment at the clinic (Madden et al., in press). Public clinics that have the capacity to alter their dosing hours should consider undertaking a consultation process with their clients to assess whether earlier or later dosing hours would better service client needs.

It is of note that the majority of public clinics have opening hours that would not support the requirements of clients engaged in full-time employment or education. This may act as a disincentive for some clients to enter treatment, and a barrier to pursuing education or employment among those already in treatment. However, excluding geographical restrictions, those people who are in full-time employment are generally stable and financially independent enough to be dosed at a community pharmacy. Public clinic dosing for clients in full-time employment is not optimal in terms of potential restrictions on their ability to engage in non-treatment activities due to daily clinic attendance and restricted dosing hours. It is also not optimal for public clinics whose free services should be reserved for those clients who are less stable.

### ***3.3 Pharmacotherapy provision***

#### **3.3.1 Dispensed pharmacotherapies**

All clinics except one provided methadone. Regarding available methadone preparations, 74% (n=25) provided Methadone Syrup<sup>®</sup>, 50% (n=17) provided Biodone Forte<sup>®</sup>, and 24% (n=8) provided both preparations of methadone. All clinics provided buprenorphine (Subutex<sup>®</sup>). Buprenorphine-naloxone (Suboxone<sup>®</sup>) was not provided at any of the clinics at the time the survey was conducted.

#### **Recommendation 5**

Consideration should be given to the impact of providing buprenorphine-naloxone from public clinics with the objective of encouraging the transfer of stable clients from public clinics to community pharmacies. Since buprenorphine-naloxone is the preparation of buprenorphine recommended for clients identified as stable enough to be in receipt of regular unsupervised doses, and clients as stable as this would generally be managed at a community pharmacy, it seems that the regular provision of buprenorphine-naloxone from public clinics should not be encouraged. Exceptions may be made for rural areas and for clients returning to a public clinic due to destabilisation. In addition, where high levels of supervision are available (such as at a public clinic) there is no reason to provide unnecessary medication (naloxone) to clients.

#### **Rationale and suggested approaches to achieving this:**

The move to increase the flowthrough of clients from public clinics to community pharmacies would be supported by recommending that clients on buprenorphine are only considered suitable for buprenorphine-naloxone after a period of stable community dosing. This approach would be entirely in keeping with the recommendation made below that methadone takeaways should not routinely be provided from public clinics, since access to takeaways makes it more difficult to motivate clients to transfer to a pharmacy. The receipt of unsupervised doses is a major incentive for pharmacy transfer.

#### **3.3.2 Methadone takeaway provision and charges**

Forty-one percent (n=14) of clinics providing methadone indicated that they provided takeaway methadone doses. Of these clinics, 60% (n=8) provided takeaways free of charge. The remaining six clinics charged \$5 per takeaway dose. A division of these clinics according to the AHS they reside in is presented in Table 6. As can be seen in the table, there is inconsistency between clinics within some AHS regarding policies for takeaway provision and takeaway fees. This may be due to issues regarding previous AHS boundaries and recent amalgamations.

**Table 6.** Number of clinics in each AHS providing takeaway methadone doses

AHS	Total clinics	Clinics providing takeaways		Clinics providing free takeaways	
		n	%	n	%
GSAHS	1	-	-	-	-
GWAHS	4	3	75	2	50
HNEAHS	4	-	-	-	-
NCAHS	7	6	86	2	29
NSCCAHS	4	2	50	2	50
SESIAHS	4	-	-	-	-
SSWAHS	5	-	-	-	-
SWAHS	6	3	50	2	33

**Recommendation 6.1**

It is recommended that public clinics do not routinely provide takeaway doses of methadone, buprenorphine, or buprenorphine-naloxone. Where geographical distances or absence of community pharmacy dosing places make daily attendance difficult to the extent that it threatens retention in treatment, it may be acceptable to provide the minimum number of takeaway doses necessary to maintain the client in treatment.

**Recommendation 6.2**

Where methadone takeaways are provided, these should not be provided free of charge. Consideration may be given to means of payment that do not involve cash handling or increased risk to staff.

**Recommendation 6.3**

An annual methadone takeaway audit should be conducted that includes an assessment of the documentation within the notes that supports the suitability for takeaway methadone doses in those clients receiving two or more unsupervised doses per week. The *Stability Assessment Flowchart* may assist in this documentation (see Appendix C). All clients in receipt of any takeaways must be informed of appropriate safe methadone takeaway storage practice.

**Rationale and suggested approaches to achieving this:**

Where possible, the provision of methadone takeaways by public clinics is best limited to situations where there is a lack of available community pharmacy dosing places, when geographical distances from clients' homes makes daily attendance for supervised dosing impractical, or when a client has a disability that makes daily attendance for dosing difficult. This is particularly relevant in rural and remote areas. Any changes to takeaway practice should occur

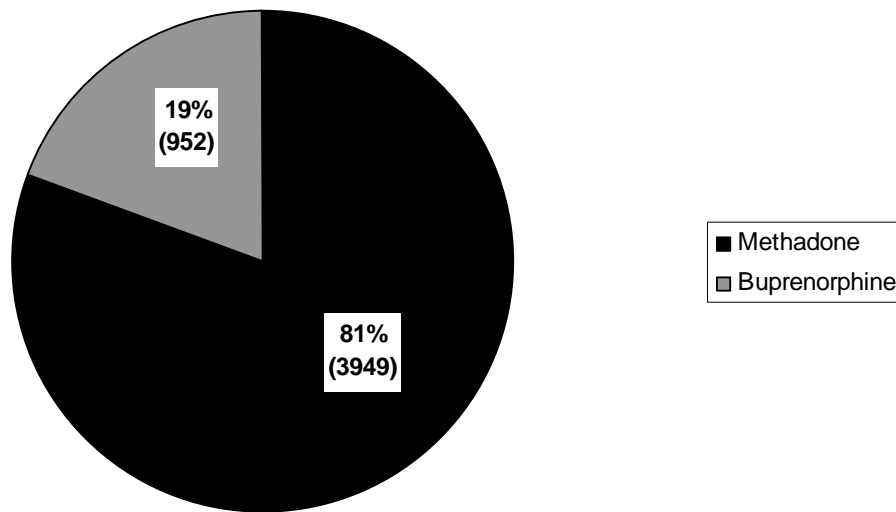
only after client consultation and should be implemented gradually over a period of several months. Consistency, although difficult to achieve in some large AHS, would assist in achieving equity of service delivery.

The provision of takeaway methadone doses is one of the major incentives for clients to transfer treatment to a community pharmacy (Treloar, Fraser, & valentine, 2007; Madden et al., in press). This incentive needs to be balanced by the financial disincentive that transfer to a pharmacy incurs. It is likely that clients will be most resistant to pharmacy transfer when a public clinic provides takeaways, particularly if provided free of charge. Takeaways provide clients with increased flexibility by removing the requirement for daily attendance at the dosing site. Clients have reported that the provision of methadone takeaways has many benefits including increased convenience and flexibility, less travel time and associated costs, and fewer restrictions on employment (Treloar et al., 2007). The provision of methadone takeaways has been associated with improved treatment outcomes (Pani & Pirastu, 2000; Pani, Pirastu, Ricci, & Gessa, 1996; Rhoades, Creson, Elk, Schmitz, & Grabowski, 1998).

Services may also consider the potential additional benefits to the public clinic of ceasing takeaway provision, such as reduced requirements for hospital pharmacists and other resources in preparing takeaway doses, and the reduced potential for takeaway diversion near the public clinic.

### **3.3.3 Proportion of methadone and buprenorphine clients managed at public clinics**

In June 2006, 84% of clients on opioid treatment in NSW were on methadone, across all dosing sites (NSW Health, unpublished data, December, 2006). In the current survey, 81% of clients managed by public clinics were on methadone treatment (Figure 7).



**Figure 7.** Total clients managed at public clinics according to pharmacotherapy type

There was wide variation between AHS in the proportion of public clinic managed clients on methadone or buprenorphine. GWAHS and SWAHS had the lowest proportion of clients on buprenorphine (13% and 14% respectively) while GSAHS had more than twice that proportion of clients on buprenorphine (32%). Results for each AHS are presented in Figure 8.

Please refer to footnote below for explanation of data collection anomalies for Sections 3.3.3-3.3.5<sup>2</sup>.

<sup>2</sup> For data provided in Sections 3.3.3-3.3.5 (relating to Figures 7-12), the total client numbers are not consistent between each section for each AHS. This is also the case for aggregate NSW data for total client numbers between each section. The total number of clients represented is 4,901 in Section 3.3.3, 5,348 in Section 3.3.4, and 3,891 in Section 3.3.5. Despite relating to core treatment data, 17 clinics provided data that was not internally consistent. The problem in data provision for these questions is likely due to the absence of a consistent data collection and monitoring process in NSW. Although we do not believe that the variations in the data provided undermines the validity of the main findings from this section of the report, future monitoring will be better serviced using a consistent NSW dataset.

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■ Methadone ■ Buprenorphine

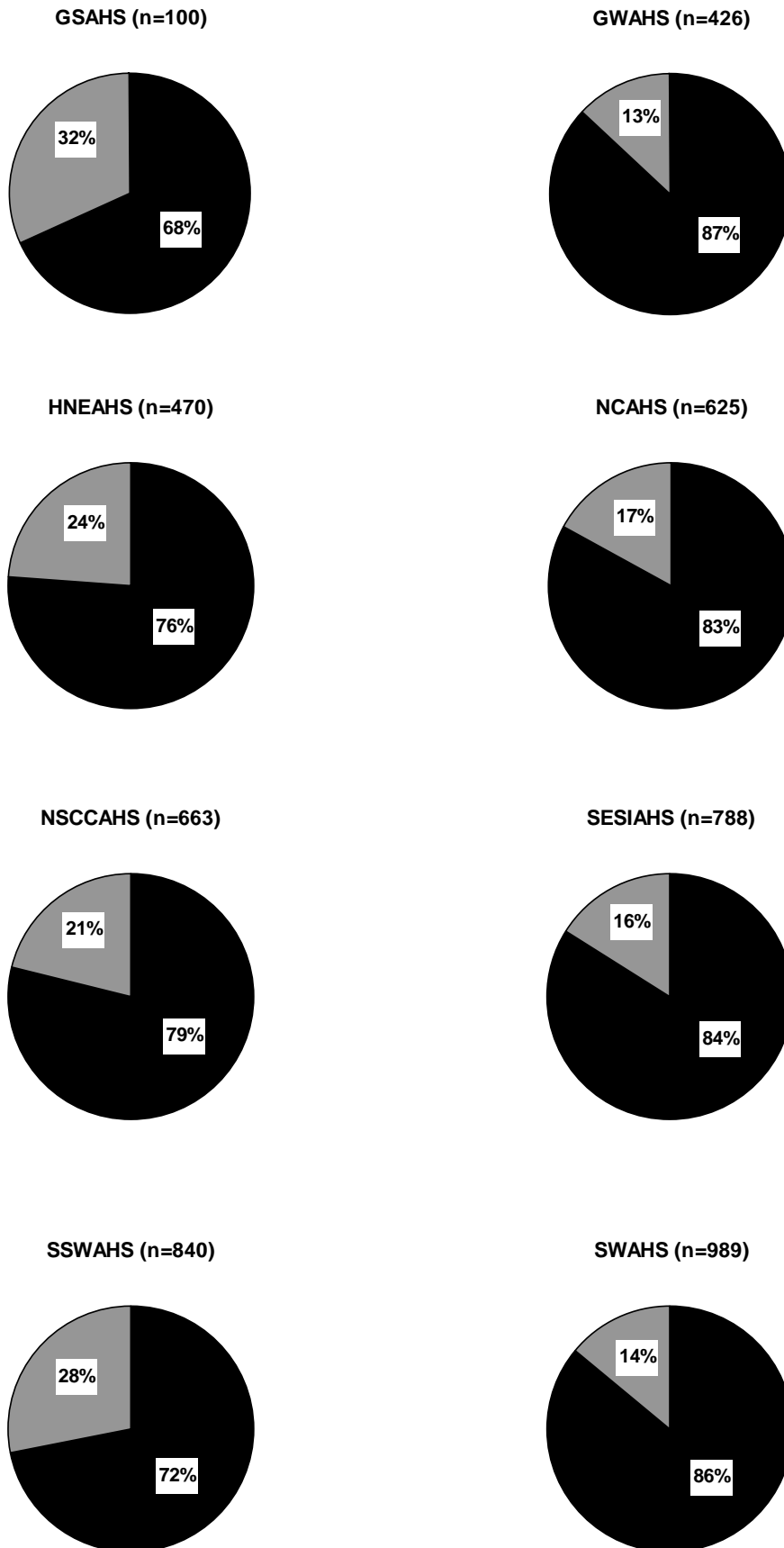
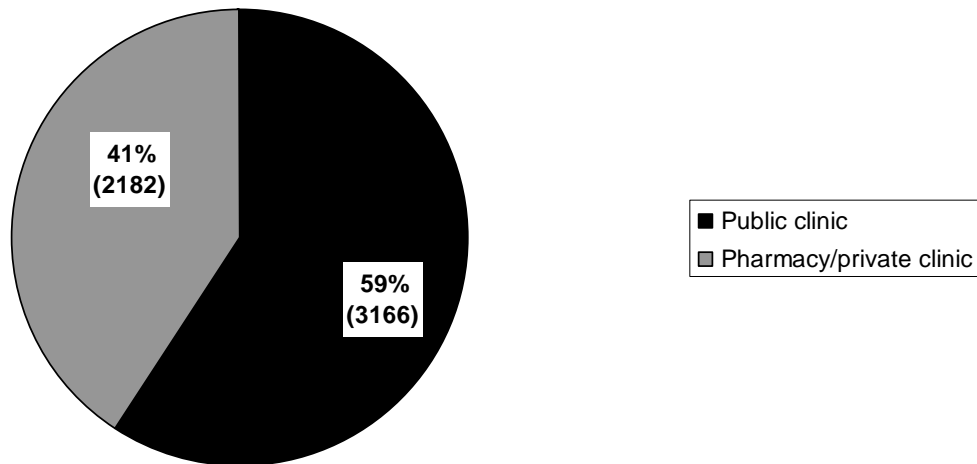


Figure 8. AHS breakdown of total clients managed at public clinics according to pharmacotherapy type



### 3.3.4 Where are public clinic managed clients dosed?

Among public clinic managed clients (for definition, see 3.2.7 *Number of clients managed by public clinics*) in the current survey, the majority received their dose at the public clinic (59%) while the remainder were dosed at a community pharmacy or private clinic (41%, see Figure 9).

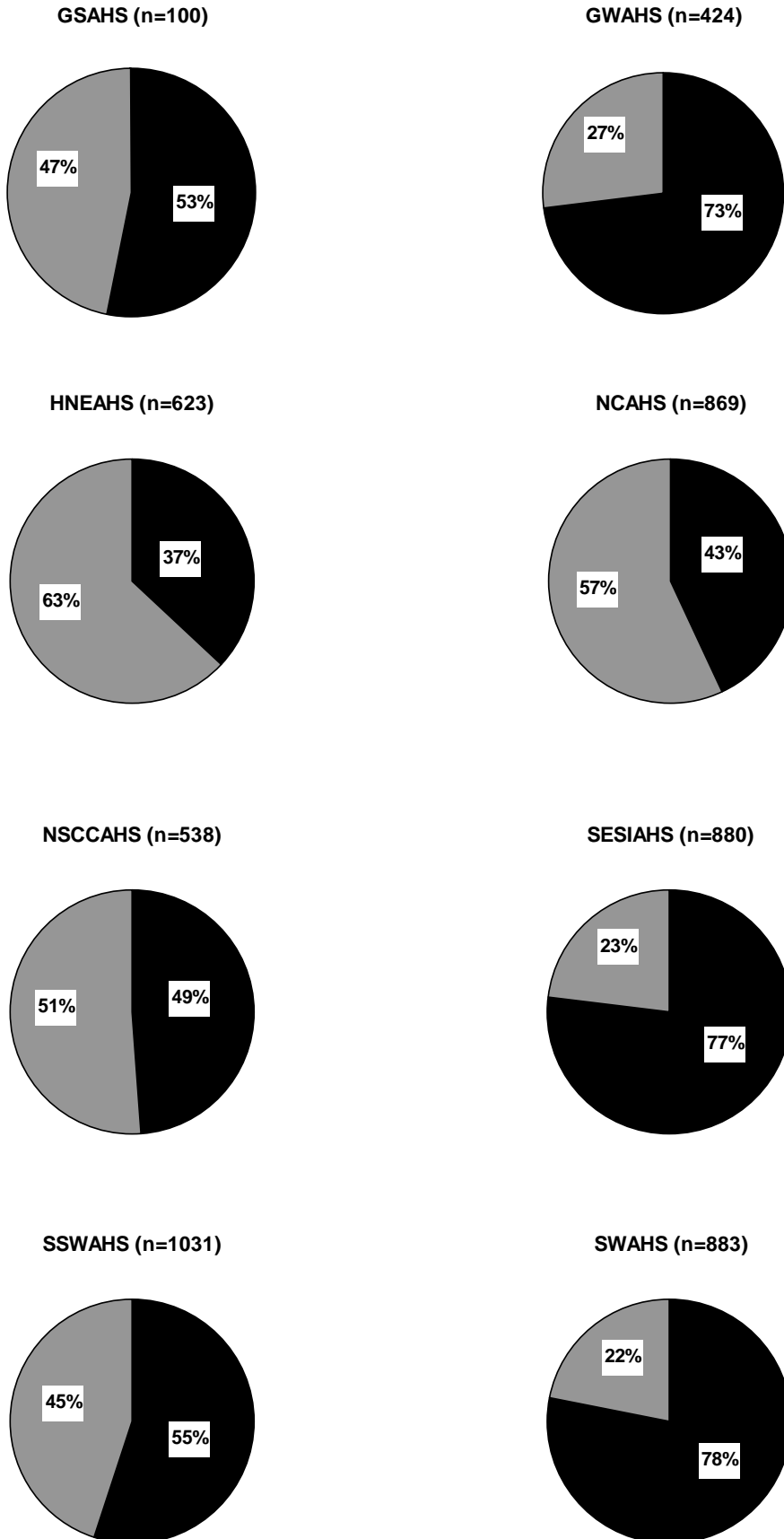


**Figure 9.** Proportion of public clinic managed clients dosed at a public clinic or community pharmacy/private clinic

The analysis of dosing sites for public clinic managed clients according to AHS revealed wide variation between AHS in the proportion of clients receiving their doses at a public clinic or a community pharmacy/private clinic. While SWAHS, South East Sydney/Illawarra Area Health Service (SESIAHS), and GWAHS have less than 30% of their public clinic managed clients receiving their doses at a community pharmacy or private clinic, HNEAHS, NCAHS, and Northern Sydney/Central Coast Area Health Service (NSCCAHS) have more than 50% of their public clinic managed clients dosed at a community pharmacy or private clinic. Results for each AHS are presented in Figure 10.

State-Wide Advisory Team (SWAT)

■ Public clinic ■ Community pharmacy/Private clinic



**Figure 10.** AHS breakdown of the proportion of public clinic managed clients dosed at a public clinic or community pharmacy/private clinic

### **Recommendation 7.1**

NSW Health should consider providing a benchmark for the flowthrough of clients in public clinics.

#### **Rationale and suggested approaches to achieving this:**

At present, neither local data monitoring processes nor centrally collected data permit client turnover to be accurately assessed. Therefore, it is suggested that there are two possible measures for monitoring client turnover at public clinics using either locally or centrally collected data.

#### **1) Minimum percent movement of clients to community pharmacy per month (locally collected data)**

Turnover or flow through at a public clinic can be expressed as the proportion of the total number of clients at that clinic at the start of the month who have transferred out to pharmacy by the end of the month (i.e.,  $\% \text{ turnover} = \text{number of clients transferred to pharmacy during a one month period} \div \text{total number clients dosed at the clinic at the start of the month}$ ). At present, routine data collection in most AHS does not permit this monitoring of percentage turnover each month.

Please refer to Appendix D for an example of benchmarking.

#### **2) Cross-sectional composition of clinic population by time in treatment (centrally collected data)**

If clinics act as induction and stabilisation facilities there would be an expectation that the composition of the clinic would reflect a turnover of clients and, as such, only a minority of clients will have been in treatment at the clinic for more than two years. Available Pharmaceutical Services Branch (PSB) data currently enables clinics to have their client populations described as having different proportions in treatment for different time periods. Assuming most clients will be transferred to community dosing after stabilisation (typically after at least three months in treatment), and that the majority of clients will eventually be able to be transferred to community dosing, we have suggested that the cross-sectional composition of clinics should be approximately as follows:

- 20% in treatment at the clinic for less than three months;
- 20% in treatment at the clinic for three to six months;
- 20% in treatment at the clinic for six to 12 months;
- 25 % in treatment at the clinic for 12 months to two years; and

- 15% in treatment at the clinic for more than two years.

In practice, this recommendation may be found to be unrealistic given the variation in size, resources, and treatment demand between clinics. A more acceptable approach may be for each clinic to set its own flowthrough benchmark.

### **Recommendation 7.2**

SWAT recommends that public clinics aim to have the majority of their managed clients dosed at a community pharmacy.

- For metropolitan areas, it is recommended that for public clinic managed clients, one-third be dosed at the clinic and two-thirds at non-public clinic dosing sites.
- For regional and rural areas, it is recommended that 50% of public clinic managed clients be dosed at the clinic and 50% at non-public clinic dosing sites.

In determining these benchmarks, consideration must be given to the particular circumstances affecting individual clinics in regional and rural areas where limited community pharmacy places may be available and travel access and costs to clients may be prohibitive. In regional and rural areas, it is recommended that public hospital dosing be actively engaged to compensate for the relative paucity of dosing community pharmacies (see Recommendations 2.1 and 2.2).

### **Rationale and suggested approaches to achieving this:**

Many public clinics have very restricted capacity to take on new-to-treatment clients. This is because the majority of vacancies are taken by priority groups (see Section 1.2). Consequently, there is a need to increase the flowthrough of stable clients to community pharmacy dosing so that more space can be made to induct and stabilise new-to-treatment clients in the optimal setting of a clinic. It is important to note that community pharmacy dosing alone does not open up new treatment places. Both case manager and prescriber access may also be limiting factors in the capacity to provide care. For many clinics, there is a culture among clients and staff that is not conducive to the routine transfer of clients from public clinic to community dosing. In some cases, legitimate resourcing issues and limited pharmacy availability are in part responsible.

### **3.3.5 Who prescribes to public clinic managed clients?**

In June 2006, excluding prescribers working solely in the Justice Health system (less than 10), there were 662 prescribers registered to prescribe opioid pharmacotherapies in NSW (Pharmaceutical Services Branch, unpublished data, December, 2006). Of those prescribers, only

414 actually had clients at that time. This suggests that there were over 200 registered prescribers outside the gaol system who could have taken on clients.

Prescribers provide PSB with a range of information, some of which is mandatory and some of which is optional. One of the optional fields is whether they are a generalist or specialist (drug and alcohol, psychiatrist, or other). Of those 414 prescribers, approximately 208<sup>3</sup> can be identified as general practitioners<sup>4</sup>. Four 'dual' sector prescribers should be added to this, making the total 212. After removing all public prescribers and all specialists from the count, a further 44 prescribers remain unallocated to a specialty and have not been included in these calculations.

This number, 212, is a remarkably small number of GPs across NSW, and it is clear that an increase in GP involvement would enhance both the capacity of the public system, and client access to primary care.

#### **Calculation of proportion of GP prescribers in total GP workforce:**

The Commonwealth Department of Health and Ageing provides a range of statistics on the GP workforce (headcount, full workload equivalent (FWE), FTE). The first two datasets are suitable for these calculations.

If the number of GPs in NSW in 2005-2006 is taken by headcount, it is 8,062.

If the number of GPs in NSW in 2005-2006 is taken by full workload equivalent, it is 6,310.

GP prescribers per GP headcount:

$$212 \div 8,062 \times 100 = 2.63\%$$

GP prescribers per GP FWE

$$212 \div 6,310 \times 100 = 3.36\%$$

According to NSW Health, in June 2006 the majority of clients in opioid treatment in NSW had a private prescriber (59%) (NSW Health, unpublished data, December, 2006). For the remainder, 28% had a public clinic prescriber, 10% had a Justice Health prescriber, and 3% had a dual sector

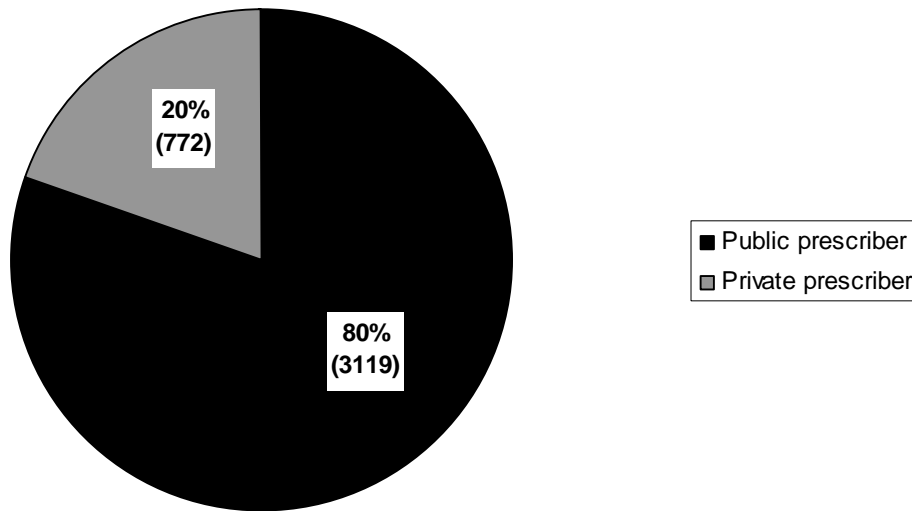
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<sup>3</sup> Full private prescribers with patients.

<sup>4</sup> This is through either self identification or identification by SWAT. Not all prescribers complete the category of 'specialty' on the PSB form; consequently, there are some gaps in the data, limiting the accuracy of these approximations.

prescriber<sup>5</sup>. Inaccuracies are likely to exist more frequently among smaller categories. For example, at the time of writing there were only four dual prescribers in NSW which is less than 3%.

Many clinics expressed difficulty in determining with accuracy the number of publicly prescribed and privately prescribed clients at their clinics. The following data relates to 29 clinics only as six clinics did not provide information regarding the proportion of clients with a public or private prescriber. This represents data omitted for approximately 1,200 clients. For the remaining data, 80% of clients managed at a public clinic had a public clinic prescriber while 20% had a private prescriber either at a private clinic or a GP (see Figure 11).



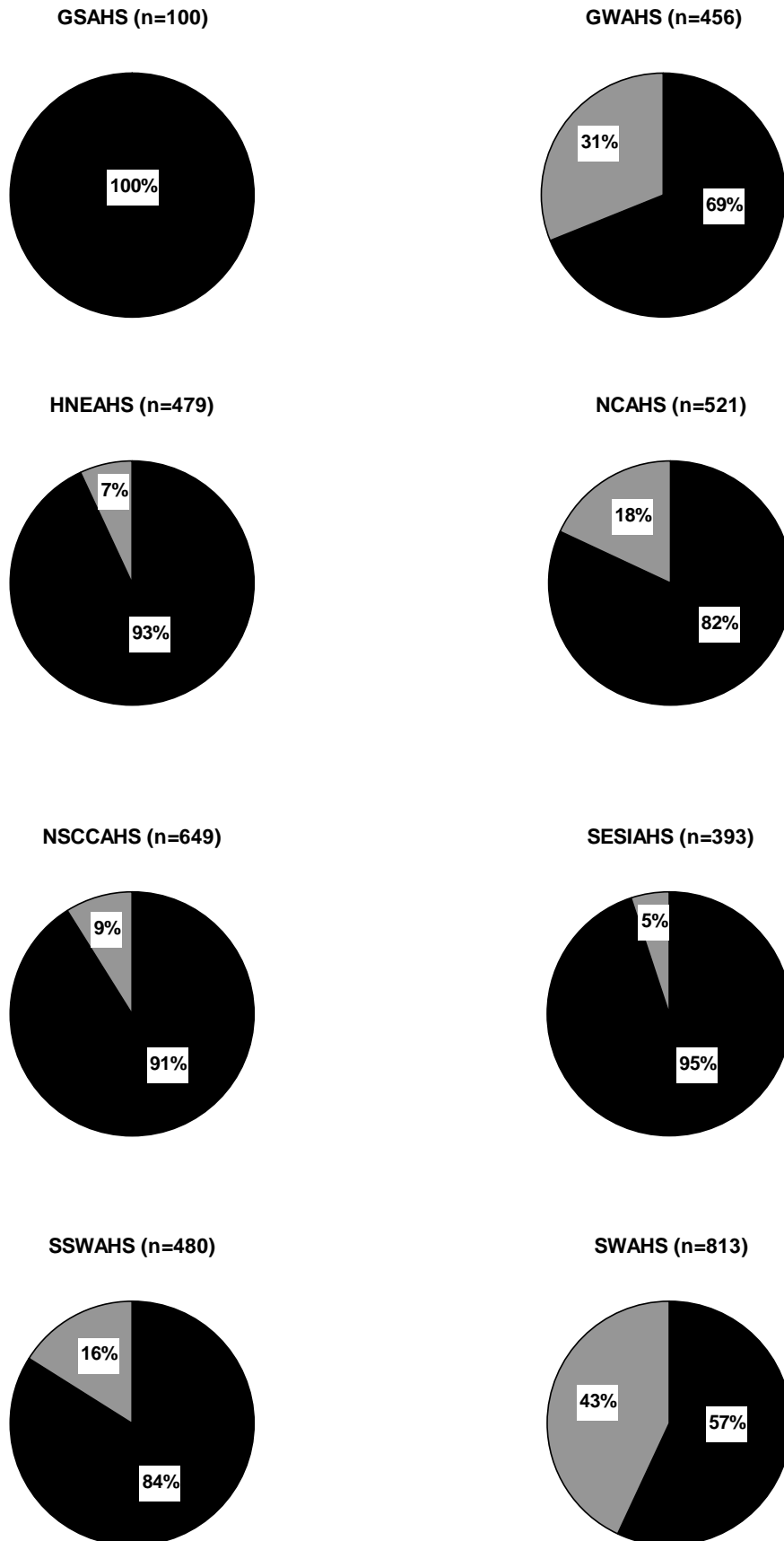
**Figure 11.** Proportion of public clinic managed clients with a public clinic prescriber or private prescriber

There was wide variation between AHS in the proportion of public clinic managed clients with a public or private prescriber. While 100% of clients managed by public clinics in GSAHS were reported to have a public clinic prescriber, in SWAHS, almost half of public clinic managed clients had a private prescriber (43%). Results for each AHS are presented in Figure 12.

<sup>5</sup> 'Dual sector' indicates an authority as both a public and a private prescriber.

State-Wide Advisory Team (SWAT)

■ Public prescriber ■ Private prescriber



**Figure 12.** AHS breakdown of the proportion of public clinic managed clients with a public clinic prescriber or private prescriber

### **Recommendation 8.1 – GP prescribing**

Public clinics should increase the direct involvement of GP prescribers in the management of clients dosed and stabilised at a public clinic. Consideration could be given to offering GPs the opportunity to prescribe to their opioid dependent clients within the public clinic. Further information regarding GP management of opioid dependent clients will be found in the *Patient Journey Kits* (SWAT, 2007a) (see below for strategies for recruiting more GPs).

### **Recommendation 8.2 – GP prescribers working to clinic policies**

Where a GP prescriber requests that a public clinic provide dosing and/or case management to a client, it is advisable that there is a formally negotiated agreement between the clinic and the GP. This may include a written agreement that the GP will comply with the policies of the clinic. Most importantly, GPs should agree to the principle of transferring stable clients to community pharmacies, and should work closely with clinic staff in identifying stable clients. Please refer to Appendix E for sample letter/agreement.

### **Recommendation 8.3 – GP primary care provision**

Clinics should aim to have all clients on the books of a named GP for primary care provision within six months of commencing treatment. It is recommended that clinics ask all clients if they have a GP and if they do not, they should be strongly encouraged to obtain one for their primary health care needs. Primary care is not a service routinely delivered within the public clinic system. Where clients do not have a GP but have indicated they would like one, clinics should assist the client in obtaining a regular GP.

### **Rationale and suggested approaches to achieving this:**

Given the high level of primary health care needs among clients in opioid treatment and the difficulty in some areas in accessing primary health care services (Donnermeyer, Barclay, & Jobes, 2002; Friedmann, Alexander, Jin, & D'Aunno, 1999; Treloar et al., 2004), a priority for public clinics must be to enhance client access to GPs. This is particularly important given the new GP Mental Health Care Medicare item numbers released in November 2006, which are only available through a client's regular GP. These item numbers allow GPs to refer clients to psychologists and other allied health services.

Public clinics may underestimate the proportion of clients who have a GP for primary care. A recent audit of almost 500 public clinic clients in SSWAHS indicated that more than two-thirds had a regular GP and in most cases these clients were happy to consider their GPs becoming their prescribers (SSWAHS, unpublished data, 2006). It is suggested that all public clinics



determine what proportion of clients have a regular GP, and whether these clients would consider their GPs becoming their prescribers. Please see Appendix F for a copy of the *SWAT GP Public Clinic Audit Form*.

**Strategies for recruiting more GPs include:**

**1) Bring the GP into the clinic**

Some GPs have suggested that they would be more likely to work with drug and alcohol clients if they were able to see them outside the surgery. In some cases, this may be because of reluctance on the part of GP partners or other surgery staff to have drug users in the surgery. In other cases, it may be that the GP would feel more confident in treating drug users with the support of experienced staff. There are two main approaches that could be taken:

- Public clinics may consider offering sessional payment for prescribing and where possible, primary care provision. This process can be supported by utilising local professional networks such as the Divisions of General Practice, existing local prescribers, and local drug and alcohol services.
- Public clinics may attract GPs to work onsite at the public clinic by offering a ‘peppercorn’ rent. In such cases, GPs would obtain their remuneration through Medicare bulk billing. It is suggested that NSW Health investigate how such relationships could function without impinging upon existing state and Commonwealth relationships. It may be useful to use the existing practices adopted by some AHS as a template for this.

**2) Improve financial remuneration for GPs**

Public clinics may consider providing support for GPs in developing, delivering and completing formal shared care plans and treatment referral initiatives. These would include the new GP Mental Health Care Plans under the Better Access to Mental Health Care Initiative, the GP Management Plan which includes Team Care Arrangement (TCA) and Case Conferences under Enhanced Primary Care (EPC). The potential for GPs to provide an even wider range of services to this client group benefits not only the GP in terms of remuneration, but also the client in terms of the delivery of quality care. Public clinics should see these myriad of benefits as yet another reason to engage local GPs in the care of their clients (see below).

**3) Utilisation of Patient Journey Kits**

A series of *Patient Journey Kits* (SWAT, 2007a) have been developed to facilitate GPs in optimising the management and remuneration associated with care of opioid dependent patients. The kits will provide GPs with a guide to developing a comprehensive care plan in combination with a

business plan. The *Patient Journey Kits* support the delivery of enhanced medical and psychosocial support services accompanied by a framework to optimise the use of defined item numbers that improve both GP remuneration and client care.

#### **4) Continued access to education**

Local and state-based organisations should provide GPs with wider access to clinical education relevant to primary care providers. Increased educational and clinical opportunities should be made available through the Australian General Practice Training Program run by General Practice Education and Training (GPET). Existing resources developed by and for GPs should be the primary source of this educational material (e.g., ‘Can Do’ Initiative: Managing Mental Health and Substance Use in General Practice, Australian General Practice Network, 2006). Support from specialist groups such as the Chapter of Addiction Medicine should also be considered.

#### **5) Long-term commitment to GPs from NSW Health**

The desired changes in clinical practice, level of community engagement, and referral pathways require a long-term, consistent approach from NSW Health. Feedback from Divisions of General Practice across NSW revealed a lack of confidence in the sustainability of the relationship with public services.

Maintaining the long-term commitment of GPs to drug and alcohol clients will be influenced by the level of support available to them from public specialist services, including appropriate assessment of client suitability for transfer.

### ***3.4 Clinic capacity***

Of the 21 clinics (60%) who indicated that their clinics had a defined maximum client capacity, 20 provided information regarding determinants of that capacity. Table 7 displays the proportion of clinics that determine their client capacity by: clients per FTE case managers; clients per FTE prescribers; clients per dosing hours; clients per four-hour medical session. While these were considered to be proxy measures for benchmarking resources to service provision, only eight clinics (23%) reported that they use benchmarks to determine capacity. These benchmarks were: 30 clients per FTE case manager; 35 clients per FTE case manager; 50 clients per FTE case manager/120 clients per FTE prescriber; and 50 clients per FTE case manager/dosing hours.

**Table 7.** Determinants of client capacity by clinics with a defined maximum capacity

Determinant	Number of clinics (n=20) <sup>a</sup>	% of n=20	% of all clinics
Clients/FTE case manager	16	60	46
Clients/FTE prescriber	7	35	20
Clients/dosing hours	7	35	20
Clients/four-hour medical session	2	10	6
Other <sup>b</sup>	5	25	14

<sup>a</sup> Clinics were able to select more than one response

<sup>b</sup> Funding; 'decided by Service Director'; 'client and staff safety vs overcrowding'; 'clients involved in research/noise levels/incidents'; 'historically 100 clients is manageable'; 'Occupational Health and Safety issues'; and 'previous experience of maximum capacity'.

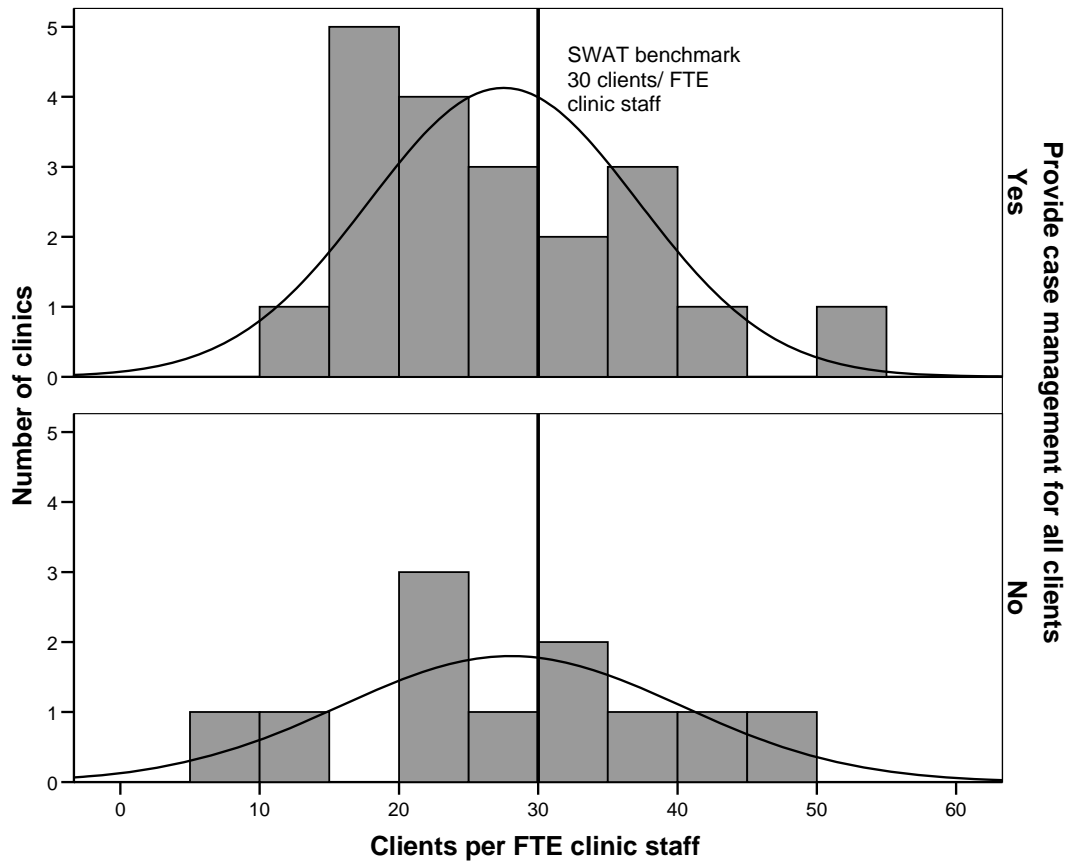
### 3.4.1 Clients managed per FTE clinic staff

The mean number of clients per FTE clinic staff member (excluding administration staff and medical officers) for each clinic is presented in Figure 13. This figure shows the breakdown of calculated clients per FTE for clinics who indicated they provided case management for all clients and those who were selective in who they provided case management for. The mean number of clients per FTE clinic staff at clinics providing case management for all clients managed by the clinic was 27.5 (SD=9.7), and 28.0 (SD=12.2) for clinics not providing case management to all clients managed by the clinic. SWAT benchmark is indicated by the reference line on the x-axis (30 clients per FTE clinic staff).

#### Recommendation 9

It is recommended that a benchmark be set to standardise the ratio of clients to staff in public clinics across NSW. The ratio should be the minimum required to co-ordinate care and support movement to pharmacy. The figure may vary depending on the complexity of the client group, which should be comprised of a combination of stable and unstable clients. SWAT recommends that this ratio be 30 clients (case managed) per FTE clinic staff (not including administration staff and medical officers). Please refer to Appendix D for an example of benchmarking.

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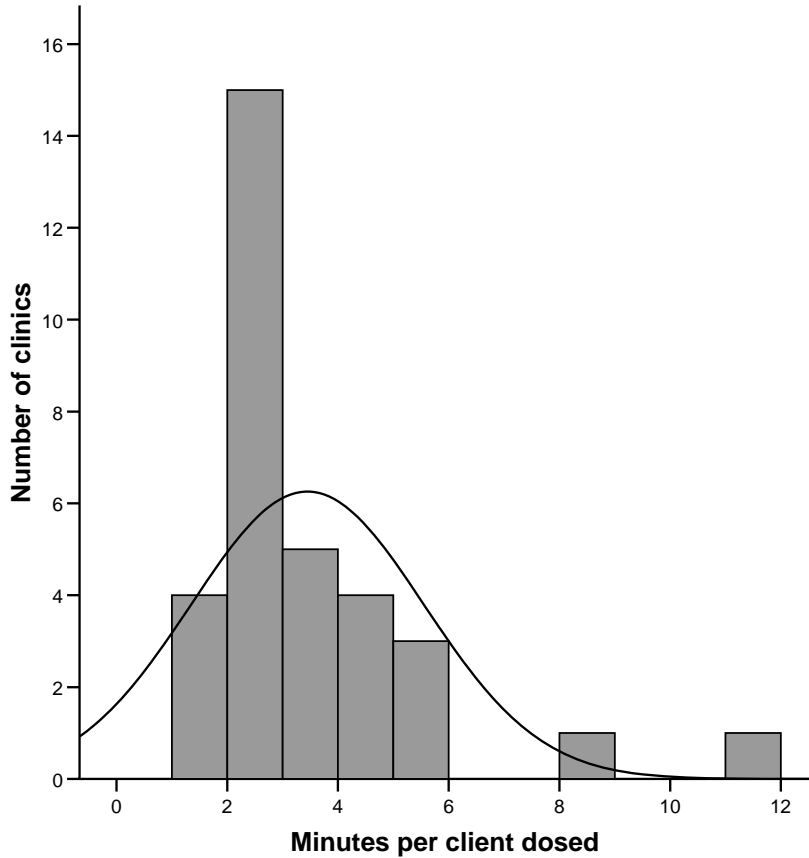
**Figure 13.** Mean number of clients per FTE clinic staff according to which clients clinics provide case management for

### 3.4.2 Transfers from correctional facilities

Many clinics report ongoing difficulties with the processes that support the transfer of clients from correctional facilities to public clinics. To support continuity of care, these clients require immediate access to dosing at a public clinic on release (NSW Department of Health, 2005b). Although some clients with a predetermined release date are discharged from Justice Health with a care plan that has been developed in liaison with the local AHS, in other cases, clients are released at short notice directly from court and do not have a co-ordinated discharge from Justice Health.

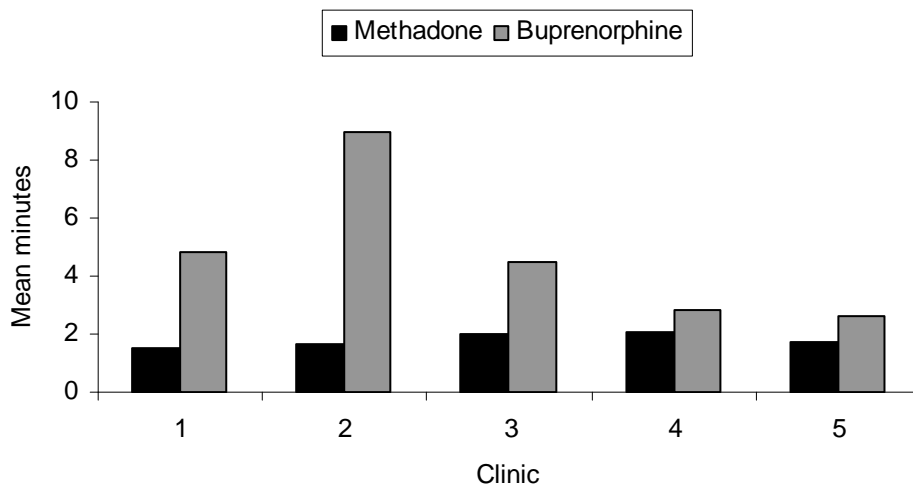
### 3.4.3 Minutes per dosed client

The mean number of minutes per dosed client according to dosing hours per day combined for methadone and buprenorphine dosing was 3.4 minutes (SD=2.1). The number of minutes per dosed client for each clinic is presented in Figure 14.



**Figure 14.** Mean minutes per dosed client combined for methadone and buprenorphine according to dosing hours per day

Figure 15 displays the minutes per dosed client according to pharmacotherapy type for each clinic that provided separate dosing times for methadone and buprenorphine dosing. The clinics are identified by number only.



**Figure 15.** Minutes per dosed client according to pharmacotherapy type for the five clinics with separate methadone and buprenorphine dosing times

### **Recommendation 10**

To assist clinics in estimating required opening hours for dose administration, it is suggested that benchmarks be established across NSW in regard to time allocated for dosing clients. SWAT recommends these benchmarks are:

Methadone: Two minutes per client. This is consistent with existing NSW Health guidelines (NSW Department of Health, 2000). This should include a compliance check such as initiating a conversation with clients after they have taken their doses, to ensure that they have been swallowed.

Buprenorphine: Five to 10 minutes per client. If more than one client is dosed at one time, 10 to 20 clients may be dosed per hour. Variations in dosing benchmarks for buprenorphine are necessary because of differences between clinics in the size of the dosing area, supervised administration practices, and the way buprenorphine is prepared (e.g., whole tablets, broken into pieces, crushed).

#### **Rationale and suggested approaches to achieving this:**

In terms of determining clinic capacity, opening hours available for dosing appears to be a rate-limiting factor. In addition, a significant proportion of staff time is involved in dispensing. Being able to determine how long a clinic is required to remain open using these benchmarks will help clinics rationalise dosing hours required for the number of clients dosed each day. It may assist some clinics in reducing or altering dosing times, allowing staff to attend to other clinical issues. Individual clinics will continue to determine the optimal use of available time and space to permit the safe provision of both methadone and buprenorphine.

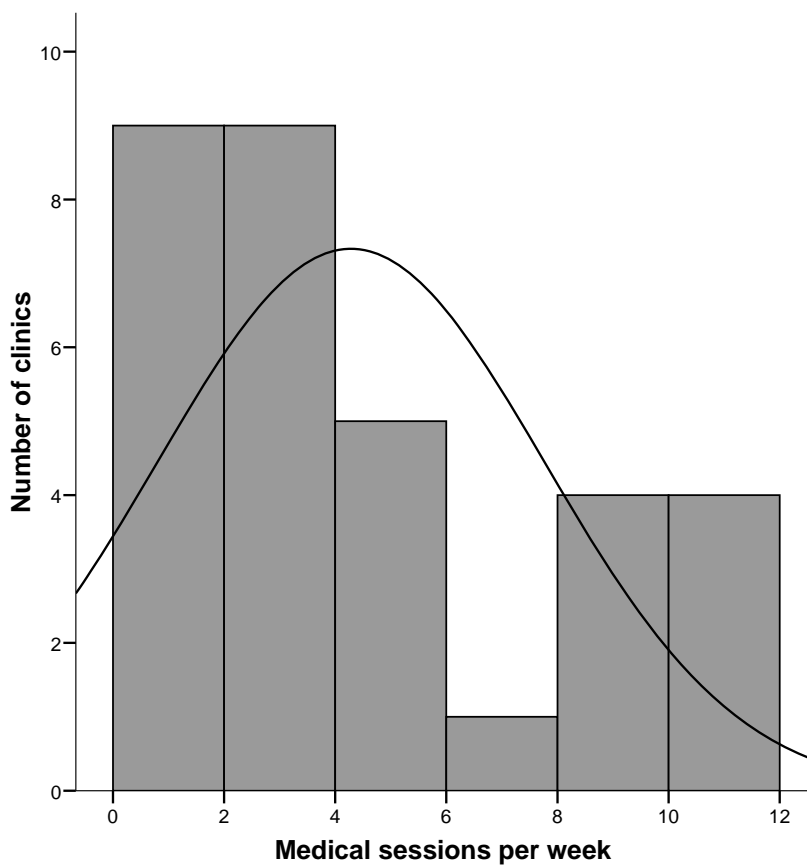
Where the size of the dosing area means that only one buprenorphine client can be dosed and observed at one time, there is pressure on that client to absorb his/her dose as quickly as possible. In other clinics, space has permitted a number of clients to be dosed separately but observed as a group while their doses are absorbing (usually three to five clients at any one time). While this approach may reduce dosing time, there are anecdotal reports from Justice Health clients that it is easier to divert when a group of clients are dosed together, particularly when staff are required to observe one client while dosing another. Further, there are anecdotal reports that the way buprenorphine is prepared influences the amount of time required for absorption. For further discussion on the practice of supervised dispensing of buprenorphine please refer to the *NSW Community Pharmacy Practice Survey* (SWAT, 2007b).

Recommendations have not been made in this report as to whether separate dosing times or dosing areas for methadone and buprenorphine are more efficient than combined dosing. This is in part due to differences between clinics in the number of clients on each pharmacotherapy, staffing capacity, physical layout of the clinics including the existence of separate dosing areas for methadone and buprenorphine, and the ability of clinics to supervise dose absorption for more than one buprenorphine client at one time. Issues of client privacy also need to be taken into consideration.

It is acknowledged that, should clinics routinely provide psychotropic medications, the required dosing hours for a given number of clients would need to be revised (see Recommendation 3).

### 3.4.4 Medical sessions

The total number of four-hour medical sessions provided each week at clinics with on-site medical officers is presented in Figure 16. The mean number of medical sessions provided each week was 4.3 (SD=3.5).



**Figure 16.** Number of four-hour medical sessions provided at public clinics each week

### 3.4.5 Medical sessions per client numbers

The mean number of clients seen per four-hour medical session was 10.4 (SD=5.3, range: 4-25). Based on the total number of clients managed at each clinic and the total number of four-hour medical sessions available, SWAT calculated a mean number of clients managed by a clinic per four-hour medical session available per week. SWAT calculated that for every 46 clients (SD=39.0) managed by the clinic, there was one four-hour medical session available per week (see Figure 17). After discussion with the three clinics with outlying data (i.e., more than 100 managed clients per four-hour medical session), it was clear that clinical staff were concerned that clients were not being seen frequently enough and that their high ratios were a result of not attracting medical officers to their clinics. The adjusted mean number of clients per medical session, after removing the outliers, was 35 clients. SWAT benchmark is indicated by the reference line on the x-axis (30 clients per four-hour medical session).

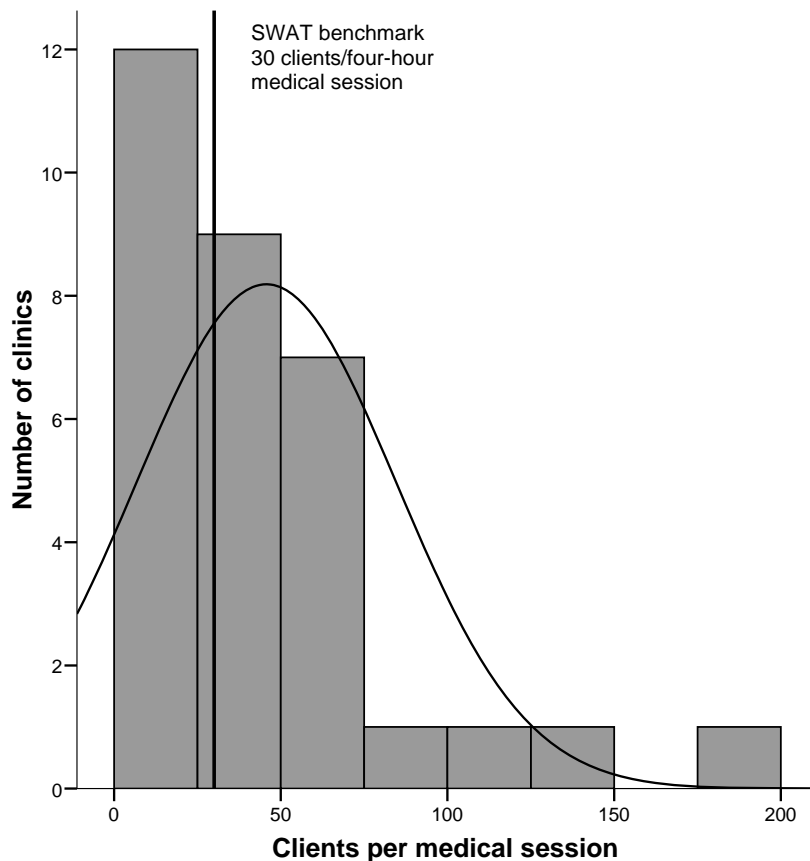


Figure 17. Clients per four-hour medical session at public clinics



### **Recommendation 11.1**

It is recommended that benchmark times be established across NSW for medical services offered in public clinics. The SWAT recommended benchmark is for every 30 clients managed by the clinic, a four-hour medical session should be available each week. For example, a clinic that manages 240 clients will require eight four-hour medical sessions per week.

### **Recommendation 11.2**

A clear definition is needed as to what is required of a medical officer during a clinical review of a client. Please refer to Appendix G for an example of benchmarking medical sessions.

### **Recommendation 11.3**

In each four-hour medical session, between eight and 10 clients should be reviewed by the medical officer:

- A standard review: between 20 and 30 minutes;
- New clients: one hour (no more than one new client per four-hour medical session in most cases); and
- New Justice Health transfers: between 30 minutes and one hour (depending on the quality of information accompanying the client).

Please refer to Appendix G.

### **Rationale and suggested approaches to achieving this:**

The findings from this study suggest wide variation in the number of clients that individual medical officers see in a four-hour medical session (range: 4-25 clients per session). Discussions with NUMs indicate that there is also an inconsistency in the number of clients that different medical officers see in a medical session. This makes it difficult for them to determine how many medical sessions are required per week for a given number of clients. Although in some areas high client numbers per medical session is a function of very limited access to medical officers, in other areas this is not the case. NUMs working closely with their clinical and medical directors may optimise the use of available medical officer resources within the clinic.

Benchmarking clients per medical session is required for a number of reasons:

- To allow NUMs to determine how many medical sessions they need to allow clients to be seen at a frequency that is consistent with existing recommendations and good clinical practice (NSW Department of Health, 2006a).
- To allow medical officers and their managers to determine what proportion of the doctor's working week (or how many four-hour medical sessions) can be reasonably

expected to be devoted to opioid treatment within the clinic setting, given the size of a particular clinic. This may support calls for increased drug and alcohol medical resourcing in some AHS.

- Support for these benchmarks can also be obtained by way of example. Consider a clinic managing 120 clients. Using the recommended benchmarks they would require four four-hour medical sessions per week. This would permit between 32 and 40 clients to be seen each week. Using the lower limit of 32 medical appointments per week and accepting a failure to attend rate of 25%, 24 clients would be reviewed each week. This would permit all clients to be reviewed every 5 weeks, well within a benchmark of prescriber reviews every three months (NSW Department of Health, 2006a). Accepting that some clients need to be seen more frequently and others less often, this benchmark would permit the following review frequencies to be provided assuming 96 available medical review appointments per month (i.e., 24 appointments x four weeks) (see Table 8).

**Table 8.** Review frequency for a clinic offering 96 clinical review appointments per month

<b>Review frequency</b>	<b>Number of clients</b>	<b>Required appointments per month</b>
Weekly	5	20
Fortnightly	20	40
Monthly	20	20
Quarterly	50	17

### ***3.5 Clinic practice***

#### **3.5.1 Case management (care planning)**

Ninety-one percent of clinics (n=32) provided on-site case management. Clients at the remaining three clinics received case management at the Centre for Addiction Medicine, and were located in SWAHS.

The vast majority of clients who had a public prescriber were provided with case management at the clinic, and three-quarters of those dosed at the clinic that had a GP prescriber also received this service. As can be seen in Table 9, only a minority of clinics provided case management to clients with a GP prescriber dosed at a community pharmacy.

Case management was provided through a named (fixed) case manager at the majority of clinics (83%, n=29), through duty case managers at three clinics (9%), and, through case managers at the Centre for Addiction Medicine at three clinics (9%).

**Table 9.** Proportion of clinics providing case management to different client groups

	Public prescriber		Private prescriber	
	n	%	n	%
Public clinic dosed	33	94	26	74
Community pharmacy dosed	32	91	3	9

### 3.5.2 Waiting lists

One in four clinics (26%, n=9) reported that they had a waiting list for opioid treatment at the clinic. Two clinics had less than 10 people on the list, three clinics had between 11 and 20 people, three clinics had between 21 and 50 people, and one clinic had a waiting list of more than 50 people. Feedback on preliminary results from this survey also indicated strongly that the term ‘waiting list’ is highly contentious, and many AHS staff are not comfortable in the use of the term.

Of the nine clinics with a waiting list, eight clinics provided harm reduction advice when unable to offer immediate treatment, six clinics referred to another public clinic, five referred to a private clinic, five referred to a GP, 4 offered detoxification (e.g., buprenorphine, home detoxification), and one offered counselling.

Information was not collected from clinics that did not have a waiting list regarding the ability of those clinics to take on new non-priority clients. Consequently, information was not collected on the responses of those clinics when they were unable to immediately induct new clients on treatment. The lack of a formal waiting list in the majority of clinics does not necessarily mean that these clinics have vacancies.

#### Recommendation 12.1

Consideration should be given to benchmarking the maximum time between client presentation and commencement of assessment, prescribing, or dosing. Currently, this may not be practical because of the lack of spaces in treatment programs across NSW and an absence of consistent data collection, but in time could be a useful indicator of service capacity.

### **Recommendation 12.2**

NSW Health may consider, in discussion with NUMs, monitoring the inability of services to provide timely treatment for people requesting it. Access to treatment may be separated into assessment, prescribing, and commencement of dosing. Standard data collection should be recorded on a monthly basis with other statistics providing each AHS with information on how many treatment seeking people they were unable to commence on treatment each month. Data to be collected may include age, gender, reason for inability to provide treatment (e.g., assessment, prescriber, case manager, or dosing place), whether other treatment providers had been approached, and whether the client was in a priority or non-priority group.

### **Recommendation 12.3**

That a standardised response be developed by each AHS for when a public clinic is not able to offer an opioid treatment place to a person requesting treatment. This would include a courteous expression of regret, written and/or verbal; a risk assessment; information provision about private clinics, other prescribers, and local drug and alcohol services including harm reduction services, non-government organisations (NGOs), and Alcohol and Drug Information Service (ADIS); encouragement to return to the clinic after a period of time; or referral to counselling services.

### **Recommendation 12.4**

It is recommended that all clients have a copy of their care plans (signed by client with a copy in the notes) within one month of commencing treatment with at least an annual review.

### **Rationale and suggested approaches to achieving this:**

Monitoring capacity as described above would result in clinics being able to determine at the end of each month how many clients seeking treatment were unable to be provided with an assessment or a prescriber within a four-week period. This information could be used to plan service delivery and identify unmet health needs. In addition, the term 'waiting list' is sometimes used in a way that is politically contentious in other areas of health care, and may be best avoided if another term can be developed. Giving a patient his/her care plan must be regarded as a minimum standard of treatment communication with a patient about his/her care.

### **3.5.3 Prescriber review**

The majority of clinics (74%, n=26) reported that they have a minimum period for prescriber review. Three clinics have a minimum period of less than one month, 14 clinics have a minimum period of one to three months, seven clinics three to six months, and one clinic more than six

months. Therefore, approximately half of clinics (49%, n=17) have a minimum period for prescriber review of up to three months.

### **Recommendation 13**

That a benchmark be established at each clinic for prescriber reviews to occur for every client at a minimum of every three months. One way of ensuring this occurs is for the prescriber to provide prescriptions for no longer than three-month duration. Clients who are demonstrably unstable should be reviewed more frequently.

#### **Rationale and suggested approaches to achieving this:**

The new *NSW Opioid Treatment Program Clinical Guidelines for methadone and buprenorphine treatment of opioid dependence* state that all clients should be reviewed at least four times each year by an experienced clinician (NSW Department of Health, 2006a). This is particularly important for clients dosed at community pharmacies who are likely to be in receipt of takeaways.

### **3.5.4 Time-limited public clinic dosing**

Seventy-one percent of clinics (n=25) do not have time-limited public clinic dosing (potentially meaning that they could be dosed at a public clinic for the duration of their treatment). Among clinics that do have time-limited public clinic dosing, policies regarding time limits included 3 months stabilisation at a public clinic before transfer to community pharmacy dosing (n=3), 6 to 12 months at a public clinic (n=2), until stabilisation occurs and community pharmacy place available (n=2), and, takeaways to be stopped after 5 years at a public clinic (n=1). Although the finding that the majority of clinics do not have time limits on public clinic dosing is broadly consistent with SWAT recommendations that clients should not be transferred to a community pharmacy until appropriately stable, the expectation should still be that the majority of clients are moved out from a public clinic within 6 months to 2 years of commencing treatment (see Recommendation 7.1).

## ***3.6 Shared care practice***

### **3.6.1 Community pharmacy shared care practice**

Ninety-one percent of public clinics (n=32) stated that they routinely transfer stable clients to community pharmacies for dosing. A possible reason why some clinics reported that they do not transfer stable clients to community pharmacies is that there are no pharmacies in their areas either providing opioid treatment or willing to take on additional clients.

Of the 32 clinics reporting that they transfer clients to community pharmacies, all reported having a current list of pharmacies to which they refer clients. There was a mean of 19.2 pharmacies (SD=17.6) on each clinic's list, ranging from two pharmacies to 66 pharmacies at individual clinics. GSAHS and GWAHS had the fewest number of pharmacies they were able to refer clients to. While 75% (n=24) reported that they monitored the capacity of pharmacies to take on additional clients, 91% (n=29) reported that they had mechanisms for tracking the number of clients transferred from the clinic to community pharmacies. Ninety-one percent (n=29) reported that they have a return policy for clients who become unstable while receiving treatment at a community pharmacy.

In the preceding 12 months, 47% (n=15) reported that the number of pharmacies to refer clients to had remained the same, 38% (n=12) reported an increase in the number of dosing pharmacies (mean=5.0, SD=8.5), and 9% (n=3) reported a decrease in the number of dosing pharmacies (mean=1.5, SD=0.7).

#### **Recommendation 14.1**

It is essential that community pharmacies are reassured that public clinics will take back clients who become unstable at a community pharmacy. Public clinics should monitor the proportion and number of transferred clients that remain without incident at community pharmacies. Please also refer to the *NSW Community Pharmacy Practice Survey* (SWAT, 2007b).

#### **Recommendation 14.2**

AHS should consider providing financial inducements to community pharmacies either to commence dosing or reduce costs for clients. This may facilitate transfer of clients to community pharmacies and for some public clinics may be economically attractive since community pharmacy dosing costs are considerably lower than dosing at a public clinic (NSW Department of Health, 2005a). Resource and financial implications of developing such a relationship could be explored by the NSW Pharmacy Guild and NSW Health.

#### **Recommendation 14.3**

NSW Health should consider subsidising community pharmacy dispensing fees for clients on opioid treatment. For example, in the Australian Capital Territory (ACT), clients pay 50% of the dispensing fee (\$15 per week). Another approach could be that dispensing fees for supervised doses of opioid pharmacotherapies are included on the PBS so clients can work towards the safety net threshold beyond which the receipt of their medication would be free.

#### **Rationale and suggested approaches to achieving this:**

In order to make space in public clinics for new-to-treatment clients, those clients least in need of daily supervision and intensive clinical support should be the ones transferred to community dosing. Ensuring that only stable clients are moved ensures that both client and pharmacist have the best chance for a positive outcome. It is envisaged that, under these circumstances, the rate of transfer of clients from public clinics to community pharmacies (defined as the proportion of publicly dosed clients transferred to a community pharmacy each month) in most areas will be slow. More importantly, the rate of return of identified 'stable' clients is likely to be even lower. This may ease the concerns of NUMs, some of whom have expressed concern about the possibility of an influx of returned clients and how this would impact upon the clinic.

As reported earlier, the majority of public clinic clients would prefer to be dosed at a community pharmacy (Madden et al., in press). However, many cannot pay for pharmacy dispensing fees with clients reporting a median fee of \$10 they were able to pay each week. Clients on low incomes, including pensions and other benefits, will be particularly disadvantaged in this regard. One approach to initiating a move to pharmacy may be to adopt a graduated process of transfer such that clients receive gradually more doses from a community pharmacy. Such an approach, whilst providing the opportunity for clients to establish a relationship with the pharmacist and address any barriers to permanent transfer, it is not without potential problems. Twin-site dosing for a single client would require two prescriptions and would increase the monitoring requirements for these clients (especially with regard to missed doses). Thus, any clinic using such a process would need to stress that this would be a time-limited strategy for a given client.

Of note, NSW Health has recently terminated the existing pharmacy incentive scheme. This is likely to have a significant negative impact upon the goals of the SWAT project. Reducing financial remuneration to participating pharmacies is likely to have the following consequences:

- 1) Participating pharmacies may withdraw from the program.
- 2) The possibility of service expansion may be damaged since it is only within the community pharmacy sector that this opportunity exists.
- 3) The reduced level of pharmacy involvement may jeopardise the ability of GPs to manage clients in the community because of reduced dosing places.
- 4) Participating pharmacies may increase their dispensing fees.
- 5) If pharmacy dispensing fees were to increase, public clinic clients may be less likely to accept transfer to a community pharmacy if financial concerns are a major barrier to transfer.
- 6) Some community pharmacy clients may request a return to public clinic dosing if they are unable to afford more expensive dispensing fees.
- 7) Client debt may increase and is less likely to be tolerated with the possibility of patients being terminated at their dosing sites.
- 8) The goodwill of a professional group who are the mainstay of treatment delivery (dosing > 40% of clients) may be lost.
- 9) Pharmacies may be less likely to expand their involvement such as providing

### **3.6.2 Standard assessment processes for pharmacy transfer**

Clinics who refer clients to community pharmacies for dosing were asked to identify whether they had 'standard assessment processes or tools' to: identify stable clients; support the appropriate transfer of clients for public clinics to community pharmacies; support information exchange between public clinics and community pharmacies; and, provide information to clients about their suitability for community pharmacy transfer. Results are presented in Table 10.



**Table 10.** Number of clinics who have standard assessment processes or tools regarding transfer of clients to community pharmacies

Standard assessment process or tool	Number of clinics	
	n	%
Identify stable clients	21	66
Support community pharmacy transfer	24	75
Support information exchange between public clinics and pharmacies	24	75
Provide information to clients about their suitability for pharmacy transfer	19	59

**Recommendation 15**

That NSW Health recommend to AHS Directors of Drug and Alcohol that public clinics routinely utilise the *Stability Assessment Flowchart* (Appendix C) for the assessment of client stability and suitability for transfer to community pharmacy dosing.

**Rationale and suggested approaches to achieving this:**

This recommendation is made in light of education that was provided to most public clinics across NSW during 2006 regarding the assessment of client stability, and the positive response to the development of this flowchart from clinic staff. Please see *Evaluation of SWAT Stability Assessment Training* report (SWAT, 2007c) regarding this training and its implementation in public clinics across NSW.

**3.6.3 Pharmacist clinical placements**

In the preceding 12 months, only three clinics (9%) had any pharmacist clinical placements. Of those, two clinics reported that they had had only one pharmacist clinical placement in the preceding 12 months.

**Recommendation 16.1**

NSW Health could provide a training module for all NSW universities offering pharmacy degrees covering all aspects of drug and alcohol relevant to pharmacy practice.

**Recommendation 16.2**

In order to provide pharmacists-in-training with a better understanding of their important role in the delivery of OTP in NSW, it is recommended that, in collaboration with the NSW Branch of the Pharmacy Guild, the Pharmaceutical Society of Australia (PSA), University of Sydney, University of Newcastle, and Charles Sturt University (Wagga Wagga and Orange campuses), all public clinics actively provide access to placements for pharmacy students.

**Rationale and suggested approaches to achieving this:**

Pharmacy student placements would form part of undergraduate clinical placements. A set of core standard outcomes or tasks for all universities involved in the program could be developed covering all public clinics in NSW.

**3.6.4 GP shared care practice**

Less than half of public clinics (49%, n=17) reported that they transfer stable clients to GPs for private prescribing of methadone and buprenorphine. Among those clinics, all reported that they have an up to date list of GPs to refer clients to (n=17). The mean number of GPs on each clinic's GP prescriber list was 6.6 (SD=5.4). The number of GPs on the list ranged from one to 18 at individual clinics. While 71% (n=12) of clinics who refer clients to GPs for prescribing reported that they monitor the capacity of GPs to take on additional clients, 76% (n=13) have mechanisms for tracking the number of clients transferred from a public prescriber to a GP prescriber. The majority of these clinics reported that in the preceding 12 months, the number of GPs to whom clients could be referred had remained the same (76%, n=13). Two clinics reported an increase in the number of GP prescribers while one clinic reported a decrease.

Clinics who refer clients to GPs for prescribing were asked whether they have 'standard processes or tools' to: support the appropriate transfer of clients from a public clinic prescriber to a GP prescriber; support information exchange between public clinics and GPs; provide information to clients about their suitability for transfer to a GP for prescribing; and, support client referrals from GPs into the clinic. Results are presented in Table 11.

**Table 11.** Number of clinics who have standard assessment processes or tools regarding transfer of clients to GP prescribing

Standard assessment process or tool	Number of clinics	
	n	%
Support transfer of prescribing to a GP	11	65
Support information exchange between public clinics and GPs	12	71
Provide information to clients about their suitability for transfer to a GP	9	53
Support client referrals from GPs to the clinic	14	82

**Recommendation 17**

Public clinics should consistently and routinely follow up clients transferred to a GP prescriber to provide ongoing support to both. This would maintain a relationship between the clinic and prescriber and provide an opportunity for the early detection of problems experienced by the client or the prescriber. In some areas, providing ongoing, on-site case management support for

GPs has been found to be an effective strategy to support GP prescribers. Clinics should contact each GP prescriber at a minimum of twice a year and offer to review the client if required.

**Rationale and suggested approaches to achieving this:**

Clients transferred to GP care should be followed up by the public clinic and offered reviews with a local specialist in the event that the GP becomes concerned. Improving the exchange of information between care providers and specifically ensuring that clients contribute to this process is comprehensively addressed in the *Patient Journey Kits* (SWAT, 2007a). Finally, it is encouraging that many clinics state that they utilise standard tools and monitor transfers. It is possible that the high percentage reporting use of such tools may be referring to the *Stability Assessment Flowchart* (Appendix C). A follow up of its use within clinics and the impact of training upon staff and clinical practice is presented in *Evaluation of SWAT Stability Assessment Training* (SWAT, 2007c).

**3.6.5 Divisions of General Practice and GP clinical placements**

Sixty percent of clinics (n=21) reported that they have contact with any of their local Divisions of General Practice. Six clinics (17%) reported that they had GP clinical placements in the preceding 12 months. The mean number of GP placements was three (SD=1.5).

**Recommendation 18.1**

It is important that public clinics establish and maintain regular contact with their local Divisions of General Practice. This will facilitate the engagement of local GPs in the care of opioid dependent clients. Both NUMs and staff specialists should be responsible for developing such relationships. In addition, NSW Health should explore opportunities to support these relationships by working closely with the NSW Alliance of Divisions of General Practice.

**Recommendation 18.2**

Public clinics and their Clinical Directors should offer clinical placements to interested GPs. This is a way of enhancing the skills of GPs and of engaging more GPs in opioid treatment. It can be undertaken in conjunction with NSW Health (such as when funds are available to support GPs to do this).

**Recommendation 18.3**

In order to encourage more GPs to engage in the care of opioid dependent clients, the contact details of newly accredited GP prescribers should be provided to their local public clinics so that the NUMs and staff specialists may develop a supportive working relationship. The responsibility for this rests with the Course Coordinator of the Pharmacotherapies Prescriber Accreditation

Course, which is managed by the Coppleson Committee in Continuing Medical Education at the University of Sydney.

**Rationale and suggested approaches to achieving this:**

Feedback from the Divisions of General Practice has identified difficulties in developing ongoing positive working relationships with public clinics because of AHS amalgamations, changes in personnel, policies and procedures, and the short-term nature of funding to projects set up to support them. It is of note that some AHS in particular have expressed concerns that the removal of funding for the GP Pharmacy Liaison Officers in 2005 has had a significant impact on the ability of AHS to liaise effectively with GPs and community pharmacies.

## 4. Conclusions

This report has detailed the findings from the *NSW Opioid Treatment Program Public Clinic Survey* conducted during 2006 by the State-Wide Advisory Team (SWAT): Drug Health Streamed Shared Care. Although NSW may be a single state with a single administrative authority, the challenges and available resources vary enormously across the state and, as such, a ‘one size fits all’ approach to staffing, resource allocation and benchmarking in public OTP clinics will not be appropriate. However, across all clinics the commitment, professionalism, resilience, compassion, knowledge and skills of the staff and especially the NUMs were of the highest standard. SWAT has only been able to achieve its outcomes because of the extensive involvement of key stakeholders from the inception to completion of the project. The members of SWAT wish to express our unreserved thanks and appreciation for the enormous amount of time and especially the goodwill that has been shown to us throughout the project.

The survey identified wide variations in culture and priorities at public OTP clinics across NSW in addition to wide variations in staffing levels, resources, and operational practices. These variations result in unequal access to treatment and inconsistency in service delivery across the state. As a result, benchmarking of key items has been recommended as a way of increasing consistency of service quality and provision across NSW. Because of the vastly differing needs and challenges facing metropolitan and rural areas, however, these benchmarks may require local adjustment to take into account these considerable differences.

The major findings of the study were consistent with the concerns and difficulties identified by clinicians prior to the commencement of the study and confirmed the existence of restricted and often incomplete provision of opioid treatment programs across NSW. There was a poverty of additional on-site medical and psychosocial services provided to clients attending public OTP clinics and wide variation in clinical staffing ratios which impacted upon the frequency of review by both prescribers and case managers. Relationships with local Divisions of General Practice varied between clinics and it was clear that little emphasis was placed by clinics upon accessing GPs in the community to become either primary care providers or prescribers for stable patients.

There was wide variation in the utilisation of community pharmacy dosing by public clinics. Previous research by the SWAT project (*Pharmacy Capacity Survey*, SWAT, 2006; *NSW Community Pharmacy Practice Survey*, SWAT, 2007b) had identified between 2,000 and 4,000 unfilled pharmacy places across NSW, with the majority of pharmacies reporting vacancies. Although pharmacy

dosing places were not always available where they were most required, in many areas this was not the case. Following analysis of the data from these pharmacy reports and subsequent consultation with clinics, we identified a number of barriers to moving clients out to pharmacy. These included from a clinic perspective, clinic culture, clinic priorities, the reluctance of clients to pay and the absence of standardised assessment and selection criteria. Other barriers included the absence of sufficient incentives to leave the clinic, such as the provision of takeaways at almost half of public clinics in NSW.

However, across NSW there seemed to be agreement that a proactive approach was required to move stable clients out to community dosing in order to permit public clinics to provide increased access for non-priority groups. This approach appeared to have support among staff and NUMs. There also appeared to be a high level of support for adopting a standardised approach to assessment of client stability using tools such as the *Stability Assessment Flowchart* and accompanying resources (Appendix C).

It should be noted that the recent decision by NSW Health to terminate the existing pharmacy incentive scheme at the end of 2007 (which provides financial incentives to community pharmacies participating in the NSW OTP) is likely to impact significantly upon the SWAT project's aims to expand existing treatment capacity for those with opioid dependence. This decision will reduce the current financial remuneration obtained for all pharmacies (\$200 per client per year up to a maximum 20 clients). It is possible that pharmacists will seek to recover this lost income by increasing dispensing fees which will further deter new clients moving to community pharmacy and may lead to an influx of returning clients to public clinics. The decision may have serious consequences for the longer-term strategy of increasing community treatment provision for this group, especially in rural areas.

Finally, the absence of defined clinic capacities and limited data monitoring processes within many clinics made comparisons between clinics difficult and will impede future attempts at supporting local service development. Public clinics would like to provide the highest quality of care possible but ultimately will be unable to achieve this without improved integration with mainstream local health care services in order to facilitate the direct provision or brokerage of such services. The minimum health services required for OTP clients are dental, mental health and hepatitis C screening and treatment.

At present, the absence of a co-ordinated framework and clearly defined clinical pathways for clients in opioid treatment does not permit the optimal use of available resources and may limit the benefits attainable from the treatment. In addition, any attempts at improving the recruitment of GPs to deliver opioid treatment will continue to be impeded in the absence of strategies that are consistent, long term and which acknowledge the wide variation in resources, needs and geography of different parts of NSW. Approaches are most likely to be successful if they facilitate public clinics in developing mutually supportive relationships with GPs and community pharmacies. It is hoped that the work undertaken by SWAT and its recommendations within this report, the *NSW Community Pharmacy Practice Survey* report (SWAT, 2007b) and *Pharmacy Capacity Survey* report (SWAT, 2006), in combination with the *Patient Journey Kits* (SWAT, 2007a) and clinical data-mapping exercises will help develop the required strategic directions that are required if the health of those with drug-related problems are to benefit from the resources already committed to them.

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## **6. Appendices**

**Appendix A: Opioid Treatment Program Public Clinic Survey**

**Appendix B: NSW Public OTP Clinics Contact List**

**Appendix C: Stability Assessment Flowchart; supportive notes; and tips for clinicians**

**Appendix D: Example of benchmarking**

**Appendix E: Sample GP letter/agreement**

**Appendix F: SWAT GP Public Clinic Audit Form**

**Appendix G: Example of benchmarking medical clinic sessions**

## Appendix A: Opioid Treatment Program Public Clinic Survey

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### SWAT PROJECT OTP PUBLIC CLINIC QUESTIONNAIRE

SWAT would like to understand more about your service. In particular, we would like to know what your current capacity is to manage clients on OTP and whether this has been explicitly determined. We would also like to know some basic information about arrangements to support the shared care between local GPs and Pharmacists and the clinic.

To this end, could the NUM or Manager of each of your clinics please complete the following short survey?

If you would like help understanding any of the questions or if you have any difficulty completing the survey please contact SWAT Project team at [SWAT.project@sswahs.nsw.gov.au](mailto:SWAT.project@sswahs.nsw.gov.au) or (02) 4633 4110.

#### General clinic information:

1.	Clinic name:		
2.	Address:		
3.	Phone number:		
4.	Name of manager:		
5.	Area Health Service :		
6.	Are you a (please tick <input checked="" type="checkbox"/> one only):		
	<input type="checkbox"/> Stand-alone clinic not attached to any health facilities <input type="checkbox"/> Stand-alone clinic attached to a hospital <input type="checkbox"/> Clinic attached to an in-patient unit	<input type="checkbox"/> Clinic based in a Community Health Centre <input type="checkbox"/> Other (please describe): ..... .....	
7.	In addition to opioid replacement treatment, what other services are provided directly out of your clinic (i.e. on-site service, not referred)		
	<input type="checkbox"/> Case Management <input type="checkbox"/> Inpatient residential or rehabilitation <input type="checkbox"/> Needle and Syringe Program <input type="checkbox"/> Outpatient detox <input type="checkbox"/> Dentist <input type="checkbox"/> Dispensing of other medications, e.g., anti-depressants, anti-psychotics <input type="checkbox"/> Treatment groups <input type="checkbox"/> Treatment for alcohol dependence <input type="checkbox"/> Treatment for cannabis dependence	<input type="checkbox"/> Treatment for stimulant dependence <input type="checkbox"/> Treatment for benzodiazepine dependence <input type="checkbox"/> Psychiatrist <input type="checkbox"/> GP Primary Care <input type="checkbox"/> Family Planning clinic <input type="checkbox"/> Hepatology Clinic <input type="checkbox"/> Other (please describe): ..... ..... .....	
<b>Dispensing information (only complete if dispense on-site):</b>			
8.	Do you dispense: Methadone	<input type="checkbox"/> no <input type="checkbox"/> yes	Buprenorphine <input type="checkbox"/> no <input type="checkbox"/> yes Biodone <input type="checkbox"/> no <input type="checkbox"/> yes
9.	Takeaway doses:		
	Do you provide methadone takeaway doses?	<input type="checkbox"/> no <input type="checkbox"/> yes	If yes, is there a cost: <input type="checkbox"/> no <input type="checkbox"/> yes
	What is the cost (if applicable): \$ ..... / takeaway		

10.	<p><b>Hours of operation</b> (complete all information as applicable):</p> <p>Monday - Friday: <input type="checkbox"/> Open <input type="checkbox"/> Closed                  Saturday: <input type="checkbox"/> Open <input type="checkbox"/> Closed                  Sunday: <input type="checkbox"/> Open <input type="checkbox"/> Closed</p> <p>Clinic opening time: .....                  Clinic closing time: .....</p> <p>Dispensing hours (from – to):                  Methadone/ Biodone dispensing hours: .....                  Buprenorphine dispensing hours: .....</p> <p>Saturday: <input type="checkbox"/> Open <input type="checkbox"/> Closed                  Sunday: <input type="checkbox"/> Open <input type="checkbox"/> Closed</p> <p>Clinic opening time: .....                  Clinic closing time: .....</p> <p>Dispensing hours (from – to):                  Methadone/ Biodone dispensing hours: .....                  Buprenorphine dispensing hours: .....</p>	
	<p>If you have different set times please explain below:                  .....                  .....                  .....</p>	
<b>Client information / Clinic Capacity</b>		
11.	Current total number of clients managed at the clinic: .....	
12.	Number of methadone/biodone clients: .....	Number of buprenorphine clients: .....
13.	Could you please tell us the number of clients managed from your clinic that are currently:	
	Dosed at the clinic: .....	Publicly prescribed: .....
	Dosed at a pharmacy or private clinic: .....	Privately prescribed (e.g., through GP or private clinic): .....
14.	Do you have a defined maximum capacity for number of clients that can be managed by the clinic <input type="checkbox"/> no →Go to question 16 <input type="checkbox"/> yes if yes, what is the maximum capacity .....	
15.	<p>If you have a defined capacity, how do you determine the maximum number of clients that can be managed by your clinic (either through benchmarking or what generally informs your client capacity):                  If you tick <input checked="" type="checkbox"/> more than one option then please <b>circle</b> the one that is most important</p> <p><input type="checkbox"/> Clients / FTE Case Manager  <input type="checkbox"/> Clients / FTE Prescriber  <input type="checkbox"/> Clients / half-day medical sessions</p> <p><input type="checkbox"/> Clients / dosing hours  <input type="checkbox"/> Other: .....</p> <p>Do you use benchmarks to determine capacity?  <input type="checkbox"/> no →Go to question 16  <input type="checkbox"/> yes if yes, please specify how you calculate the maximum number of clients?                  e.g., (1) "Staffing numbers - each FTE case manager has a maximum of 50 clients each" or (2) Based on prescriber numbers - 150 clients / FTE prescriber.</p> <p>.....                  .....</p>	
16.	<p>Do you have a waiting list?  <input type="checkbox"/> no → Go to question 18  <input type="checkbox"/> yes How many clients are on it? <input type="checkbox"/> &lt; 10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> &gt; 50                  If limited, what types of clients are you currently able to offer treatment to, e.g., priority only:                  .....</p>	
17.	<p>For those clients that you are unable to provide immediate service to, what do you do (you can tick <input checked="" type="checkbox"/> more than one option)?</p> <p><input type="checkbox"/> Refer to private clinic  <input type="checkbox"/> Refer to a GP  <input type="checkbox"/> Refer to another public clinic  <input type="checkbox"/> Advise of waiting list</p> <p><input type="checkbox"/> Provide harm reduction advice  <input type="checkbox"/> Other: .....</p> <p>.....                  .....</p>	

<b>Staffing</b>		
	Do you have medical officers: <input type="checkbox"/> no → Go to question 19 <input type="checkbox"/> yes If yes, please let us know how many FTE (where FTE = 5 days or 10 x ½ day or 4 hour sessions):	
18.	Number of public Staff Specialists (FTE) : .....   Number of VMOs (FTE) : .....	
	Number of Public CMO / Registrars (FTE): .....   Number of sessional GPs (FTE) : .....	
	Total number of medical sessions run / week for all MOs (1 session = half day or 4 hours) : .....	
	Number of clients seen every session (e.g. 30 pts/ half day or 4 hour session): .....	
	Other staff as applicable (where FTE = 5 days or 10 x ½ days):	
19.	NUM (FTE) : .....   Nurses/Case Manager(FTE) : .....	
	Administration(FTE) : .....   Other (FTE) : ..... please specify roles: .....	
<b>Clinic Practice</b>		
20.	Are there minimum periods for prescriber review of clients? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> N/A If yes, are they: <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> > 6 months	
21.	Do you provide case management for <b>all patients managed by the clinic</b> regardless of dosing site or prescriber <input type="checkbox"/> yes → go to question 22 <input type="checkbox"/> no If no, do you provide case management for patients that are: <input type="checkbox"/> Publicly prescribed, publicly dosed <input type="checkbox"/> Privately prescribed, publicly dosed <input type="checkbox"/> Publicly prescribed, privately dosed <input type="checkbox"/> Privately prescribed, privately dosed <input type="checkbox"/> Do not provide case management at all <input type="checkbox"/> Other: .....	
22.	Where case management is available, are is it through a: <input type="checkbox"/> Named (fixed) case manager <input type="checkbox"/> Duty case manager <input type="checkbox"/> Other: .....	
23.	Is case management for clients' time limited? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, for how long, e.g., case managed for a maximum of 6 months: .....	
23.	Is the availability of public dosing time limited? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, for how long, e.g., dosed for a maximum of 6 months: .....	
<b>Shared Care Practice</b>		
	<b>Pharmacy shared care</b>	
24.	Do you transfer stable clients to pharmacies for private dosing <input type="checkbox"/> no → Go to question 31 <input type="checkbox"/> yes → Go to question 25	
25.	Do you have an up to date list of pharmacists in your area that you refer to? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, how many are there: .....	
26.	Do you monitor the capacity that local pharmacists have to take on additional stable clients? <input type="checkbox"/> no <input type="checkbox"/> yes	
27.	Do you have any mechanisms for tracking the number of patients transferred from clinics to pharmacies, e.g., databases <input type="checkbox"/> no <input type="checkbox"/> yes	
28.	Over the past 12 months, have the number of dosing pharmacies in your area <input type="checkbox"/> stayed the same <input type="checkbox"/> increased by ..... (number) <input type="checkbox"/> decreased by ..... (number)	
29.	Do you have a return policy for clients who become unstable at pharmacy <input type="checkbox"/> no <input type="checkbox"/> yes	
30.	Do you have <b>standard assessment processes or tools</b> to: - identify stable clients <input type="checkbox"/> no <input type="checkbox"/> yes - support the appropriate transfer of clients from public clinics to pharmacies <input type="checkbox"/> no <input type="checkbox"/> yes - support information exchange between public clinics and pharmacies <input type="checkbox"/> no <input type="checkbox"/> yes - provide information to patients about their suitability for transfer to pharmacy <input type="checkbox"/> no <input type="checkbox"/> yes If yes, please describe (or attach relevant documents) ..... ..... .....	

31.	Have you had any Pharmacist Clinical Placements within your clinic within the past 12 months, e.g., pharmacy students <input type="checkbox"/> no <input type="checkbox"/> yes if yes, how many .....
<b>GP shared care</b>	
32.	Do you transfer stable clients to GPs for private prescribing <input type="checkbox"/> no → Go to question 40 <input type="checkbox"/> yes → Go to question 33
33.	Do you have an up to date list of GPs in your area that you are able to refer to? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, how many are there: .....
34.	Do you monitor the capacity that local GPs have to take on additional stable clients? <input type="checkbox"/> no <input type="checkbox"/> yes
35.	Do you have any mechanisms for tracking the number of patients transferred from clinics to GPs, e.g., databases <input type="checkbox"/> no <input type="checkbox"/> yes
36.	Over the past 12 months, have the number of GPs in your area that you can refer patients to: <input type="checkbox"/> stayed the same <input type="checkbox"/> increased by .....(number) <input type="checkbox"/> decreased by ..... number
37.	Do you have a return policy for clients who become unstable at pharmacy <input type="checkbox"/> no <input type="checkbox"/> yes
38.	Do you have <b>standard assessment processes or tools</b> to: - identify of stable clients <input type="checkbox"/> no <input type="checkbox"/> yes - support the appropriate transfer of clients from public clinics to GPs <input type="checkbox"/> no <input type="checkbox"/> yes - support information exchange between public clinics and GPs <input type="checkbox"/> no <input type="checkbox"/> yes - provide information to patients about their suitability for transfer to GPs <input type="checkbox"/> no <input type="checkbox"/> yes If yes, please describe (or attach relevant documents) ..... ..... .....
39.	Do you have <b>standard processes or tools</b> to support patient referrals from <b>GPs into your clinic or service</b> , e.g. fax or phone numbers, assessment sheets feedback etc. <input type="checkbox"/> no <input type="checkbox"/> yes If yes, please describe (or attach relevant documents) ..... .....
40.	Do you have contact with any of your local GP Divisions? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, which one/s: .....
41.	Do you have contact with your local GPET? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, which one: .....
42.	Have you had any GP Clinical Placements within your clinic within the past 12 months <input type="checkbox"/> no <input type="checkbox"/> yes if yes, how many .....
<b>Private clinic shared care</b>	
43.	Are there any private clinics in the area? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, how many are there: ..... What is this clinics relationship with them (e.g. public clients use them as dosing sites) ..... .....
<b>Survey information</b>	
44.	Date completed:
45.	Completed by: Name: _____ Phone: _____ Position: _____ Email: _____

**Thank you for finishing the survey. Please return completed survey to:  
 SWAT Project Team, Drug Health Services, Sydney South West Area Health Service**



*Appendix B: NSW Public OTP Clinics Contact List*

AHS	Clinic	Phone	Address
GSAHS	Crossroads Clinic	02 6299 1725	103 Crawford St Queanbeyan 2620
GWAHS	Acacia Clinic, Dubbo	02 6841 5802	cnr Myall & McGuinn Dr Dubbo 2830
GWAHS	Broken Hill Pharmacotherapy Clinic	08 8080 1604	Thomas St Broken Hill 2880
GWAHS	Chifley Cottage, Bathurst	02 6339 5258	Bathurst Base Hospital Howick St Bathurst 2795
GWAHS	Orange Opioid Treatment Service	02 6392 8600	96 Kite St Orange 2800
HNEAHS	Cessnock Pharmacotherapy Service	02 4991 0461	View St Cessnock 2325
HNEAHS	D&A Clinical Services (Northern)	1300 660 059	Locked Bag 9783 NEMSC Tamworth 2348
HNEAHS	Newcastle Pharmacotherapy	02 4923 6215	Royal Newcastle Hospital cnr Pacific & King St Newcastle 2300
HNEAHS	The Cottage Clinic, Taree	02 6592 9918	PO Box 35 Taree 2430
NCAHS	Clarence Clinic, Grafton	02 6640 2303	Arthur St Grafton 2460
NCAHS	Praxis, Coffs Harbour D & A Service	1300 662 263	345 Pacific Hwy Coffs Harbour Sth 2450
NCAHS	Kempsey Opioid Treatment Clinic	02 6562 6066	Kempsey Hospital Polwood St Kempsey 2440
NCAHS	Morton Street Clinic, Port Macquarie	02 6588 2970	Morton St Port Macquarie 2444
NCAHS	Nimbin Methadone Unit	02 6689 1030	Nimbin Hospital Cullen St Nimbin 2480
NCAHS	Riverlands Opioid Treatment Program	02 6620 2244	cnr Hunter & Uralba St Lismore 2480
NCAHS	Tweed Opioid Treatment Program	02 5506 7612	Solander St Tweed Heads 2485
NSCCAHS	Herbert Street Clinic	02 9906 7087	Royal North Shore Hospital St Leonards 2065
NSCCAHS	Kullaroo Clinic, Gosford	02 4320 2502	PO Box 361 Gosford 2250
NSCCAHS	Sydney Road Centre, Manly	02 9949 1099	109 Sydney Rd Manly 2095
NSCCAHS	Wallama Clinic, Wyong	02 4394 8180	Wyong Hospital PO Box 4200 Lakehaven 2263
SESIAHS	Bungora Centre	02 4228 1511	2 Urunga Pde Wollongong 2500
SESIAHS	Caringbah Methadone Clinic	02 9540 7702	cnr Kareena Rd & The Kingsway Caringbah 2229
SESIAHS	Kogarah Clinic – St George OTP	02 9350 2055	2 South St Kogarah 2217
SESIAHS	LAMP Opioid Treatment Program	02 4422 7088	7 Lawrence Av Nowra 2541
SESIAHS	Langton Centre	02 9332 8777	591 South Dowling St Surry Hills 2010
SESIAHS	Rankin Court Treatment Centre	02 9361 8030	366 Victoria St Darlinghurst 2010
SESIAHS	Kirketon Rd Centre	02 9382 7440	cnr Darlinghurst Rd & Victoria St Kings Cross 2011
SSWAHS	Bankstown Drug Health Services	02 9722 8293	Bankstown Hospital Eldridge Rd Bankstown 2200
SSWAHS	Canterbury Drug Health Services	02 9787 0272	Canterbury Hospital Campsie 2194
SSWAHS	Coopers Cottage	02 4634 4177	Campbelltown Hospital Therry Rd Campbelltown 2560
SSWAHS	Jacaranda House	02 9828 6250	Liverpool Hospital Elizabeth St Liverpool 2170
SSWAHS	RPAH Drug Health Services	02 9515 7611	Page Bldg Lvl 5 Missenden Rd Camperdown 2050
SWAHS	Blacktown Methadone Unit	02 9621 3600	Unit 7/1 Marcel Cres Blacktown 2148
SWAHS	Fleet Street Opioid Treatment Unit	02 9840 3888	4a Fleet St North Parramatta 2151
SWAHS	Gateway Clinic	02 4734 1340	PO Box 63 Penrith 2751
SWAHS	Lithgow Opiate Treatment Service	02 6350 2750	cnr Col Drewe Dv & Great Western Hwy Lithgow 2790
SWAHS	Ward B4B	02 9845 8721	Westmead Hospital cnr Hawkesbury and Darcy Rd Westmead 2145
SWAHS	Woodlands Clinic	02 4784 6545	Blue Mountains Hospital Locked Bag 2 Katoomba 2780
SWAHS	Centre for Addiction Medicine	9840 3465	Bldg 55, 1-11 Hainesworth St North Parramatta 2150

## *Appendix C: Stability Assessment Flowchart; Supportive notes; and Tips for clinicians*

State-Wide Advisory Team  
(SWAT): Drug Health  
Streamed Shared Care

SYDNEY SOUTH WEST  
AREA HEALTH SERVICE  
NSW HEALTH

### **Assessment of stability – identifying parameters for transfer to community pharmacy**

*(Please note this algorithm is a guide to clinical practice and judgement, it does not replace clinical judgement).*

The transfer to pharmacy dosing has many advantages for clients.

<i>The vast majority of clients would prefer to be dosed at a pharmacy.</i>
<i>More normal existence</i>
<i>Freedom to be dosed at times that suit them</i>
<i>Access to takeaways</i>
<i>Easier for work/ study/ family</i>
<i>Not having to come to a clinic</i>

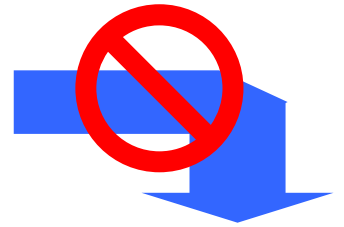
- Clients should not normally be considered for transfer to pharmacy until they have been on supervised methadone for at least three months and buprenorphine for one month.
- Clients who move to pharmacy need to be considered stable (see below).
- Stable means that they have been on the same dose of medication for several weeks and that this keeps them comfortable and free from any side effects; that they attend daily and are not routinely missing doses or are refused them. There should also be evidence of no or significantly reduced illicit drug use (through examination/urines) and there should be no concerns regarding overdose, self harm or child protection.
- *When transferring clients **clinicians should also consider the possible disadvantages of pharmacy transfer such as any possible deterioration due to lower levels of monitoring and access to support (e.g., among those with acute mental health issues or those regular poly-drug users presenting with high risk intoxication).***
- Stable clients are the ones who are most likely to do well in the less supported environment of the community pharmacy. They should be in possession of the necessary social and behavioural skills to engage in such a therapeutic relationship since these are the clients that pharmacies will be most comfortable in accepting.
- Pharmacists are able to supervise clients daily and may be able to identify deterioration or improvement in clients and should be contacted routinely after transfer especially around the time of new prescriptions to ensure things are going well. They may sometimes be able to supervise other medications if required.
- Positive feedback should be provided to your client explaining why he/she are being considered appropriately stable for transfer to a community pharmacy.

- Please use the box over the page to help you and your client identify if he/she is suitable for transfer to a community pharmacy. Any barriers to moving can then be dealt with in a revised care plan and addressed in further clinical review meetings.

## Stability Assessment Flowchart

**Contraindications to transfer to community pharmacy: (behaviour last 4-8 weeks)**  
**Any of these should be seen as a potential contraindication to community transfer.**

<i>Parameter</i>	<i>Y/N</i>	<i>Comment</i>
Withdrawal between doses		
Peak dose sedation after dosing		
Still craving for heroin		
Regular and problematic injecting drug use		
Risky substance use/overdose risk		
Urine drug screen results showing continued illicit drug use		
Irregular attendance for dosing		
Episodes of refused dosing/presenting intoxicated/threatening behaviour		
Recent diversion		
Acute significant mental health problems/risk of self harm		
Child risk/protection issues		
Unstable accommodation		



The client should remain at the clinic and in discussion with his/her case manager/prescriber causes for current instability should be identified and addressed in a revised care plan. Transfer should be revisited in eight weeks.

**If no contraindications then consider for transfer**



**Indications to support transfer**

<i>Parameter</i>	<i>Y/N</i>	<i>Comment</i>
Medication stability		
No risky substance use/overdose risk		
Urine and examination support significantly reduced / nil injecting use		
Attends regularly/good presentation		
No recent refused doses/diverted doses		
No current acute mental health problems/risk of self harm		
No child risk issues		
Stable accommodation/stable social and financial situation		



Find pharmacy.  
 Arrange prescriber review.  
 Arrange transfer.  
 Remind re safe storage of medications.



Maximum of four-week scripts for first three months. No or very limited takeaways. Regular feedback/contact with dosing pharmacy.

## Supportive notes for the assessment of stability of clients on methadone/buprenorphine

*Dr Adam Winstock*

### Medication stability:

#### Medication stability

The optimal dose for the client is one which is sufficient to abolish withdrawal discomfort for the full interdosing interval, and support a significant reduction in, or cessation of, craving for and use of other opioids, without inducing significant toxicity or side effects. *Clients should have been on the same dose for at least four weeks for it to be considered a stable dose.*

- Assessment of dose adequacy (with respect to abolition of withdrawal discomfort) can easily be obtained by taking the client through a typical day focusing on the relationship of withdrawal to time of dosing, craving, consequences of missing a dose and sleep adequacy. Dose coverage should be such that the client is completely comfortable for a period in excess of 24 hours (at least 28 hrs).
- Suppression of use: higher doses of buprenorphine and methadone are associated with reduced opioid use and cravings, through the development of an increased tolerance to opioids (through increased receptor occupancy). In practice, this means that on-top use of illicit opioids is less reinforcing in those people on high doses of substitute opioids (which hopefully translates into them using less). Ask: Have they used heroin recently? If so, did they feel it? How much do they need to use to feel an effect? If they are still able to use heroin at levels similar to that before commencing treatment, then they need to go up on their dose (as they also do if they are still craving).
- No adverse effects, peak post-dose effects, day time sedation/driving risk issues.
- No storage risk for children – you should check where they are stored, that risk issues have been attended to and that you document your advice and feedback in the notes.
- Interactions with other medications.

For those on less than daily dosing with buprenorphine, the following three questions are useful in helping to identify dose adequacy.

1. Are you as comfortable on non-dosing vs. dosing days? (If no, increase the dose).
2. Do you sleep as well on non-dosing days? (If no, increase the dose).
3. Are you any more likely to use on non-dosing days? (If yes, increase the dose).

## Compliance with treatment

Recent diversion
Erratic/threatening behaviour
Irregular attendance for pick up
Episodes of refused dosing/presenting intoxicated

On commencing treatment at public clinics or pharmacies, clients are asked to sign a treatment contract outlining the behaviours and expected involvement of clients in their treatment program. Such contracts are aimed at maximising benefit to the client while minimising risk to the service and other clients by providing agreed ground rules for treatment.

The four items listed focus on compliance, i.e., the consumption of medication as directed with respect to both frequency of attendance and administration of medication.

Issues of diversion – attempting to remove a supervised dose from the dosing area (in the case of supervised doses), or the injection or passing on of methadone/buprenorphine doses (most commonly from takeaways) – is an area fraught with difficulty. Poorly defined by both services and clients, the response to suspicions over diversion needs to be handled in a consistent fashion with an emphasis on client and community safety, as well as attending to reasons behind the diversion (e.g., being stood over, ambivalence over treatment, keeping for a ‘rainy day’, selling for other’s use, etc).

Issues of unacceptable behaviour need to be addressed consistently with all clients with an emphasis on feedback both verbally and in writing, explaining the nature of the behaviour and why it was not acceptable. Many clients (especially those with unstable mental illness, acute drug intoxication or those with personality disorders) may not be aware of their behaviours or of the impact they have upon others. It is important to explore the reasons behind such episodes especially when staff are considering terminating the client from the program. Such decisions need to be taken in light of the potential harmful consequences that may arise should the client be discharged from treatment, since it is this group that are most vulnerable and are most likely to suffer adverse consequences if discharged from treatment.

Irregular attendance and missing doses is also suggestive of issues that need to be explored with the client. It is also sensible to ensure that good attendance and good presentation are also given as positive feedback to the client when applicable.

Refusal by staff to dose a client due to the client’s intoxicated presentation needs to be documented and an immediate risk assessment carried out – including advice about the risk of other acute drug use (CNS depressants). Clear feedback at the time to be repeated when the client next presents and is not intoxicated is important. It should include an explanation of why the dose was refused, the risks of intoxication and an inquiry as to what the intoxication was due to and what triggers prompted it.

Where possible, a urine drug screen should be obtained. Breathalyser results should be noted. Refusals to dose and erratic or threatening behaviours are of particular concern since the risks of intoxicated persons receiving doses in the community are significant and it may also suggest that the client is unable to adopt the appropriate social and behavioural skills required to effectively support community dosing. Repeated intoxicated presentation is also an issue that needs to be addressed.

### Drug use stability (risky use of drugs/alcohol)

Regular injecting drug use – examination
Urine drug screen results
Unstable/risky substance use
Recent attempts of self harm/overdose

In an ideal world, stable drug use would be zero use of all illicit drugs, alcohol and benzodiazepines. In reality, however, stable drug use can be considered as the use of substances in a manner that does not impair an individual's ability to engage/benefit from treatment or impair his/her level of psychosocial functioning. A very good marker (among IV drug users) of more stable use is the cessation or significant reduction of regular IV drug use. However, in your assessment, not only should attention be given to the frequency of use but also to the acute toxicological consequences (overdose and intoxication-related behaviours) and route-related consequences (e.g., blood borne virus transmission). Assessment of these areas permits many opportunities for harm reduction feedback. Overdose and attempted self harm/suicide behaviours should often be addressed together and inquiry about the intent of any overdose specifically sought.

Examining injecting sites should be a routine part of your assessment. Where there is upper limb venous access with evidence of use (by urines or by self report), there is generally no need to examine more distal sites. However where on examination there is no easy upper limb access and there is the suggestion of ongoing IV use, examination of the injecting sites (as directed by the client) is useful, both in terms of assessing frequency and local route-related damage but also to provide the clinicians with baseline data and the opportunity for harm reduction advice on risky injecting practices. Be clear why you are examining sites and if you see something and are not sure what it is, ask. It is a great chance to engage the client and to learn all at once. Serial observations can provide useful information and a chance to provide feedback on positive behavioural change.

Clearly, there are no absolute levels of drug/alcohol use that are synonymous with stability in every client. Some clients may be able to hold down a job, attend regularly for their dose, and display low-risk behaviours but still continue to inject on a weekly basis. As long as there are no other indications (based on careful collation and analysis of clinical and corroborative information) then this should not in itself be seen as a contra-indication to transfer to a community pharmacy. Clearly, a client who is injecting regularly should be encouraged/supported to reduce his/her use (either through **Motivational Interviewing** or dose increases).

The use of other drugs is obviously to be addressed especially where they are related to intoxication-related risk behaviours or acute toxicological risk such as overdose. There is a need to exclude other potential risky behaviours such as 'doctor shopping'. Whilst evidence can be obtained from general inquiry and self-report, examination and random urines are very useful in supporting a history of self-reported significant reduction from regular use of other drugs. The need to refrain from other regular IV use, e.g., of amphetamines, needs to be addressed and, if frequent (e.g., >1/week), may be considered as potential contraindications to transfer. Other investigations such as LFTs and weight measures may also be useful.

Assessment of drug use is thus based on information obtained from the client, on clinical observations of the client (including examination of injection-sites and urine results), dosing compliance and discussion with significant carers and/or other treatment providers. The ability to hold down a job is one indirect measure of drug use stability.

### General health:

Acute significant mental health problems
Acute significant physical health issues

When considering the transfer of clients to a community pharmacy, consideration must also be given not only to the positive impact of reduced levels of supervision and monitoring on well-functioning clients, but the potential adverse consequences of reduced supervision/monitoring on those less well clients, especially those with acute mental illness or physical health problems. Engagement with mental health services or acute medical services (including antenatal services) may be easier for clients dosed at public clinics. Public clinics may also easily support the supervised consumption of other medications such as anti-depressants and anti-psychotics. High-risk clients requiring regular follow up or essential medication supervision (e.g., those with TB on medication) should be considered as being more optimally managed within the public clinics. For those commencing on anti-retroviral medications, a period of review after commencement to ensure no destabilisation is suggested before transfer.

### Psychosocial risk factors:

Unstable accommodation
Budgeting concerns
Child risk or protection issues

Clients should not be transferred if they are homeless or do not have stable and safe accommodation. In some instances, this may be related to financial difficulties. Help with budgeting and motivating clients to move is important (see 'Tips for Transfer'). Finally, child protection issues must be considered with clinicians using all available information to make an informed and documented decision on this issue. **At this point, it is worth noting the safety issues surrounding any potential takeaways and highlighting to the client the risks of methadone consumed by a child. This should be emphasised again on receipt of any takeaways and again regularly thereafter (especially when a client receives an increase in the number of takeaways).** Such advice must be documented in the notes. It is the responsibility of all clinicians to advise on the safe storage of methadone and document such advice. **THE FRIDGE IS NEITHER NECESSARY NOR A SAFE PLACE FOR METHADONE TAKEAWAYS.** For your information, methadone syrup (which has a preservative) can be safely stored under 25 degrees (i.e., *out* of the fridge) with an expiry date of about three years from time of manufacture. For Biodone (no preservative) the expiry is less at about 12 months.

### Finally ....

Completing the form can be a useful mode of engagement and way of tracking clients' progress towards community pharmacy dosing over time. It can also be used to make treatment decisions transparent to the client and to help clinicians give positive feedback to clients.



## Tips for clinicians to talk to clients about transferring to a community pharmacy

*Dr Adam R Winstock*

In a recent survey of 450 OTP clients dosed at public clinics across NSW, 80% indicated they would prefer to be dosed at a pharmacy. However, most clients don't want to go to a pharmacy because of the cost and they perceive it as 'losing out'. Therefore, the idea of transferring to a community pharmacy needs to be rebranded. Our task is to get stable clients to weigh up the pros and cons of moving to pharmacy and MOTIVATE them to consider that moving from a public clinic even at cost (often not as great as they think) is a good thing.

As many clients within the public health system have been there for many years, the idea of moving may be initially unacceptable. Clients may think they are being personally 'picked' on. Therefore, it is usually more appropriate that clinics ensure that all clients know that all clients are routinely considered for transfer after a period of initial stabilisation. This is because clinics are resources for new, vulnerable and chronically unstable clients. Explaining the wider context of opioid treatment in NSW can be a helpful backdrop to discussions.

### The following are not acceptable reasons for not moving to a pharmacy:

- I do not want to go
- It's not fair
- I will write to my local member
- I don't want to pay
- I cannot afford it
- You can't make me go

Going through the process of assessing for transfer in itself can be useful to help in identifying things that are not going well for clients and can be worked on during their time at the clinic and can give focus to meetings with your clients. Identifying a client as stable using the transfer tool and giving clear feedback can be a way to let your clients know that they are progressing in treatment. The move can normalise a life, provide the option for takeaways, often is cost neutral (if you take into account travel etc), provide more flexible hours for work or study and increase time available for the family. Most importantly, they do not have to come to the clinic.

One approach to identifying whether clients are suitable for transfer to a pharmacy and to rebranding a move as a reflection of positive changes in the client's overall wellbeing and behaviour, is to be absolutely transparent about how you can decide on whether a client is stable or not. Going through the *Stability Assessment Flowchart* together in a case review session can be a helpful way of doing this. It can also be useful to having a framework to assess the day to day roles and responsibilities that the client has to fulfil and using this as a guide to (1) daily costs incurred in attending the clinic-transport and routine activity costs such as coffee, etc., (2) inconvenience and possible motivators for moving from the public clinic, (3) possible risk factors or other problems that may get worse in the face of reduced monitoring at the clinic. A simple framework for obtaining all this information in a non confrontational manner is to gain a very clear understanding of what a typical day is like in clients' lives -

1. What time do they wake up and why? People may wake early due to an alarm clock waking them or they may experience unwanted early morning waking which can be a symptom of depression, or they may wake in withdrawal. How do they feel on waking? People with depression often report feeling sad on waking, while those dependent on drugs often report feeling 'sick'. If they report the latter, ask them to describe their withdrawal. Do they wake early and make sure they rush out the house to be at the clinic when it opens? In this case it may be they are under-dosed or a move to a pharmacy may allow more flexibility.
2. What do they do first thing after waking? Do they shower? Do they have childcare issues or work/study. Ask how and when clinic attendance fits in with these. Ask what happens if their children are sick or there are problems at work and they cannot get to the clinic. All the while you should be rechecking how their lives could be easier if they did not have to attend the clinic every day.
3. Ask about costs (\$) and time) in travelling to and from the clinic. Train and bus or petrol fares. Do they have breakfast/coffee before or afterwards? If so where? If not at home how much do they spend?
4. Ask about other drug use and tobacco? Ask about nights out/alcohol expenditure. More than \$50/week on drugs? Then go to a pharmacy.
5. Ask about other supports? Do they have a partner who works? Family?
6. Ask about coffee, tea and soft drinks (some clients drink litres of fizzy drinks containing caffeine each day at a big expense).

Remember you do not need to find the full \$35/week spare, just \$20 or so, then you can ask 'is it really worth \$2/day to have your life tied to this clinic?'

The use of a modified motivational matrix may also be helpful. For example a good place to start is with a simple question "do you like coming to clinic everyday?" or "what do you like least about the clinics?".

	Clinic	Pharmacy
Good things		
Bad things		

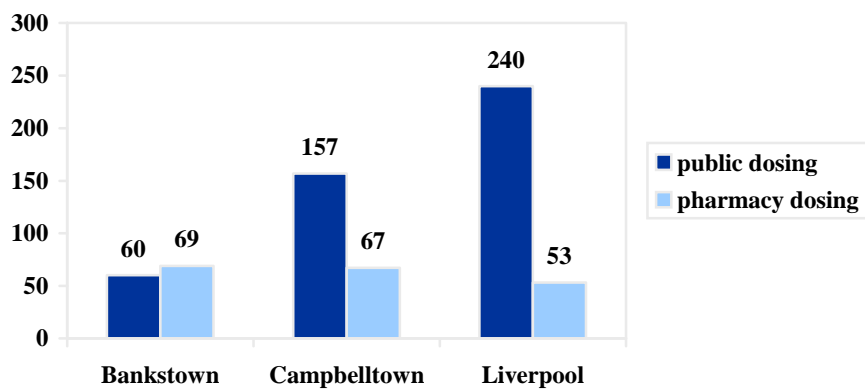
**REMEMBER TO DISCUSS THE SAFE STORAGE OF METHADONE TAKEAWAYS AND DOCUMENT IN CLIENT NOTES**

## Appendix D: Example of benchmarking

### SSWAHS Opioid Treatment Program Benchmark Model for Discussion

#### 1. Private/Community split

The % of clients on the public program that are dosed in the clinic vs. community pharmacies should be approximately 34% vs. 66%



May 04

#### 2. Community transfer

*The approximate % of clients able to be transferred to pharmacy:*

- *after three months = 30%;*
- *after six months = 60%;*
- *12 months = 80%; with*
- *20% unable to be transferred due to chronic instability.*

#### 3. Dosing client profile

The proportion of clients in treatment for six months or less who are dosed at clinic at any point in time should be 50%.

#### 4. Clinical case load per clinical FTE

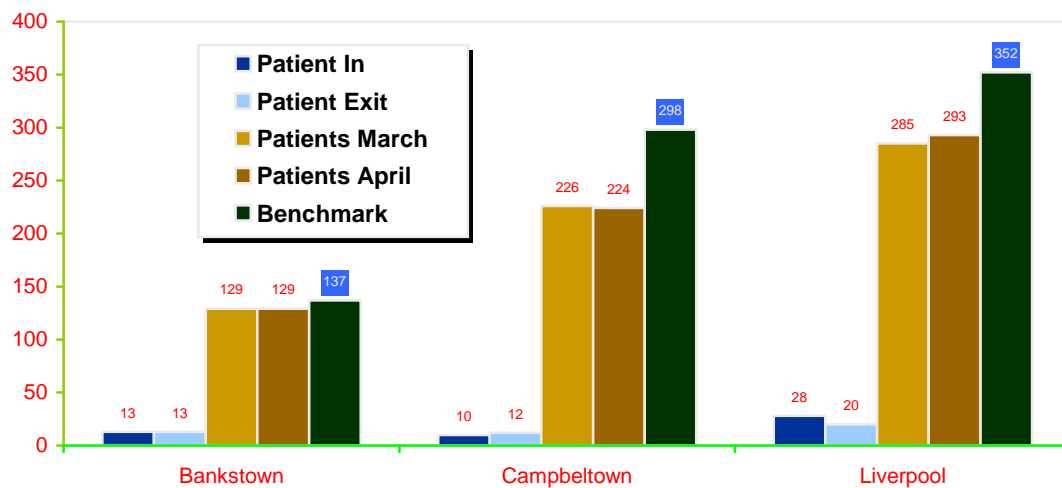
The caseload for each staff member (eg per clinical FTE) is approximately 30 clients.

## 5. Clinical FTE

The clinical FTE (as a subset of total FTE) drawn from MBT Service staffing establishment is identified as follows:

- all registered nurses and associated clinicians;
- a proportion of Unit Manager; and
- a proportion of Administrative Officer Support.

## 6. Current benchmarks and clinic size



**Unit capacity is the total number of clients treated and the ability to treat new clients over time. Capacity is influenced by:**

- Total financial allocation;
- Total Clinical FTE directed towards providing MBT;
- Actual Clinical FTE providing MBT (staff shortage);
- Skill/experience of staffing compliment;
- Nature of case management expected to be provided;
- Medical resource;
- Infrastructure; and
- Case mix.

**April 04 Services to monitor patient input as follows:**

- 215 Campbelltown 8 new per month;
- 130 Bankstown 20 new per month; and

- 285 Liverpool 28 new per month.

## 7. Length of dosing time

Considers

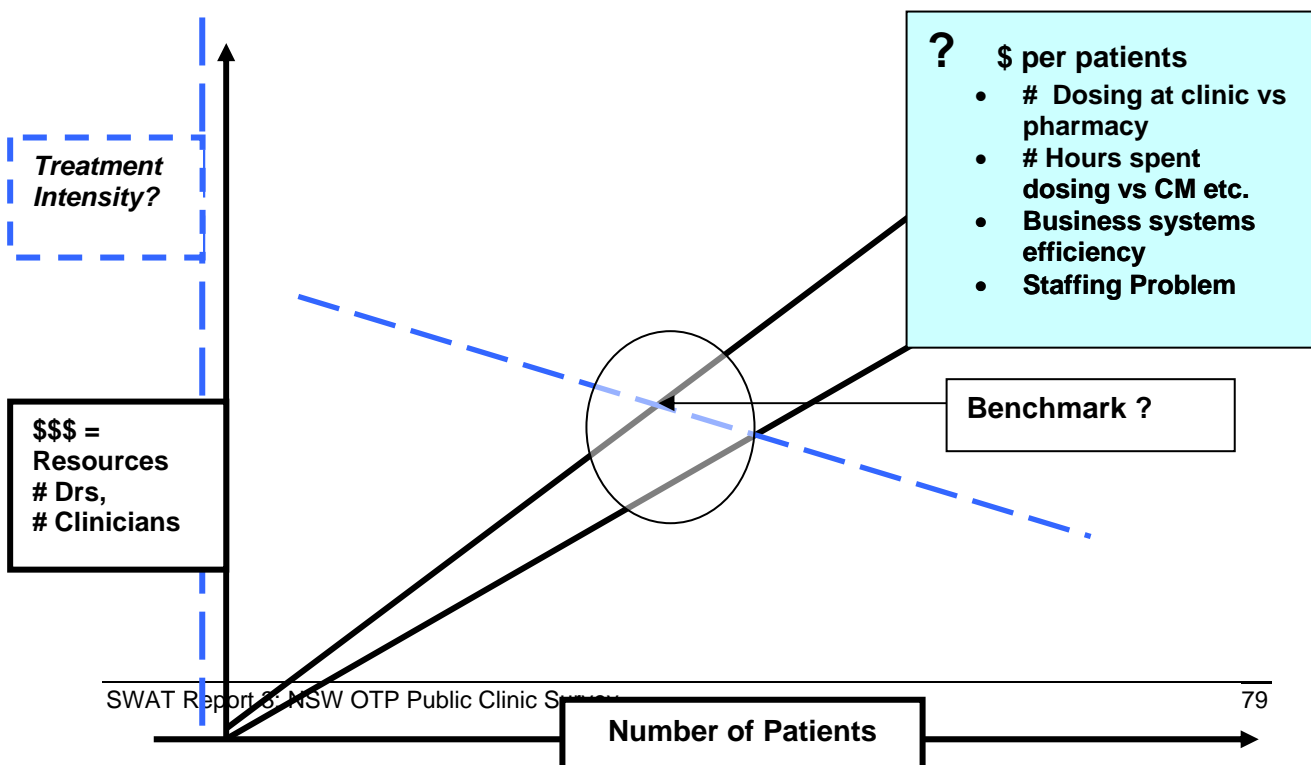
- the number of clients to be dosed;
- the drug type dispensed;
- procedures required to be undertaken during dosing such as urine collection, providing overdose information; and
- client variable such as client crisis, intoxication or new clients.

### Current Situation JUNE 04

MBT Service	Total Dosing Time	Number Clients @ Clinic	Number clients dosed per day	Minutes per Clients
Bankstown	120 mins	55	45	2.6
Campbelltown	360 mins	135	125	2.8
Liverpool	420 mins	218	195-200	2.2

### Benchmark:

Minimum two minutes per client. E.g., 60 clients = total of two hours dosing.





## ***Appendix E: Sample GP letter/agreement***

Dear Doctor

### **Re: Transfer of dosing site for patients receiving methadone and buprenorphine treatment from public clinics to community pharmacies**

As you would be aware the availability of public methadone and buprenorphine treatment services in ..... is limited and at times people in need of this treatment have difficulty accessing these services. One factor identified as impeding access to treatment is that public clinics are often full. In line with the NSW Department of Health, this service is focusing on inducting and stabilising patients with a view to initiating transfer to community pharmacy dosing for the majority of patents within three to 12 months of commencing treatment.

This clinic believes that community pharmacies are a better place for patients who have been stabilised on methadone or buprenorphine to receive their dose. At community pharmacies dosing times are more flexible, allowing for better lifestyle and increased employment possibilities. A recent study of 450 patients dosed at public clinics suggested 80% would rather be dosed at a community pharmacy.

Over the ensuing weeks, patients who have been identified as suitable, due to stability, will be transferred to pharmacies. The transfer procedure is as follows:

- patients will be notified of the need to transfer their dosing from the public clinic to a community pharmacy and will be instructed to contact you to arrange transfer; and
- patients will be provided with a list of suitable pharmacies close to where they live or work that currently have vacancies.

We would ask you to support any decision made by the clinic when it comes to transferring patients of yours to community pharmacies. Careful assessment will have been conducted to ascertain suitability for transfer. We understand that some patients may prefer to continue receiving their treatment free of charge from a public clinic, however, public services are fully committed to maximising equitable access to treatment, and particularly ensuring people who are not in treatment have access to safe stabilisation in a supervised environment. If needed, case managers are available to assist in the process. It is expected that patients once notified of the intention to transfer dosing to community pharmacies will be relocated within four weeks.

Please do not hesitate to contact me if you wish to discuss this matter.

Yours sincerely,

## Appendix F: SWAT GP Public Clinic Audit Form

CLINIC NAME.....

The information will be used to plan OTP services delivery in SSWAHS and across NSW via the Drug Health Shared Care: State Wide Advisory Team (SWAT).

Please ask all clients dosed at the clinic the following questions.

	1 Patient's age?	2 Gender M/F?	3 Do you have a regular GP? <small>If answer is yes complete Q4-7 If the answer is No choose a reason(s) 9-14</small>	4 Have you seen your regular GP in the last year?	5 Does your GP Bulk Bill?	6 Does your GP know you are on methadone or bup?	7 Would you like your GP to prescribe your methadone or bup?	9 REASON I have no need for a GP	10 REASON I have not looked for a GP	11 REASON I cannot afford a GP	13 REASON I cannot find a GP	14 ANOTHER REASON please specify
eg	27	M	YES	YES	No	No	Yes					
eg	29	F	No					✓				
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												



## *Appendix G: Example of benchmarking Medical Clinic sessions*

### Outline of Medical Clinic Sessions

Created by the former South Western Sydney Area Health Service in 2004.

#### Number of sessions per clinic

Clinics will be allocated approximately one clinic session (four-hours) per 30 patients.

#### Standardised clinic session

1 x 60-minute “new person” assessment time slot

4 x 30-minute “patient review” time slot

3 x 20-minute “stable patient review” time slot

#### Minimum frequency of appointments

It is recommended that the following appointment schedule be followed for patients inducted into the methadone and buprenorphine treatment system.

- Week 1 Assessment
- Week 2
- Week 3 Optional
- Week 4
- Week 8
- Week 12
- Then three-monthly

## **Medical Reviews**

*All activity conducted in medical reviews must be clearly documented on the day of the review and signed.*

Where possible, case managers should be encouraged to attend medical reviews to improve communication and overall continuity of care.

### **The 60-minute “new person” assessment time slot**

There is one of these per session. All clients seen in this session should already have had a completed assessment in the file.

At times there may be a need to schedule two one-hour slots in a medical clinic to accommodate a couple. In this case an adjustment must be made to another session to compensate i.e., temporarily remove a 60 minute new person slot.

### **Main client group:**

Clients who have been identified as opiate dependent following comprehensive assessment and provisionally identified to be suitable for treatment with methadone or buprenorphine.

### **Main objectives:**

Facilitate the entry of clients onto OTP (or detox) and to ensure appropriate mental health and physical health issues are identified and addressed. Hepatitis screening and plans for vaccination should also be initially addressed at this point.

### **Key activities:**

- Physical examination including whether there is any evidence of drug use e.g., IV sites;
- mental health review;
- hepatitis review including plans for vaccination;
- review of current medications, allergies and PMH need to be recorded;
- baseline UDS; and
- relevant blood tests if appropriate.

Current drug use must be assessed.

### **The 30-minute “patient review” time slot**

30-minute patient review time slots can be used to review new-to-treatment clients during their induction and stabilisation onto methadone or buprenorphine during the first three months of treatment. Generally patients should attend at least four 30-minute sessions in the first three months of treatment (as per schedule above). 30-minute sessions may also be used for routine reviews of patients every three months where it is anticipated that more than 20 minutes is required, e.g., where case managers have identified concerns they wish to be investigated.

#### **Main client group:**

- Patients being inducted into treatment;
- patients in the first three months of treatment;
- patients identified as unstable;
- stabilised patients requiring review prior to transfer to pharmacy; and
- patients in long term treatment “chronic cases”.

#### **Main objectives of session:**

- Review and where necessary adjust initial treatment plan;
- confirm patient is undergoing a safe induction; and
- review treatment progress.

#### **Key activities:**

- Assess drug use, and other risk behaviours;
- review dose;
- examine injection-sites;
- assess and respond to children at risk;
- assess and respond to self harm concerns;
- review pathology results, e.g., Serology, UDS;
- review BBV treatment; and

- review and respond to outstanding case management issues.

### **The 20-minute review time slot**

20-minute reviews should primarily be used for the review of for stable patients, where it is anticipated that no other significant problems will require attention. They may be used for long-term or chronic patients receiving their doses at clinics and who only require three-monthly reviews and prescription renewal. This time slot can also be used to discuss with stable ‘pharmacy-dosed patients’ the process of transferring their treatment to a GP.

### **Main client group:**

- Stable clients needing a prescription renewal.

### **Main objectives:**

- Assess drug use, and other risk behaviours;
- Review dose/prescription;
- Confirm stability;
- Assess for new risks or problems; and
- Provide positive feedback.

### **Key Activities:**

- Conduct pharmacy/community pharmacist review;
- Review dosing pattern;
- Assess drug use, and other risk behaviours;
- Review dose;
- Renew prescription; and
- Review and adjust treatment plan.