

ROLE	MO SPECIALTY	POSITION (OPTIONAL)

Metro North Mental Health Alcohol and Drug Service (MNMH-ADS) is seeking to develop a framework for shared care treatment (the framework) of opioid treatment program (OTP) clients. The concept of shared care and some of the essential elements are outlined in the Queensland Medication-Assisted Treatment of Opioid Dependence: Clinical Guidelines 2018 (MATOD) and reproduced below:

"Shared care is a model of service delivery where stable clients in an OTP clinic are referred to their GP for OTP support [35]. Shared care is to be encouraged because it may normalise treatment, reduce perceptions of stigma and enhance client autonomy. Further benefits include:

- *the GP (and other doctors in the practice) have a link with AOD that can assist with other referrals*
- *stable clients will have less AOD contact, allowing AOD resources to be redirected to new/complex clients.*

In the case of a stable client with a willing GP, the OTP clinic is to contact MRQ to co-ordinate the arrangement, and an Approval is issued to the GP to prescribe OTP for that client (see Section 10.3, 11.15). The OTP clinic retains overall management of OTP for the client, with the responsibilities of each party documented in an agreement. The GP will review the client regularly, provide Written Instructions to pharmacy, and contact the OTP clinic to discuss any changes in OTP dose or client stability. Annual OTP clinic review is routine, in addition to minimum three-monthly client reviews with the GP. If the GP or client has concerns, care can be transferred back to the OTP clinic." (*now Monitored Medicines Unit – MMU)*

To develop the framework appropriate for MNMH-ADS, clinicians of the Service are being asked to provide feedback on the proposed elements of the framework.

Results from the first questionnaire

The responses from our first questionnaire have been collated and as anticipated, a number of elements have already been determined by consensus while others require further consideration and defining. The results from the first round of questions are outlined below and where further clarification is sought additional questions follow.

The following items, agreed to be unnecessary framework components, have been removed:

- The need for a stable relationship to be included in the stability criteria
- The requirement for mandatory engagement in counselling to be included in the stability criteria
- Having a pharmacy debt – although this should be a managed component

General Shared Care Components

The following elements have been agreed on by the majority of respondents as accepted framework inclusions:

- Shared care should be provided on a voluntary basis
- All opioid treatment drugs and delivery formats should be considered for shared care
- There will be no minimum time requirement for clients to be registered at the clinic (e.g. transfers)
- A fast track option should be available for those referred to by their GP or authorised prescriber (AP) for OTP assessment and commencement
- Other APs should be accepted e.g. Psychiatrist, Nurse Practitioner (NP)
- A nurse portfolio should be created in clinics to manage shared care clients/liaise with GP/AP
- A Nurse grade 7 position (Nurse Navigator/CNC) would be beneficial to oversee implementation of framework, support GP/AP and clinic staff

1. Shared Care - Expected Care

Results from the first questionnaire showed that the majority of respondents thought shared care should be voluntary, however respondents were divided on whether it should be expected. The following information is to assist in determining what it means for shared care to be expected.

The question of expectation is in the context of a ‘whole-of-service’ model – not at an individual level. In considering the concept of an ‘expected’ model of service, it is important to keep in mind the goal of Queensland alcohol and drug services “to deliver a system that is comprehensive, integrated and recovery-oriented” (Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-23).

Promoting shared care with GPs facilitates client recovery by ensuring the right level of care is being provided in an appropriate setting. It aligns with the Metro North HHS Strategic Plan 2016-2020 (revised 2019), Department of Health Strategic Plan 2019-2023, and the MATOD guidelines, and assists MNMH-ADS in providing timely tertiary care for opioid dependence.

So ‘expected share care’ means that MNMH-ADS expect that QOTP clients, as part of their recovery, would move to a shared care arrangement when their individual circumstances are appropriate (acknowledging that some clients will require a significant time of specialised case management, while very complex clients may never be suitable).

Comments		
<i>I. Should shared care be an expected service wide model for MNMH-ADS clients?</i>		
	Yes	No
<i>II. When should shared care be an expected recovery focused goal?</i>		
For all QOTP clients registered with a MNMH-ADS clinic	Only new clients enrolling in QOTP with MNMH-ADS	Only those referred from a GP

2. Medication dose maximums

Concerns regarding this question were predominantly around methadone doses. MATOD guidelines suggest adverse events are more likely in doses exceeding 150mg/day, with average doses of 60-120mg required for stabilisation.

MEDICAL/NURSING STAFF ONLY

What would be an acceptable maximum dose limit for a client prescribed methadone when considering shared care?

100mg/day

120mg/day

150mg/day

Comments

3. Time on Program

A consensus was not reached regarding a minimum time frame a client should be registered on QOTP before consideration of shared care. Feedback suggested concern around the level of stability that can be achieved over particular time frames.

What is a minimum acceptable time for a client to be registered on QOTP before consideration of shared care?

3 months

6 months

12 months

No time limit – once client is assessed by MDT as medically stable

Comments

4. Clients recently released from prison

A consensus was not met regarding clients released from prison. Feedback suggested concern was around clients maintaining stability in the community after release from a prison.

What is the minimum acceptable time frame for case management at an ADS clinic, for clients recently released from prison before consideration of shared care?

3 months

6 months

12 months

No time limit – once client is assessed by MDT as medically stable and has no identified barriers to ongoing participation in program.

Comments

5. Community Prescriber Responsibilities

The responses from our first questionnaire have been collated and the following community prescriber elements have been agreed on by the majority of respondents as accepted framework inclusions:

- The GP/AP will have the ability to independently change (in line with MATOD guidelines):
 - take away dose (TAD) arrangements ie: TAD days
 - the number of TAD
 - client dosing to double/triple dosing where applicable
- The GP/AP may increase a client's dose after consulting with:
 - MNMH-ADS Medical Officer (MO)/NP
 - MNMH-ADS Case Manager (CM) - where it is expected that the CM will liaise with NP/MP
- The GP/AP may decrease a client's dose after consulting with:
 - MNMH-ADS MO/NP
 - MNMH-ADS CM
- The GP/AP must consult with MO/NP before prescribing medications of concern
- Pharmacy reports should be sent to CM and GP/AP

6. Prescribing of medications of concern

The following questions aim to identify which drugs should be listed as 'medication of concern' and under what circumstances they may be prescribed to a QOTP shared care client.

MEDICAL/NURSING STAFF ONLY

I. Which drugs should be included in the list of drugs of concern prompting a consult with the MNMH-ADS before prescription by GP/AP?

Comments

All benzodiazepines

All gabapentinoids

All antipsychotics

All antianxiolytics

All antidepressants

Only medications contained in the "Clinically significant drug interaction" list of the MATOD guidelines (pg 126)

Only medications to be monitored under the new QScript program

Other medications (please specify)

II. In what other circumstances should the GP/AP consult with MNMH-ADS regarding prescribing a drug of concern?

When increasing the dose of any of the determined drugs of concern

When decreasing the dose of any of the determined drugs of concern

When ceasing prescription of any of the determined drugs of concern

Only if the prescribing of the determined drug of concern is to be ongoing (ie long term)

7. Determining Stability of Clients

The following stability elements have been agreed on by the majority of respondents as accepted framework inclusions:

- A Multi-Disciplinary Team (MDT) review should be used to determine suitability of individual clients for shared care
- A client deemed medically stable but needing psychosocial support should not be excluded from consideration of shared care
- Input from the client’s pharmacist should be included when considering suitability for shared care

The below questions relate to stability criteria agreed upon in the first questionnaire that need further defining.

MEDICAL/NURSING STAFF ONLY

I. What is a minimum level of TAD that would indicate a stable client? Comments

- 4/week
- Weekly pickup
- Fortnightly pickup
- Monthly pickup
- No minimum - individual determination depending on client’s circumstances (eg client prefers to attend pharmacy to dose; TAD arrangement reflects client inability to attend pharmacy rather than stability)

II. What appointment attendance rate should be a minimum for consideration of shared care?

Comments

100% attendance and when needs to cancel does so with appropriate notice and timely re-booking

80% attendance and usually gives appropriate notice and timely re-books

Irregular attendance rate but identified barriers to clinic attendance (e.g. working, distance to clinic, transport issues) which may be resolved with a shared care agreement

III. What level of continued substance use would be considered appropriate for shared care? (excludes tobacco)

Cannabis use – not impacting mental health, personal or social functioning and not posing a significant medical risk

Stimulant use - not impacting mental health, personal or social functioning and not posing a significant medical risk

Additional opioid use - not impacting mental health, personal or social functioning and not posing a significant medical risk

Other substance use (e.g. misuse of prescription medication) - not impacting mental health, personal or social functioning and not posing a significant medical risk

Any substance use as long as they meet all QOTP obligations

No illicit substance use

IV. What level of alcohol use would be considered appropriate for shared care?

Safe level of consumption in line with Australian Guidelines

Episodes of binge drinking eg weekends but plans for responsible use and maintains personal/family commitments

Occasional drink only

No alcohol use

V. Those with legal matters may be considered for shared care:

Comments

- When jail terms are not expected
- When matters are ongoing (i.e. not new charges)
- Always – regardless of legal proceedings if GP/AP is accepting
- Never – does not show stability

VI. Those with child safety matters may be considered for shared care:

- When no ongoing investigations are in place ie orders have been made
- Only when long term placement orders are in place (e.g. 18 year orders)
- Only if supports are put in place to manage child safety concerns
- Child safety matters should not be a consideration

VII. Clients experiencing mental health issues should be considered for shared care:

- Only when there is no major mental illness diagnosed e.g. psychotic illness
- If diagnosed with a major mental illness they are treatment compliant and have support in place
- If participating in counselling/psychology
- Only if there are no behavioural concerns

VIII. What would constitute “Stable Personal Functioning” (with assistance from carer if disability present)?

- Attending to activities of daily living
- Managing financial responsibilities
- Maintaining family roles (eg parent, carer)
- Managing risk to self and others (ie responsible management of TADS and/or supplementary substance use)
- Stable accommodation
- Attending to health care

IX. What type of employment should a client have to be considered for shared care?

Comments

Full time employment

Regular part time or casual employment

Unemployed but actively looking for work

Unable to work due to caring/parenting responsibilities or disability

X. Are there any other factors that you believe should be considered when assessing stability for shared care?

8. Psychosocial Support

The following psychosocial elements have been agreed on by the majority of respondents as accepted framework inclusions:

- The clients requiring support during the shared care agreement should be referred to NGO if client is agreeable
- The clients support choices should be identified and noted in their treatment plan before moving to a shared care arrangement

I. What role do you see the psychosocial service playing in shared care?

II. Do you think any further supports need to be put in place for a shared care client in regard to psychosocial care?

PSYCHOSOCIAL TEAM ONLY

III. Are there any further considerations needed to ensure your team can meet the needs of a shared care client?

IV. In what way do you think your team could assist a client to move to a shared care arrangement?