AChAM submission to the Australian Department of Health consultation on the Post-market Review of Opiate Dependence Treatment Program Medicines

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Overarching statement from AChAM:

A major challenge for the Australian opiate dependence treatment (ODT) system, and the main focus for this review is to ensure that the cost of opioid treatment to the patient does not remain a barrier to participating in this treatment, as occurs with current funding models. If financial barriers are redressed, positive outcomes for the patient and the community will follow. It is also essential that the providers of this treatment, most notably community pharmacists, private medical practitioners and public sector services (e.g. Local Health Districts / Networks, hospitals, prisons) are compensated fairly to provide quality service provision and attract/retain service providers to be involved in this treatment.

1. **Describe and compare essential elements of models of service delivery for opioid dependence treatment (ODT) in Australia (and internationally) including best practice guidelines and current models (including models developed in response to the COVID-19 pandemic) that support timely access to ODT medicines through both pharmacy and non-pharmacy settings*.**

   **Non-pharmacy settings include a range of service settings where ODT medicines are delivered in Australia including, but not limited to, correctional facilities, hospitals, public and private clinics, Aboriginal Community Controlled Health Organisations, general practices and specialist clinics.*

ODT is a well-established treatment modality for opioid dependence arising from the use of illicit and pharmaceutical opioids. ODT involves a combination of

- structured opioid medication,
- psychosocial interventions,
- medical management, and ideally,
- interventions and co-ordination of services addressing a range of concurrent substance use, medical (e.g. hepatic disease, chronic pain), psychiatric (e.g. affective disorders, PTSD) and social (e.g. under-employment, homelessness, violence) conditions often experienced by clients with opioid dependence.

Medications

In Australia, only methadone (oral liquid or syrup) and buprenorphine (sublingual film, tablets and depot subcutaneous long-acting injections) are licensed opioid agonist medications for the treatment of opioid dependence. Oral naltrexone is also licensed (but not reimbursed on PBS) for opioid dependence, and has little uptake due to concerns regarding poor efficacy. In other countries, injectable opioid medications (e.g. diamorphine in several European nations and Canada), and slow release oral morphine products (in Austria, Croatia, and Germany) are also licensed and used for this indication.

In Australia, methadone treatment was the only available medication for this indication from its introduction in 1970 until 2000, and the Australian treatment framework, including funding and clinical models of care, still largely reflects the systems established during the 30 year period when methadone was the only available treatment. Sublingual buprenorphine was introduced in 2000, sublingual buprenorphine-naloxone tablets were licensed in 2006, and in 2012-3 sublingual buprenorphine-naloxone film became available. Since the mid-2000's SL buprenorphine products accounted for approximately 30-40% of the ODT population across Australia (AIHW 2021), although

the trend is towards greater use of buprenorphine products – with the proportion of patients treated with methadone falling from 69% in 2011 to 58% in 2020 (AIHW 2021). This trend will most likely be accelerated with the introduction of depot buprenorphine in late 2019, which has led to considerable uptake (see Lintzeris, Dunlop et al 2019 NSW Guidelines for depot buprenorphine treatment), particularly in public sector and prison based programs, and in many public sector services now accounts for approximately half of the total client population. This has been driven in part by the COVID pandemic (with the benefits of patients attending only once a month for dosing), but also due to the popularity of depot buprenorphine within the client population. This was demonstrated by the findings of the DEBUT study (Lintzeris, Dunlop et al JAMA Open 2020) – a randomised controlled trial conducted in sites in NSW and Victoria comparing sublingual buprenorphine to depot buprenorphine (Buvidal®), which reported superior patient reported measures of satisfaction, convenience and effectiveness, further highlighted in qualitative research with participants in the study (Barnett et al 2021). The safety and effectiveness of the alternative depot product (Sublocade®) has also been demonstrated in Australian clinical settings in the recent COLAB study (publication submitted).

Service systems

In most of Australia, ODT is delivered by a combination of:

- Public sector (state funded) multidisciplinary specialist clinics, targeting clients with complex clinical presentations and treatment needs. These typically are free of charge to clients, and in most cases have the capacity for opioid dosing of clients. The reach of these services varies from between 30-60% of the state's client population, and the 'outlier' is Victoria, which largely disbanded its state-funded opioid treatment system in the 1990's, and has no public sector clinics that provide routine dosing for clients (AIHW 2021). Most public sector clinics also support suitable clients to be dosed in community pharmacy settings, with those clients having to pay community pharmacy dosing fees. An account of the role of public sector services (target client population and model of care) is described in the 2018 NSW Opioid Treatment Program Guidelines.
- Private practitioner programs – predominately provided by general practitioners and some Addiction Medicine and Addiction Psychiatry specialists. In most cases, clients are dosed at community pharmacy settings, although the advent of depot buprenorphine treatment has involved clients being administered their injections at the medical practice, without the involvement of a community pharmacy in the dispensing or supply of depot formulations. In NSW, twelve private clinics have also been established which are funded largely by Medicare (medical staffing) and client payment for dosing on site, with clients often paying in the range of $80-90 per week for dosing.
- Prison based programs, varying in their reach, with the greatest uptake in NSW prison settings (predominately through Justice Health). Prison based programs have historically provided mainly methadone treatment due to concerns regarding the diversion and workloads associated with SL buprenorphine, however, in NSW (and other states) this is largely transitioning more to the use of depot buprenorphine treatment, following demonstration of the safety and cost effectiveness of depot buprenorphine in correctional settings in the UNLOCT study (Dunlop, White et al 2021).

The role of supervised dosing

A key issue that impacts upon costs of ODT for clients is the issue of supervised dosing at community pharmacies and private clinics. Australia established a methadone treatment framework relying on supervised daily dosing of methadone, with the opportunity for take-away doses (TADs) for clients considered at low risk of non-medical use of TADs. In most jurisdictions, methadone TADs are capped at 4 or 5 per week, based on a clinical risk assessment (as described in the National MATOD guidelines, and further described in the NSW OTP Guidelines (2018). The introduction of SL buprenorphine more or less replicated the supervised treatment system, although there is the capacity for 'unsupervised' Suboxone® treatment with clients allowed up to 30 days TADs of Suboxone, based on the prescriber's clinical risk assessment (Gowing et al, National MATOD Guidelines 2014). In practice, relatively few clients were accessing unsupervised Suboxone treatment

– until the recent COVID pandemic. This is in contrast to most international models of sublingual buprenorphine treatment. The two countries with the largest buprenorphine treatment populations – the USA and France provide buprenorphine treatment without supervised dosing. Two RCTs examining the role of unsupervised SL buprenorphine treatment have been undertaken in Australia (Bell et al 2007; Dunlop, Brown et al 2017) – both of which demonstrated comparable safety and efficacy with unsupervised buprenorphine treatment, with improved consumer satisfaction and enhanced cost effectiveness.

One of the greatest concerns associated with unsupervised ODT medications is the risk of diversion and overdose related deaths. Whilst this is relevant for methadone (a potent full agonist), the safety profile of buprenorphine (a partial agonist) means it is associated with lower overdose related deaths and 'all cause' mortality than methadone (Marteau et al 2015; Hickman et al 2018; Komrowski et al 2021, Lam et al 2021, Santo et al 2021), further highlighting the opportunity to reconsider the reliance on supervised dosing for SL buprenorphine treatment. Yet despite the international experience and the evidence supporting unsupervised buprenorphine treatment, Australia has largely persisted with a supervised dosing model of care for buprenorphine – which is the major driver of the cost of this treatment for consumers dosed at community pharmacies.

The COVID pandemic has required ODT services to reconsider their models of care – as highlighted in the Interim Guidance document developed in April 2020 (Lintzeris et al 2020), and endorsed by a number of professional (RACP, Pharmacy Society Australia, RACGP, RANZCP, APSAD, Penington Institute) and consumer organisations (AIVL). These guidelines recommended greater use of unsupervised dosing (particularly with Suboxone) and uptake of depot buprenorphine as strategies to minimise transmission of COVID within this vulnerable population. The application of these guidelines in response to COVID were examined and evaluated by Drug and Alcohol Services at South East Sydney Local Health District, examining changes to services and related client outcomes in 429 clients before and 6-months after the onset of the COVID pandemic in 2020 (Lintzeris, Deacon et al 2021). This evaluation demonstrated a marked increase in the proportion of clients accessing weekly, fortnightly or monthly SL buprenorphine treatment (from 20% to 63% of clients), an increase in the number of weekly TADs for clients in methadone treatment (from 0% to 18%), and an increase in the use of depot buprenorphine (from 12% to 24% of total cohort). The authors reported that this TAD framework was able to be safely implemented in the vast majority of clients, without deterioration in client outcomes. Since that time, SESLHD D&A Services has revised its model of care using a co-design process (involving clinician and consumer input) which has now embedded many of these changes into its treatment model moving forward. A copy of the SESLHD Opioid Treatment Program Model of Care (Lintzeris et al 2021) is provided, and reflects the likely direction that many services will implement as we have to adapt opioid treatment in response to COVID. Given that the need for ongoing vigilance and systems to minimise COVID-19 transmission will most likely need to remain in place for several years, treatment programs across Australia will need to consider how treatment is adapted, with an increasing role for unsupervised SL buprenorphine treatment, greater flexibility with methadone TADs, and increased use of depot buprenorphine.

In summary,

- the emphasis upon supervised dosing of sublingual buprenorphine is likely to diminish given the generally positive experience of unsupervised buprenorphine treatment in many services following COVID, and bringing Australian treatment models of care more in line with international approaches. This is likely to have a significant impact upon how medications are accessed and paid for by clients (see below)
- we can expect further uptake of depot buprenorphine treatment across Australia given its high levels of satisfaction and convenience for many clients, and it is not unrealistic that depot buprenorphine will become the predominant form of ODT in Australia within several years, having achieved this status already in a number of public clinics across the country.
- we can expect a gradual decline in the role of methadone treatment, a trend that has been occurring in recent years with the advent of depot buprenorphine products. Indeed, the demographics of patient in methadone treatment indicates it is increasingly used by 'older' ODT clients, with younger clients being treated more often with buprenorphine products (73.4% of

methadone treated patients are aged 40 years or older compared to 56.7% of buprenorphine treated patients). The transition of prison programs from predominately methadone to increasingly depot buprenorphine, will most likely further hasten the 'demise' of methadone treatment, as a big driver of methadone treatment was the prioritisation of methadone in prison treatment systems.

2. Examine the consumer experience, focussing on equity of access, geographical barriers to access, cultural safety, and affordability of ODT medicines across the different models of service delivery. This will include consideration of access to ODT for at risk population groups including people living in rural and remote areas, Aboriginal and Torres Strait Islander peoples and other populations who may have limited access to health care services, including ODT.

An important principle of effective ODT is informed choice for consumers regarding their ODT medication. Consumers should be able to choose their medication type, based on available evidence of safety and effectiveness, and also on the logistics and practical considerations of treatment with the medications. For example, depot buprenorphine has comparable safety and efficacy to sublingual buprenorphine, but the greater convenience of once a month dosing, often at a lower cost to the consumer, means we are seeing greater uptake of this treatment approach.

The impact of a supervised dosing model for methadone and SL buprenorphine impacts considerably on the consumer experience. The current S100 schedule of these medications (appropriately instituted in the 1970's when methadone treatment was provided only in state-funded clinics and hospitals) is no longer consistent with medications supplied at community pharmacies. Community pharmacies first became involved in dispensing ODT in the late 1980's in Victoria (in response to the need to expand ODT quickly to address the HIV epidemic), and the S100 schedule did not provide any mechanism for reimbursing the labour of community pharmacists, and this cost was shifted to consumers. This appears to have been a historical oversight – in that the there was no attempt to amend the S100 schedule to reflect the increasing role of community pharmacies. Most clients now pay approximately $40-50 per week for their methadone or sublingual buprenorphine medication. This is an inordinate burden on many clients – particularly given the low levels of employment in this client population, and that many are reliant on Jobseeker or Disability pension payments. This is particularly problematic for clients with other social and health conditions. The increasing age of ODT clients also means that they are increasingly experiencing a range of social and health problems – such as social isolation, homelessness, falls, cognitive impairment, mobility problems and chronic health conditions - as highlighted in a study of older clients in opioid and other AoD treatment (Lintzeris, Rivas et al 2016).

The supervised dosing model is particularly burdensome in regional and rural areas, where clients have to travel considerable distances to pharmacies for dosing – further adding to the expense of treatment. In many regional and rural areas, the lack of suitable public transport means that many clients must drive long distances to access treatment – which not only increases the cost and inconvenience of treatment, but also endangers community safety given a proportion of these clients are still using alcohol or other drugs.

In most jurisdictions, state funded programs are designed to address the treatment needs of clients with more severe social and health conditions, and this can alleviate the burden on consumers of community pharmacy dosing fees. However, most public sector programs have not had any significant funding enhancements in 10-20 years, and indeed in NSW where state sector funding has transitioned to activity based funding models, funding for opioid treatment programs has actually reduced by 20-30% in most services in the past 3 years. Furthermore, state funded programs need to be able to transition clients to private services (including community pharmacies) in order to avoid becoming 'silted up' with long term patients. The cost of pharmacy dosing is a major barrier to clients transitioning from public clinics to community pharmacies, and jeopardises the capacity of these programs to provide services to the next cohort of vulnerable clients seeking treatment (e.g. following release from prison, following hospital admission, or for vulnerable clients such as those experiencing domestic violence or homelessness). The need to be able to match consumer needs with appropriate services requires removal of the obstacle of cost to the consumer with community pharmacy dosing.

Another key development in the past decade has been the increasing emergence of prescription opioid dependence, with increasing proportions of patients entering ODT with a background of prescription opioid dependence, usually for the treatment of chronic pain. The current funding models highlight the inequity of the current system. For example, a patient who has developed dependence to oxycodone in the context of chronic pain treatment, may be appropriately treated with SL buprenorphine to address both pain and dependence issues. When treated with oxycodone, the patient can expect to pay $6.60 if a Health Card Holder or $41.30 for a month's supply of medication, and the medication costs go towards the annual PBS 'cap' for the patient. However once treated with Suboxone, the patient will now have to pay on average $40 a week - $160 a month – 5 times more for a patient and 25 times more if they are a Health Card holder. This financial disincentive is a barrier to optimal patient care and patient outcomes.

3. Explore the utilisation of PBS ODT medicines in Australia, including funding, benefits (health system and societal) and costs incurred in the supply and dispensing of Opiate Dependence Treatment Program (ODTP) medicines in pharmacy and non-pharmacy settings. This will include examination of current PBS restriction criteria and the impact of listing of modified release buprenorphine injections on the PBS ODTP.

As stated in response to question 1, the existing S100 funding models for ODT medications are no longer appropriate, and undermine the uptake and viability of this treatment approach given the inordinate burden upon consumers, and its impact upon state funded specialist services to target clients based upon clinical need rather than affordability of medications.

A legitimate problem with methadone is the safety concerns of this medication, with demonstrated risks of overdose deaths, particularly when TADs are diverted to people not in treatment and without tolerance to methadone. Furthermore, the oral liquid formulation requires TADs to be individually packaged and labelled by pharmacists, which increases the labour and cost associated with this treatment. Indeed, the labour for a pharmacist is comparable irrespective of whether the client attends for supervised dosing or receives a TAD. Hence, some form of reimbursement for pharmacists is required for each dose administered or packaged as a TAD.

In contrast, SL buprenorphine is a considerably safer medication, and we can expect increasing levels of unsupervised treatment (e.g. weekly, monthly supplies) in coming years, hastened by the experiences of the COVID pandemic. An advantage of SL buprenorphine formulations when provided as TADs is that daily doses do not need to be individually packaged by a pharmacist, and up to a month of TADs can be supplied as one dispensed item. This provides the opportunity for markedly reduced cost to the consumer, as the pharmacist labour is not substantially different to that involved in supplying a month's supply of another S8 medication (e.g. oxycodone) to a patient. However, despite the reduced labour for pharmacists with unsupervised Suboxone treatment, most community pharmacies continue to charge patients the same weekly price ($40-50 a week) irrespective of whether the patient attends daily for supervised dosing, or attends once a month with TADs. The justification for this practice is unclear, and there needs to be better alignment between the labour involved for the pharmacy and cost to consumer.

The re-imbursement of depot buprenorphine raises different challenges and opportunities. Depot buprenorphine cannot be supplied to the client, but must be administered by a health care practitioner (e.g. nurse, doctor, pharmacist). Increasingly we are seeing four models for this treatment:

- *Public sector (and correctional) treatment settings* – with the client attending services once a month and being administered injections free of charge to the consumer.
- *Private medical practices – with the medical practitioner or practice nurse administering the depot injection, having been supplied directly from the wholesaler, without any community pharmacy involvement*. At present, the health care provider (doctor or nurse) can access Medicare payments for this work, and/or introduce a fee for the client. Anecdotally, many medical practitioners are charging between $20 and $50 for each monthly injection.
- *Private medical practices – with the medication dispensed by a community pharmacy* and supplied to the medical practitioner or practice nurse, who administers the dose at the medical practice. At present, there is no clear payment framework for the community pharmacist, and

indeed the client may never actually attend the pharmacy. Anecdotally, some pharmacists are charging clients between $20 and $50 for each monthly injection, however the justification for this charge remains unclear. There needs to be a mechanism for community pharmacists to be reimbursed for their labour under such a model, and this should be consistent with the cost of dispensing other S8 medications.

- *Depot doses being administered at community pharmacies*. Increasingly, a small number of pharmacies have commenced administering depot buprenorphine at the pharmacy. It is unlikely that this will become widespread practice – given the need for private dosing areas, training and medical record keeping required for this practice, however it will have an important role, particularly as we expand telehealth models of care, where the prescribing medical practitioner may be in an urban setting (e.g. Melbourne, Sydney or Brisbane) for a client in a remote or rural setting who access their dose once a month at a community pharmacy in the nearest town.

The different range of services involved in dispensing ODT medications highlights that neither S85 nor the existing S100 schedule can be implemented universally. S100 systems need to be available to ensure ODT can be delivered in prison, hospital and public clinics, as removal of a S100 listing would make these treatment systems untenable. Similarly, routine S85 schedule does not adequately reimburse community pharmacies for the labour of supervised dosing (and TAD preparation for methadone).

4. Propose improved service delivery arrangements for access to ODT medicines, with an aim of identifying an ODTP that is equitable, timely, reliable and affordable for consumers and stakeholders involved in the supply and delivery of ODT medicines and cost-effective for the Australia Government.

We propose systems that ensure equitable access for consumers, without the inordinate cost burden of current reimbursement models for clients and their families.

We would like to recommend consideration of a 4-tier approach to funding ODT dosing, reflecting the different treatment arrangements most commonly used in Australia

A. Systems that reimburse methadone dosing and supervised SL buprenorphine dosing (defined here as at least 2 supervised doses per week, with up to 5 TADs per week) at community pharmacies. An equitable and simple approach is to extend current funding models in place for Staged Supply of other medications (e.g. S8 opioids, benzodiazepines), in which the pharmacist is reimbursed directly a daily fee ($8.10 per day in the first week then $4.12 per day thereafter) by the Commonwealth for each dose administered – separate to the dispensing fee for the prescription. Hence for clients accessing methadone (irrespective of the number of TADs) or where SL buprenorphine is predominately supervised e.g. (1-5 TADs per week), the pharmacist would be reimbursed $56.84 in the first week and then $28.84 per week for dosing, plus an S8 dispensing fee per prescription. The existing Staged Supply model was designed to assist people who are at risk of drug dependency or who are otherwise unable to manage their medicines safely, however it has explicitly excluded methadone and SL buprenorphine from the system. This exclusion could easily be amended.
B. A reimbursement model for unsupervised SL buprenorphine (i.e. weekly, fortnightly or monthly dispensing, with no more than 1 supervised dose within the interval) and for pharmacists dispensing depot buprenorphine to another health care practitioner (e.g. doctor, nurse) to administer. In this model, pharmacists should be reimbursed an appropriate weekly or monthly dispensing fee (e.g. $20 for either a weekly or monthly dispensing interval), which adequately compensates for their labour – most likely greater than current reimbursements for other S8 medications, and reflects the increased workloads (record keeping, communicating with prescribers) associated with ODT. This would require an amendment to the S100 listing, as it is not consistent with routine S85 payment schedule.
C. A reimbursement model for pharmacists administering depot buprenorphine (e.g. $20 per injection administered) – over and above the dispensing fee referred to point ‘B’ above, that reflects the workload for pharmacists in administering the injection, separate to dispensing.
D. A reimbursement model for medical practitioners or practice nurses administering depot buprenorphine which has been supplied directly to their practice from a wholesaler, with no

pharmacist involvement. This can be reimbursed by Medicare fees charged by the doctor / nurse, with individual patient contributions where the practitioner does not 'bulk bill', and consistent with current practice.

These are summarised in Table 1.

In order to model the cost of these options to the Australian government, we suggest we need to model future service models rather than looking back at historical trends. For example, the following conditions could be used to develop a costings model:

- Approximately 30% of ODT clients remain dosed at public sector or correctional settings where dosing is funded by state governments (not considered further in below model, but recognising the need to retain some S100 listing to ensure continuity in these essential settings)

- Of the remaining 70% of clients dosed at non-public sector services, we will most likely see shifts in the make-up of ODT in Australia, with a reduction in the proportion of patients in methadone treatment (to approximately 25-40% of client population within 5-10 years), an increase in the use of depot buprenorphine to approximately 40-50% of the treatment population, and the remaining 15-25% in SL buprenorphine, of which half will be able to be treated in an unsupervised dosing model (attending a pharmacy once a week, once a fortnight or once a month), and the other half having some mix of supervised dosing and regular TADs (e.g. 0-5 TADs per week). Furthermore, we assume that half of depot buprenorphine in private settings will be supplied by a medical practitioner without pharmacy involvement, and half will be dispensed by a pharmacist, of which half will be administered by the pharmacist, and half supplied to the doctor to administer.

With these assumptions, the following table describes the range of treatment conditions and potential funding for reimbursing health care providers for their labour, and ensures *no cost to the consumer for accessing ODT medication* – consistent with the original intent of the S100 listing of methadone in the 1970's when provided in state run services.

Table 1. Framework for funding ODT medication supply

Medication type and proportion of clients		Dosing conditions and proportion of clients		Reimbursement model for dosing	
Methadone	30%	Supervised	30%	A	Daily staged supply fee at $4.12 / day x 7 days/week + an S8 dispensing fee
SL buprenorphine	20%	Supervised	10%	A	Daily staged supply fee at $4.12 / day x 7 days/week + an S8 dispensing fee
		Unsupervised	10%	B	Dispensing and supply fee (e.g. $20 per weekly or monthly dispensing interval)
Depot buprenorphine	50%	No pharmacy involvement; doctor / nurse administers	25%	D	Doctor / Nurse reimbursed by Medicare / + private contribution if not bulk billed.
		Pharmacy dispenses only (doctor / nurse administers)	12.5%	B + D	Dispensing and supply fee (e.g. $20 per weekly or monthly dispensing interval) Doctor / Nurse reimbursed by Medicare / + private contribution if not bulk billed.
		Pharmacy dispenses and administers	12.5%	B+C	Dispensing and supply fee (e.g. $20 per weekly or monthly dispensing interval) plus Pharmacist administration fee (e.g. $20 per dose administered)

It would be possible for the Committee to develop costing models to the Commonwealth based on these assumptions, and projected client numbers, or to revise modelling accordingly.

We also believe that the variation in prices to the consumer currently charged by different between community pharmacies (some as low as $30 / week, others charge $50 / week) should be addressed, with standard reimbursement for pharmacies, as described in this above reimbursement framework.

In summary, the existing S100 listing is no longer suitable for ODT, reflecting that practice has largely shifted to community pharmacy settings and there is no reimbursement for pharmacist labour (except for patient payment which is inequitable); whilst a standard S85 listing does not reflect the workloads for pharmacists in supervised dosing or methadone TAD preparation. We recommend that a revised S100 listing be developed that reflects contemporary clinical practice, as summarised in Table 1, and that the exclusion of methadone and SL buprenorphine from the Staged Supply funding for pharmacists be removed.

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SESLHD
Opioid Treatment Program
Model of Care

14 Sept 2021

Version 1.0

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Glossary of Terms

BPN	Buprenorphine
BPMH	Best Possible Medication History
BZD	Benzodiazepines
Community Pharmacy	In this MoC, Community Pharmacy refers to pharmacies in the community that have been approved by the Pharmaceutical Regulatory Unit of NSW Health to offer an Opioid Treatment Program.
Consumer Worker and Peer Worker	A worker who primarily identifies with a lived expertise of the impact of drugs and alcohol in their life and can utilise this knowledge and skill base to support others.
Core Elements	Supports and processes that every client is requested to engage in a minimum service.
Elective elements	Additional supports and treatment that are coordinated or provided by the Key Worker. These are included in the care plan when clients have an identified need.
ISBAR	Introduction, Situation, Background, Assessment, Recommendation (standardised information transfer in clinical handover).
Key Worker	A health professional who takes a lead role in co-ordinating OTP services for the client, focussing on ensuring AoD Clinical Care Standards are implemented, and serves as the key contact for the client within the OTP service.
MDT	Multi-Disciplinary Team
MoC	Model of Care describes the way an organisation delivers services.
MOU	Memorandum of Understanding.
NGO	Non-Government Organisation.
Non-Medical Use of TADS	The use of TADs in a manner that was not prescribed or intended. This may include using by another route (e.g. injecting), hoarding doses, using multiple doses at once, not taking doses, and/or giving / selling TADs to another person for whom it was not prescribed.
OAT	Opioid Agonist Treatment – refers treatment with opioid agonist medications (e.g. methadone, buprenorphine) for the treatment of opioid dependence.

OTP	Opioid Treatment Program – refers to services providing opioid agonist treatment.
Private Practitioners	General Practitioners and Specialists (including Addiction Medicine Specialists and Addiction Psychiatrists) working in private healthcare settings (including private OTP Clinics); funded by Medicare, private health insurance and/or patient co-payments; and treating opioid dependence.
SESLHD	South East Sydney Local Health District.
TADs	Take Away Doses: doses of opioid agonist treatment medications that are dispensed in advance to the client for them to take at a future time as directed.
THN	Take Home Naloxone.

1. Introduction and Context

The SESLHD Opioid Agonist Treatment (OAT) program is a community based specialist treatment service for people with opioid dependence in the South East Sydney LHD catchment area. The OAT program is part of the wider SESLHD Drug and Alcohol Service.

Historically SESLHD has delivered Opioid Treatment Program (OTP) services within the NSW Health OTP Guidelines – the most recent version published in 2018(NSW Ministry of Health, 2018). However, the onset of the COVID pandemic in early 2020 required OTP services across Australia to modify their model of service delivery in order to mitigate the risk and manage the consequences of COVID-19 transmission in clients, staff and their close contacts, whilst minimising risks associated with opioid agonist treatment (e.g. methadone related overdoses) to clients and the community.

In March - April 2020 SESLHD made a number of changes to their OTP program, consistent with Interim National Guidance regarding Opioid treatment in response to COVID(Lintzeris, Hayes, & Arunogiri, 2020). These changes remained in place during the first half of 2021, when SESLHD committed to undertake a review of the OTP program, with the aim of co-designing a future Model of Care (MoC) that could be sustained in response to COVID and other environmental challenges that have interrupted routine services in recent years (e.g. bushfires, floods). The longer term context regarding COVID is that a 'zero COVID strategy' is likely to not be sustainable in Australia as international borders open, as a proportion of the community are not vaccinated, and as we expect new COVID variants to emerge in coming years that will impact upon the efficacy of vaccinations to prevent the spread of infections. These conditions require service providers and policy makers to reconsider how we deliver a sustainable MoC for OAT that provides safe and effective treatment, whilst protecting clients, health workers, their social contacts, and the broader community.

This review of the SESLHD OTP MoC has attempted to describe the changes that were made in response to COVID, to examine the outcomes of these changes, and to engage with consumers and service providers regarding their perspectives on future models. Specifically, the review included:

- An evaluation of service changes and client outcomes, using information extracted from electronic medical records (eMR). This evaluation compared clinical outcomes for over 400 clients in OTP treatment from the months immediately before, and for several months after the COVID pandemic began (Lintzeris, Deacon et al., in press);
- Evaluation of staff and consumer perspectives regarding the changes, and examined their preferences for how OTP services should be delivered in the future, through anonymous surveys with >100 clients and almost 40 staff members, and four focus groups – two each with clinicians and consumers;
- A co-design process, facilitated by external consultants, bringing together the key findings from (a) and (b), and reviewing draft future models of care with key stakeholders.

The co-design process aimed to develop an innovative MoC that is client centric, considers equity of access for the community, and supports integrated care and efficient use of resources. The MoC sets the vision for SESLHD OTP services in the future.

The new SESLHD OTP model of care complies with relevant regulatory requirements, builds upon existing NSW Health OTP Guidelines (2018), and aims to learn from the experiences of the past year. Whilst many procedural changes were introduced in April 2020, these changes have themselves had consequences upon how services are accessed and provided. A key difference is that prior to COVID, most clients attended OTP Clinics on an (almost) daily basis; following many of the changes, most clients do NOT attend the OTP Clinic for weeks at a time (e.g. dosed at community pharmacies or on depot buprenorphine treatment). This change requires new ways of working with clients. Change requires ongoing communication between clients and staff. The increasing Consumer Worker profile in SESLHD OTP services is a key element in this change process.

The experience of Aboriginal people within this treatment model will be an important success measure for the program. SESLHD OAT Program provides treatment to a significant number of Aboriginal people and cultural safety is essential. The emphasis within the new Model of Care on tailoring care to each client's needs provides a foundation provide treatment that considers the social and cultural determinants of health that often adversely affect aboriginal people(Marmot, 2011). Aboriginal clients will continue to have access to an Aboriginal Health Worker to support their treatment. The service will continue to strive to provide a culturally secure treatment program.

The implementation of the MoC will impact across a range of areas for consumers, clinical teams and management – including communication between clients and staff; workforce development requirements; refinement of health information and data management systems; and an evaluation framework with clear outcome measures that will enable ongoing assessment of the changes and their impact. Implementation of the new MoC will be incremental over the next 12 months, recognising the work required to address workforce and consumer related issues, and an implementation (and evaluation) strategy is proposed.

2. Foundational principles of the SESLHD MoC

The SESLHD OTP MoC outlines the way services are delivered to achieve high quality and comprehensive Opioid Agonist Treatment (OAT). The MoC aims to be client centric, considers equity of access for the community, and supports integrated care and efficient utilisation of resources. The MoC sets the vision for SESLHD OTP services in the future.

The OTP provides a combination of specialised assessment, medication management, and medical, nursing, allied health and peer support interventions that aim to help clients to address their substance use, and to regain optimal health and valued social roles.

2.1 The services

The program is delivered from three locations, in conjunction with community pharmacies located across the LHD. These are The Langton Centre, St George, and Sutherland.

2.2 The workforce

The OTP workforce comprises of multidisciplinary teams of medical practitioners, nurses, allied health professionals (including psychologists, counsellors, social workers, health education officers), aboriginal health workers, pharmacists, consumer workers, administration staff, and managers.

2.3 The clients

Client eligibility for the SESLHD OTP is consistent with NSW OTP Guidelines (Section 2.2.2). In general public OTP services prioritise clients with more complex treatment needs based on their patterns of substance use, concomitant health conditions, social circumstances and risk profile. Entry to the program is based on the principles of informed consent.

2.4 Practice principles

The SESLHD OAT programs Practice Principles have been articulated from what is important to both clients and staff in how they deliver the program.

These align with the SESLHD values of (i) Collaboration, (ii) Openness, (iii) Respect, and (iv) Empowerment. These are represented in Figure 1.

The practice principles identified below also uphold the three strategic directions outlined in the SESLHD Drug and Alcohol service plan (2017).

1. Provide accessible, high quality D&A treatment services aligned with community and individual needs. This is done in partnership with other (non-SESLHD) specialist D&A services
2. Enhance the capacity of other health (non-specialist D&A) services to manage D&A issues in their client populations efficiently and effectively
3. Ensure the sustainability and continued development of SESLHD D&A Services.

Figure 1. SESLHD OAT Model of Care Practice Principles

High quality services and treatment

The overarching Practice Principle of our services is to provide the highest quality of care.

- Our model of care is informed by the available evidence regarding safe and effective treatment, experience of specialist multi-disciplinary workforce, and the lived experience of consumers.
- Our adherence to AoD clinical care standards upholds person centred treatment.
- Client goals, outcomes and experience of treatment are regularly and routinely examined to optimise care.
- The service operates in a harm minimisation framework.
- The service openly shares our knowledge and approach with clients in formulating treatment that serves their life goals.

Collaboration

We will work together as a team, with our clients and with other service providers to provide the best health care for our community.

Therapeutic collaboration

A collaborative and egalitarian relationship between clients and workers to facilitate dialogues that lead to positive change.

Integrated health

We offer more than just opioid agonist treatment to clients, but operate in an integrated health approach that aims to

- place clients at the centre of care
- provide seamless care within the health system and its interface with social services,
- provide comprehensive support for individuals with complex needs and
- enable individuals to access services when and where they are needed

We consider and contribute to a client's physical, emotional, social, cultural and environmental needs, and will work collaboratively with other service providers to ensure seamless, effective and efficient delivery of care.

Community pathways

We work proactively with our community partners to ensure sustainable pathways beyond the clinic and OTP for treatment.

Human centred design

We know that our service programs and processes are at their best when they are co-designed and tested with diverse and divergent stakeholders, especially with those who access or may access our service.

Openness

The decisions we make are transparent and we accept accountability for our actions. Our clients and their carers have a right to know how and why decisions are made and who is making them

Client & community safety

We consider the risks to our clients and the community in how we deliver our program.

Choice of treatment

We support clients to make informed choices about their treatment, including choice of medications

Transparency

We are transparent in our decision making with clients we provide services to.

Proactive transitions

Clients are constantly navigating transitions within the OAT program. Our role is to proactively work with clients to plan, provide information and extra support to ensure the transitions are smooth and sustainable

Respect

We respect and acknowledge the contribution made by each member of our team in providing the best possible health care for our clients.

Be agnostic

We do not pass moral judgement on clients' life choices. We appreciate that clients try to make the best choices to meet their needs within their current resources and capacity. Our role is to assist clients to develop strategies that better meet their needs without compromising their safety or wellbeing.

Right to safety & autonomy

Our role is always to uphold clients' right to self-determination, autonomy and full community participation, and with the rights of client and community safety. We work with key stakeholders to ensure that our program design and delivery provides opportunities for both to be upheld. This includes cultural safety.

Least restrictive

We always consider practices that are least restrictive to clients' lives, balanced with rights of client and community safety.

Peer to peer

We value the power of and unique contribution a workforce with lived experience can offer clients in their journey, and in improving the quality of care provided by the service. We acknowledge lived

experience can provide support and guidance that is different to the inputs of clinicians and other staff.

Empowerment:

We will work with our clients and their carers to enable them to take greater control of their own health care. We acknowledge that for empowerment to work there must be trust between our clients and all staff involved in the provision of health care.

Treatment in YOUR community

The program maximises opportunities for clients to access treatment in their local community.

Capacity building

We invite clients to utilise the psychosocial supports, interventions and wellbeing education the program provides as proactive opportunities to increase their self-management and self-efficacy capabilities.

Tailored flexible supports

We tailor treatment solutions and support with clients through their changing needs and situations.

Maximum access

We provide services to as many clients we can, who have a need for specialist OAT Services. Our aim is not to keep clients in the public program indefinitely. The time in the service may vary for each client but always with the ultimate goal of clients completing treatment or transferring their ongoing treatment to their local community.

3. Components of the SESLHD OTP Model of Care

There are several key care components that form the Model of Care (MoC). Key elements include

- The Clinical Partnership: key individuals involved in client's care
- Core components of the service: central elements of care for all clients throughout their OTP episode
- Elective components of the service: elements of care that are tailored for each client, and can be flexibly included at different stages of a client's treatment
- Program Support Functions: workforce and organisational conditions that support the provision of OTP services and embed the Model of Care into routine practice.

The overarching Model of Care is outlined in Figure 2.

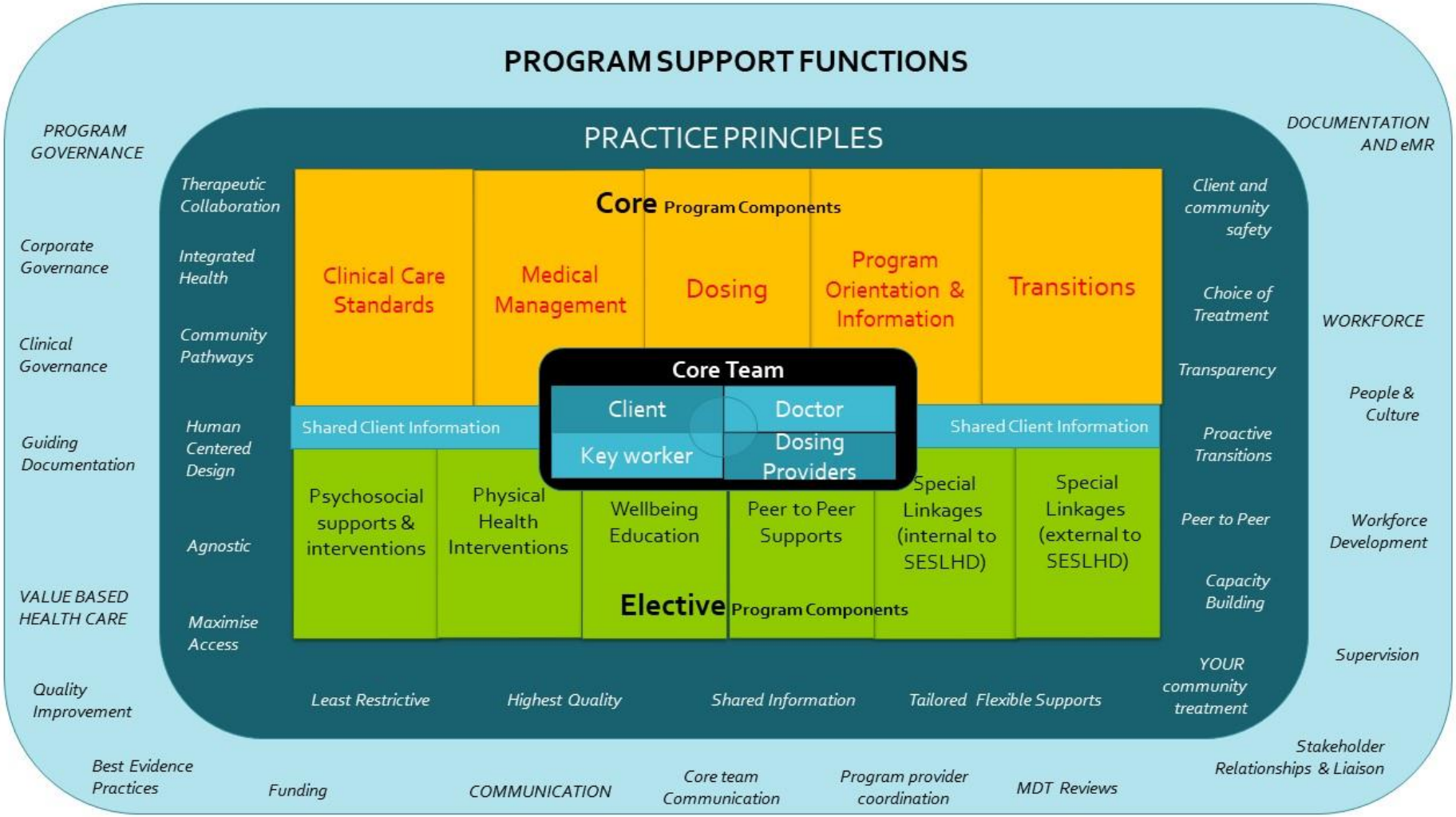

Figure 2: SESLHD OAT Model of Care

3.1 The Clinical Partnership

The **Primary Clinical Partnership** in OTP service comprises of (i) the Client, (ii) the Key Worker, (iii) the Doctor and, (iv) Dosing providers at clinics or community pharmacies. These four comprise the Core OTP team for each client.

1. A person seeking treatment for opioid dependence becomes a **Client** of the service following Intake, and remains a client until discharge from the service. OTP is a voluntary program, and informed consent underpins all aspects of care. The client may choose to engage carers, family members, or friends in their treatment, and/or may seek support and advocacy from SESLHD D&A Service Consumer Workers or external peer workers (e.g. OTL, NUAA peer line). Clients' cultural background may influence whether family or friends are included in the Primary Clinical Partnership with the Client making the final decision on their inclusion.
2. Every OTP client will have a designated **Key Worker,** defined as a health professional working within the OTP service who takes a central role in coordinating OTP treatment with the client, and ensures the NSW AoD Clinical Care Standards are implemented in a timely manner. The Key Worker provides continuity, ensuring the client knows who to access for information and assistance. Key workers work as part of a multi-disciplinary team, drawing on the expertise of other professional disciplines as required.
3. The **Doctor** is the SESLHD medical practitioner (an addiction medicine specialist, addiction psychiatrist or registrar) that holds the individual patient authority for OAT (the 'permit'), prescribes opioid agonist medication for the client, liaises with other treatment providers, and monitors the client's health status.
4. **Dosing providers** are health professionals involved in dispensing and/or administering opioid agonist medications to clients, and may be part of the clinic (e.g. nurses and pharmacists at Langton, St. George, or Sutherland OTP) or pharmacists working in community pharmacies.

The Model of Care requires strong engagement, communication, and collaboration between all members in the clinical partnership, especially the client. The range of service providers involved in the client's care, their roles and interventions should be identified and documented in the client's Global Care Plan, and reviewed at regular intervals.

Additional providers are engaged as indicated by the global care plan and the key worker's scope of practice. Additional providers can be drawn from within the OTP teams (e.g. social worker, psychiatrist), within SESLHD D&A Service (e.g. aboriginal health workers, consumer workers, counselling team, forensic program, Assertive Community Management team, hospital consultation & liaison service), other services in SESLHD (e.g. Mental Health, dental services, BBV services), or external to SESLHD (including other medical or allied health specialists, non-government organisations, National Disability Insurance Scheme providers and GOs, NDIS, DCJ workers). A client's GP is considered an 'additional provider', who usually plays a key role in co-ordinating social and health care services for the client in the community, consistent with the principles of integrated health care.

Regular and effective communication between OTP services and additional providers is an important element of the Model of Care, consistent with the NSW AoD Clinical Care Standards and principles of integrated health care.

Shared Information:

The role of each member of the OTP clinical partnership, their scope and expectations should be clearly articulated, and communicated verbally and in writing for each client. Clients should know the names of their 'team', their role and how to contact them. This should be updated as required, particularly at transition points in the client's OTP treatment. Clients should be given the opportunity to include family and other supports in their primary partnership, particularly where culturally indicated. There should also be clear communication with clients regarding the roles of Additional Providers associated in their care, and documented in the client's global care plan. This should be updated at regular intervals.

3.2 Core elements of OTP service

There are 5 (five) Core elements of the service provided for **all SESLHD OTP clients** (figure 3)**,** which are in keeping with the safe provision of OAT and the implementation of the NSW AoD Clinical Care Standards. The OTP Core elements are predominately delivered by the core team (clinical partnership between client, key worker, doctor and dosing provider).

3.2.1. Clinical Care Standards

The provision of the NSW AoD Clinical Care Standards (NSW Health, 2020) is an essential component of safe and effective AoD treatment for all clients, including for those in the OTP (figure 4). These include:

- Intake: involves a brief assessment of the client's presenting issues, substance use and high risk conditions (health or social issues). Clients may self-refer or be referred by health providers (e.g. GP, other OTP providers, HAD-CL, other SESLHD units, Justice Health). Intake services are provided by the SESLHD D&A Centralised Intake service, with Intake workers liaising with each OTP team to determine client eligibility and organise a comprehensive assessment where indicated.
- Comprehensive Assessment involves a structured assessment of the client's reason for presentation, substance use, prior and current AoD treatment, physical and psychological health (including screening for cognitive impairment), and social circumstances (including social and family networks and supports, legal, housing, vocational and financial conditions). Particular focus should be given to details of prior and current OTP, including medication type (e.g. methadone or buprenorphine), treatment provider and response to treatment.
- Global Care Planning: engages clients in collaboratively planning their treatment program so that it is tailored to their individual goals and needs. The Elective Program Components that are

relevant should be included in the GCP. Transfer of Care plans for dosing and/or prescribing should be included in the GCP.

- Monitoring of treatment progress and outcomes. Including regular monitoring of substance use, health and social conditions (e.g. using ATOP and other patient reported measures as appropriate (e.g. Brief Pain Inventory for pain, MoCA for cognition, biological monitoring)
- Identifying, responding to and monitoring risk including (but not limited to) non-attendance risk, risks of domestic violence, child protection concerns, overdose risks (including provision of Take Home Naloxone (THN)), risks of harm to self or others, injecting risk practices, falls risk, and unwanted pregnancy.
- Transfer of care – including appropriate handover and documentation when clients transfer their care to other OTP service providers or discontinue OAT (completion of withdrawal from OAT, or discharge against medical advice).

Figure 3: OAT Program components and delivery foci

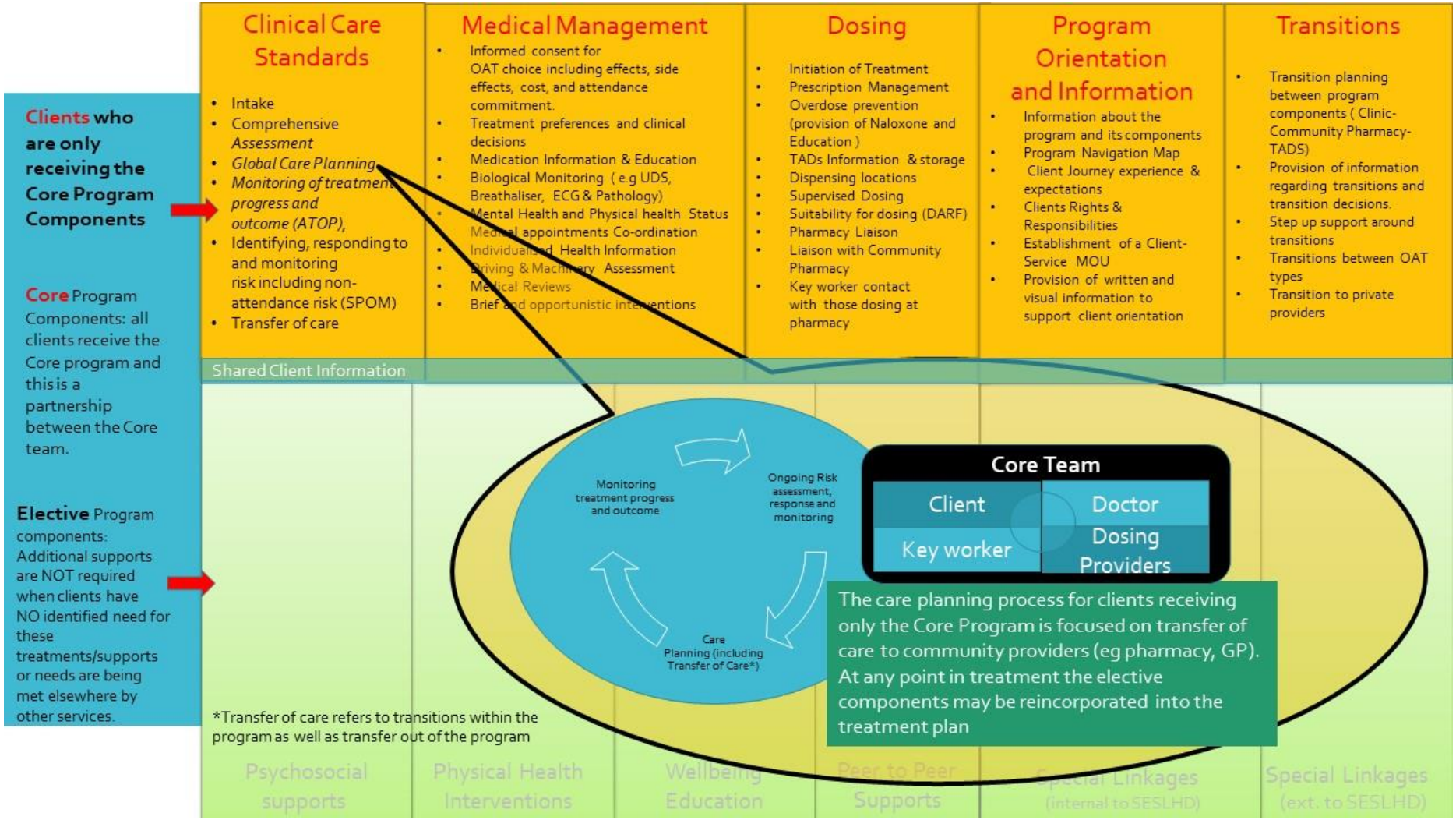

Figure 4: Core Delivery Functions

In SESLHD D&A Services, Intake is co-ordinated by the Central Intake process working with each OTP service. The Comprehensive Assessment (as documented in eMR) is usually conducted by an OTP nurse or allied health professional, followed by a medical assessment with the OTP medical practitioner, following which a treatment plan is initiated. Clients accessing the OTP on "temporary transfer" arrangements from another OTP will not be required to have a comprehensive assessment; staff will obtain a clinical handover from the other service, and when the transfer occurs collect the NSW MDS data and conduct a clinical review using the ATOP.

A key worker is usually assigned within 1-2 weeks of the client undertaking their Comprehensive and medical assessments, and thereafter, the key worker is responsible for co-ordinating the remaining care standards of global care planning, treatment monitoring, risk management and transfer of care, in collaboration with the other members of the client's core OTP team.

Each key worker should engage with clients in implementing the clinical care processes according to the client's medical and social needs and strengths, working in collaboration with Core OTP providers (medical practitioner, dosing providers) and Additional Providers (e.g. GP, other service providers), recognising that these are likely to change throughout the client's treatment over time.

Shared Information:

OAT clinicians and peer workforce should share information with clients about Clinical Care Standards and how they underpin the treatment process.

3.2.2. Medical Management

Medical management in the OTP program is overseen by the client's OTP medical practitioner. Key roles and activities include:

- To work with clients to identify and provide their opioid agonist medication options (methadone, SL BPN, depot BPN), based on informed consent principles and effective communication regarding the available evidence, benefits and limitations of different medications, potential side effects, client's preferences, logistics and long-term cost of treatment choices (e.g. dosing conditions, pharmacy expenses).
- Attend to regulatory requirements of prescribing opioid agonist treatment, including NSW Health Authority to prescribe permits, and ensuring prescriptions comply with regulations;
- Prescribe opioid agonist medications safely and effectively, consistent with NSW OTP Guidelines and the SESLHD Model of Care;
- To attend to potential adverse events and drug-drug interactions associated with prescribed opioid agonist medications; this requires the medical officer to regularly undertake and document best possible medication histories (BPMH (DAS SESLHD, 2021b)) and update medication history on eMR. Where appropriate Pharmacists will assist in gaining a BPMH, particularly where secondary source verifications are required.
- Determine dispensing locations according to clinical criteria and client preference, including access to Take Away Doses (TADs) as clinically indicated, and to regularly liaise with dosing providers. The medical officer is responsible for regularly updating this information in the eMR OST Module.

- Assess, manage and monitor mental and physical health status of the client (including regular best possible medication reviews), and to work with other health providers as appropriate. This may include treatment for co-occurring conditions such as HCV, mental health, chronic pain and other substance use disorders including tobacco;
- Co-ordinate biological monitoring as indicated (e.g. UDS, breathalyzer, blood tests (including viral serology), ECG);
- Attend to risk practices associated with opioid agonist treatment, including risk mitigation for TADs, overdose prevention (including THN provision), Driving & Machinery Assessment Medical Reviews;
- Communicate regularly with key worker, dosing staff and additional service providers as clinically indicated.
- Provide individualised health information to clients (and carers as appropriate).

Shared Information:

Clients should be provided with information about the range of opioid treatment medications, their pharmacological effects, and the impact that medication choices have on later treatment delivery (eg dosing location, TADS, and cost).

Transitioning to private practitioners

In order for SESLHD OTP services to be able to have the ability to intake new clients, it is imperative that clients transition to private practitioner when clinically indicated, and for the medical practitioner and key worker to assist clients in this transition. It is expected that most clients will transition into other opioid treatment programs over time – usually into community settings with GP or specialist practitioners, or to private clinic programs. Transfer of a client's prescribing doctor usually also involves transferring key worker and dosing functions to community providers, and exit from the SESLHD OTP service, and is a major transition point for the client.

The NSW OTP Guidelines (Section 2.2.3) provides guidance on determining whether a client needs to be prescribed in a public clinic – or whether they are suitable for treatment in a community setting. These conditions are summarised in Table 1.

Clients and private practitioner may require additional supports during this transition. The client may already be familiar with their next prescribing doctor (e.g. existing GP, previous treatment), or may be referred to a new doctor they have not previously seen, and the latter scenario may increase anxiety for the client (and doctor). For descriptions of transitioning care is provided in Section 3.2.3 below.

Actively supporting clients to transition to private practitioners helps to ensure that SESLHD OTP services can more readily accept new clients and receive return referrals for clients whose needs have become too complex for a private setting and need a specialist program.

Table 1. Matching OAT prescribers with clients

Prescriber in Public OTP service	Prescriber in other community or private setting
High levels of polydrug use, particularly alcohol, benzodiazepine or methamphetamine use disorder	Other substance use not clinically problematic
Serious or unstable physical and/or mental health issues. This may include recent overdose history, cognitive impairment, significant risk of harm to self or others	No other serious health conditions requiring active interventions Physical or mental health issues (if identified) can be adequately addressed by private practitioner.
Significant psychosocial issues such as homelessness, domestic violence, child protection concerns	Stable social circumstances, with good supports No other risk factors identified (harm to self or others, domestic violence, child protection, homeless)
Clients who require more intensive services, assertive follow-up and/or coordination across a range of service providers due to: ▪ recent release/discharge from custody or hospital ▪ pregnancy or recent child birth ▪ engagement with multiple service providers requiring active case coordination, such as community services, drug court ▪ a history of poor engagement with services, frequent missed appointments. ▪ significant cultural issues impacting on treatment (e.g. Aboriginal, CALD clients)	

3.2.3. Dosing

Dosing refers to administration (by nursing staff) or dispensing (by pharmacists or medical practitioners) of opioid agonist medications. The roles and activities include:

- Safe administration and dispensing of opioid agonist medication as prescribed, and according to NSW OTP Guidelines, SESLHD Procedures and Business Rules, and local Standard Operating Procedures (SOPs).
- Prescription Management (including use of iDose technology within SESLHD OTP services)
- Safe initiation of opioid agonist treatment, including regularly monitoring for adverse events
- TADs Information & storage consideration, and risk mitigation, including THN provision

- Attending to high-risk medication issues, including managing intoxicated presentations, missed doses, and monitoring and review of clients initiating opioid agonist treatment
    - Communicate regularly with key worker, prescribing doctor and additional service providers as required.

Key workers and medical practitioners should liaise regularly with dosing staff regarding client attendance for dosing, and any issues identified (e.g. missed doses (DAS SESLHD, 2021c), intoxicated presentations(DAS SESLHD, 2021a), behavioural concerns).

Shared Information:

Clients should be informed that most clients will be accessing their dosing at their local community pharmacy. This information should be shared early in the engagement with clients.

Determining dosing site: clinic or pharmacy.

In general, dosing at a SESLHD OTP clinic is a transitional arrangement prior to clients moving to community pharmacy. Some clients may require a temporary return to clinic dosing for short periods of time until they become suitable to return to pharmacy. A small number of clients may not meet clinical criteria for pharmacy dosing and remain dosing at clinics long term. See figure 5.

It is important that services ensure that dosing sites are matched to client needs and preferences. With regards to methadone and SL buprenorphine, the need to limit congregation at public clinics (in response to COVID), and the limited capacity for the number of clients that can be dosed at public clinics requires that clients will transition to community pharmacy, unless the prescribing doctor identifies contra-indications or serious concerns regarding the suitability of community pharmacy dosing, or where no community pharmacy can be identified for a particular client (e.g. due to previous client behaviour at pharmacies).

The indications for a client to be dosed at a public clinic include:

1. Initiation of OAT usually requires regular dose adjustment and daily monitoring of clients (eg Drug and Alcohol Review Form [DARF]), which are more easily facilitated with clinic dosing. This normally applies until client stabilises their OAT dose (e.g. up to 1-2 months methadone, 1-2 weeks Suboxone). Note clients with low risk factors (no significant polydrug use, medical or social problems) can initiate treatment with dosing at community pharmacy, and details regarding initiating at a community pharmacy (client criteria and treatment procedures) are identified in Section 2.2.3 of the NSW OTP Guidelines (NSW Ministry of Health, 2018).
2. Release from custody: usually first 4 weeks following release from custody
3. Frequent missed doses (≥3 doses per week) or extended periods missed doses (4 or more days consecutive) for any reason (Non-attendance, intoxication)
4. Frequent intoxicated presentations at dosing site (e.g. presenting once a week or more in past month)
5. Alcohol use disorder requiring frequent breathalyser assessment
6. Regular non-attendance at appointments with prescribing doctor or key worker.
7. Concerns identified by community pharmacist (e.g. behavioural difficulties)

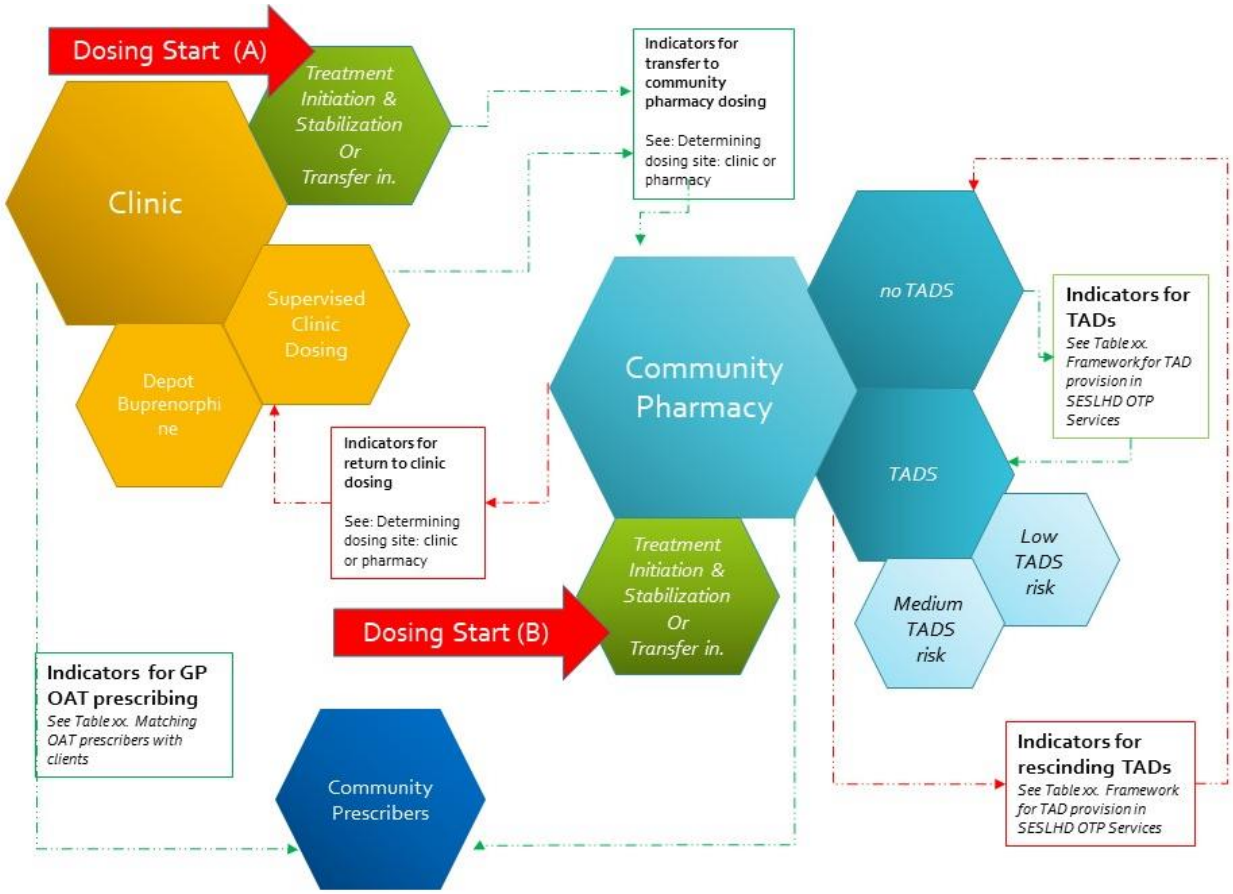

Figure 5: Dosing Locations.

In general, clinic dosing is most appropriate at the initiation of OAT, and most clients can transition to pharmacy dosing within 1 to 6 months of commencing treatment. In some instances, a client at a pharmacy may develop issues that require them to return to clinic dosing (e.g. regular missed doses during a period of homelessness, or relapse to heavy substance use with frequent intoxicated presentations or missed doses) until these issues can be addressed.

Transitioning to community pharmacy dosing

This represents a shift from historical approaches, whereby expectations regarding transitioning to pharmacy has not been clearly identified within OTP teams or with clients. Whilst a recent survey suggests most OTP clients have a preference for dosing at a community pharmacy, there are a minority of clients who may be reluctant to transfer to community pharmacy. This may occur for a number of reasons:

- Financial implications of community pharmacy dosing fees;
- Anxiety about making changes to their routine;
- Fear that they are being 'kicked off the program', and/or uncertainty about how they access help or support from the OTP service if they are not attending regularly (e.g. where there may have been a history of opportunistic 'catch-ups' with key workers;
- Poor prior experience with dosing at a community pharmacy;

Transferring to a pharmacy is a 'transition point' that requires additional supports for many clients. A range of strategies can assist this transition. These include:

Clear and consistent communication with clients at regular intervals. This includes at entry into the OTP, and at regular reviews with key workers and prescribing doctor. Issues regarding dosing sites are included in Program Orientation Guide. Clients need to understand the expectations regarding pharmacy dosing at the outset of their treatment, as this may impact upon their choice of medications (e.g. a client wishing to avoid pharmacy dispensing fees may choose depot BPN treatment which is generally associated with lower client dosing fees in the community).

Identifying and addressing potential barriers identified by the client (see list above). In some instances, additional support from key workers or consumer workers (e.g. attending the pharmacy with a client who is anxious about the change) may be required.

Financial barriers to dosing at a community pharmacy are not routinely a reason for continuing dosing at a public clinic long-term. Where financial barriers are identified, refer to the SESLHD DASBR/15Financial assistance scheme for clients of the Drug and Alcohol Service , which provides capacity to support clients transitioning to (or remaining at) a community pharmacy. SESLHD OTP will no longer routinely support requests for returning to clinic dosing for 'financial respite' reasons.

Liaison with and support to community pharmacists

Community pharmacists play an integral role in delivering safe and effective OAT, have regular contact with clients being dosed at pharmacies, and have an important role in supporting clients and in communicating with the key worker and prescribing doctor.

Key workers and doctor must liaise regularly with community pharmacists in monitoring client progress, attendance for dosing, intoxicated presentations, or any other issues or concerns regarding client behaviour or payment of dosing fees.

Individual pharmacies may wish to enter into a formal Agreement or MoU between the community pharmacy and OTP service, which identifies the roles and responsibilities of the pharmacists and OTP service, with the client being made aware of the agreement.

Shared Information:

Clients are told about the role that Community Pharmacy will have in their ongoing treatment early in their engagement with the OTP program. This information is also provided in written format. In the client navigation map.

Providers should reinforce that when accessing their dosing through Community Pharmacy they are still an active SESLHD OTP client, have a key worker, and continue to receive treatment and support from the OTP team.

Supervised dosing and take-away dosing schedules.

Historically, treatment of opioid dependence with methadone or buprenorphine in Australia has been based on daily, supervised dosing at a pharmacy or clinic, with access to takeaway or unsupervised doses available according to individual client circumstances. Supervised dosing provides some benefits, but many clients find the requirements of daily supervised dosing intrusive

and not compatible with community re-integration through activities such as work or study. Recent developments (risks associated with COVID-19, introduction of depot buprenorphine products) have changed the landscape regarding supervised and unsupervised dosing decisions. Whilst COVID has increased risks to clients and staff of regular attendance for dosing, depot buprenorphine has obviated many of the concerns or risks associated with unsupervised doses. The potential benefits of different dosing schedules are shown in Table 2. There are also potential harms associated with takeaway doses of opioid medicine to the client, to others intentionally or accidently (e.g. children) using opioid medicine, and to the broader opioid treatment program (Table 3).

Table 2. Potential benefits of different dosing regimens

Supervised dosing	**Unsupervised dosing or use of BUP-XR**
▪ Greater adherence to the medicine regimen, with less diversion to others and less non-medical use (e.g. unsanctioned dose changes, injecting) of medications ▪ Less risk of overdose, with less risk of dosing of intoxicated clients, following missed doses (lowered tolerance), or use of excessive doses ▪ Daily structure and routine that can be important for many clients early in treatment.	▪ Improved re-integration into normal daily activities and routines by reducing the inconvenience of regular pharmacy attendance (particularly for workers, or in regional or rural areas) ▪ Reduced cost of treatment to clients by reducing dispensing fees (for unsupervised Suboxone®, BUP-XR treatment) and travel costs ▪ Reduced risks of COVID-19 transmission for clients, staff and their social contacts (e.g. household members) ▪ Facilitates treatment engagement by enabling clients with travel difficulties, work or other commitments to maintain regular dosing ▪ Enhanced treatment outcomes, in which positive behaviours (e.g. regular attendance for appointments or dosing, cessation of other substance use) are linked to increased access to takeaway doses, consistent with the principles of contingency management ▪ Greater client self-autonomy in the management of their medicine and treatment in general, consistent with the principles of chronic disease management ▪ Reduced stigma associated with regular attendance at pharmacies, particularly where there are concerns regarding confidentiality for the client ▪ Reduces contact with other clients who may still be actively using and can serve as a trigger for relapse

Table 3. Potential harms associated with unsupervised doses

Activity	Safety Concerns
Client using takeaway dose whilst intoxicated on other drugs	Further intoxication, sedation and overdose. Particular concern with methadone, or clients initiating treatment
Client being dosed after period of several missed doses	Intoxication or overdose (if has reduced tolerance) on recommencing. Particular concern with clients on high doses of methadone (e.g. >80mg daily). Precipitated withdrawal if recommencing SL BPN/BNX after recent opioid agonist use (e.g. heroin)
Poor medicine adherence (e.g. taking higher or lower doses than prescribed)	Intoxication and overdose Reduced treatment effectiveness if missing OAT doses (e.g. running out of medicine early, relapse to other substance use, destabilised other conditions)
Use by non-prescribed routes (e.g. injected, intranasal)	Intoxication, overdose (higher peak plasma concentration) Vein damage, infections, blood borne viruses
Intentional or accidental use of opioid medicine by person for whom not prescribed	Intoxication and overdose risk (particular concern with children and others with low opioid tolerance) Opioid related harms, including adverse drug effects, route of administration, economic, legal and psychosocial consequences Development of dependence to medicine if used regularly
Illegal activities associated with selling, diverting or possession of medicines not prescribed to client	Regulatory and legal and consequences
Client being a robbery target while transporting doses home	Physical or emotional harm due to robbery. Use of opioid mediation by person for who not intended (see safety concerns above).
Poor reputation of opioid treatment from non-medical use of unsupervised medicine	Stigma against clients and treatment services Reduces attractiveness of treatment to target population, health providers and community

The takeaway guidelines in the SESLHD MoC reflect the need to individually tailor dosing conditions according to the relative benefits and risks for the client, the service and the broader community. The guidelines aim to strike a balance between client autonomy, practitioner duty of care and public concerns about diversion of medicine. Dosing decisions are based on phase of treatment, medicine used and risk assessment (see below). Going outside of these guidelines is a clinical decision that requires documentation.

Generally, during the induction and stabilisation period supervised dosing is recommended. This is because of frequent dose adjustments, development of tolerance to medicines, ongoing client assessment, and changing patterns of substance use, general health and living conditions. The risk of harms from takeaway doses is higher during this period. It is also an opportunity to develop rapport and trust with a new client. Treatment with buprenorphine-naloxone enables a faster and safer induction and stabilisation phase than methadone, accommodating earlier access to takeaways and unsupervised dosing of buprenorphine-naloxone.

Making and documenting decisions regarding takeaway or unsupervised dosing

Prescribing doctor should conduct and document regular risk assessments regarding the suitability of takeaway doses. When assessing the risk of takeaway dosing, harms to the client, to others and to the broader community need to be considered. A risk assessment for takeaway dosing can be generally performed using clinical information routinely obtained as part of regular reviews by the treating team with clients. TAD schedules should be reviewed frequently (minimum of every three months), particularly as client's circumstances, substance use and health conditions change.

Table 4: **Framework for TAD risk assessment in SESLHD OTP Services**, Table 5: **Defining substance use and TAD risk** and Table 6**: SESLHD OTP Framework for TAD schedules** highlight the key approaches to determining TAD conditions for individual clients.

Decision making regarding TADs requires:

- structured clinical assessment (conducted and documented using ATOP and clinical interviewing)
- a review of dosing histories (including communication with dosing staff) to identify risk factors,
- working with clients (and carers) to identify and implement risk mitigation strategies (see below). This must include completion of (a) Safe Storage and Use Medication Agreement completed (copy in file, copy provided in client information pack for those receiving TADs); (b) assessment for and documentation of THN interventions in eMR.
- communication with the client regarding dosing schedules, how decisions are made and reviewed, and client's responsibilities regarding safe use of TADs (see Table 7). All clients accessing TADs are to receive Client Information Pack regarding safe use of TADs.
- communication with the treatment team regarding dosing conditions (including updating OST Modules in eMR) and responsibilities of different team members (see Table 7)

Risk assessments require communication and exchange of relevant clinical information between the clients and service providers, particularly between OTP providers involved in prescribing, dosing, key worker roles, and in some cases with other health, custodial health services, or welfare agencies as required.

Table 4. Framework for TAD provision in SESLHD OTP Services

Criteria area	Related Harm/ Indicator	Low Risk TAD related Harms	Mod Risk TAD related Harms	High Risk TAD related Harms
Substance use	Low, moderate or high risk defined table below	Low risk substance use re: TAD safety	Moderate risk substance use re: TAD safety	Higher risk substance use re: TAD safety
'Misadventure' with TADs	Evidence of TAD diversion to others; attempted diversion at dosing site	No concerns	Past history (past 6-12 months) but no recent concerns (past 3 months)	Evidence of recent concerns (within last 3 months)
Stable OTP dosing	Missed doses (for any reason - including non-attendance or intoxicated presentations)	No or infrequent missed doses (<1 day a week past month average)	Infrequent missed doses (<3 doses per week past month average	Frequent missed doses (≥3 doses per week) or frequent extended periods missed doses (>3 days consecutive)
	Commencing treatment	Stable OTP dose (usually at least 2 months in methadone treatment and 2 weeks Suboxone treatment)	Stable OTP dose (usually at least 1 month in methadone treatment, or at least 1 week in Suboxone treatment)	Recent initiation OTP treatment and dose not yet stabilised (usually 1st month methadone, 1st week Subxone)
Health factors increasing TAD risks	Concerns re: TAD safety from health conditions (e.g. liver, respiratory disease, psychosis, suicide risk, impaired cognition)	No concerns	Concerns regarding health conditions and TAD safety	Concerns regarding health conditions and TAD safety
Social factors increasing TAD risks	Capacity for safe storage and use of TADs: includes homeless, pressure to divert, children, DV	No concerns	Minor concerns re: safe storage and use of TADs	Concerns re: safe storage TADs or use of TADs
Non-attendance at appointments	Repeated non-attendance limits risk assessment.	No concerns	Repeated non-attendance at appointments	Repeated non-attendance at appointments and no recent clinical review
Issues attending for dosing	TADs settings should also reflect client needs / ability to attend for supervised dosing – e.g. work, travel, transport, mobility issues, closed pharmacy. Where TAD safety does not align with capacity for dosing – tailor response accordingly (alternative arrangements such as carers, temporary transfers)			

Table 5. Defining substance use and TAD risk

	Low risk substance use re: TAD safety	Moderate risk substance use re: TAD safety	Higher risk substance use re: TADs
Opioids. Heroin or non-medical use prescription opioids	No recent use and low risk for 'relapse' or resumption of use	Infrequent use of unsanctioned opioids (<3 days / week on average)	Frequent use (e.g. ≥3 days/week on average) High risk injecting (e.g. deep vein injecting, history of injecting TADs)
Alcohol	No or low-risk use (drinking <4 STD/day) No evidence recent intoxicated presentations (e.g. BAL >0.05, overdoses, falls)	Drinking 4-8 STD / day on 3 or more days per week (average). Past history but no recent (past 3 months) intoxicated presentations (e.g. BAL >0.05, overdoses, falls)	Diagnosed active Mod-severe alcohol use disorder (AUD) Drinking ≥8 STD / day on ≥3 days a week Recent (past 3 months) intoxicated presentations (BAL>0.05, overdoses, falls)
Benzodiazepines Low dose: <20mg oral diazepam equivalent / day (ODE) High dose: ≥20mg ODE / day	No use of BZDs or Low dose BZD use as prescribed, with communication between OTP team and doctor prescribing BZDs, AND No evidence of BZD-related intoxication (e.g. intoxicated presentations at dosing, overdose, falls) or withdrawal (e.g. seizures, severe anxiety, panic attacks)	Reported low dose use as prescribed but no communication with BZD-prescribing doctor. High dose BZD use as prescribed, with communication between OTP team and doctor prescribing BZDs Infrequent (<3 days / week) non-medical use Past history (6-12 months) but no recent (past 3 months) BZD-related intoxication or withdrawal	High dose use as prescribed but no communication with prescribing doctor Frequent (≥3 days per week) non-medical use; Recent history (past 3 months) BZD-related intoxication or withdrawal
Stimulants (ATS, cocaine)	No use of stimulants or infrequent use (e.g. less than once a week past month)	Infrequent use of stimulants (<3 days a week on average);	Frequent use of stimulants (>3 days a week on average)
Sedative medications Eg. Pregabalin, trycyclic antidepressants, antipsychotics, GHB	No use or low dose use only as prescribed (with communication with prescribing doctor) No evidence of harms (e.g. overdose, intoxication, falls, discontinuation effects)	High dose use but only as prescribed and communication with prescribing doctor Infrequent (<3 days / week) non-medical use Past history (6-12 months) but no recent (past 3 months) intoxication or withdrawal No evidence of harms (e.g. OD, intoxication, falls, discontinuation effects)	Frequent non-medical use (≥3 days per week) High dose use with no communication with prescribing doctor) Evidence of harms past 3 months (e.g. OD, intoxication, discontinuation effects)
Injecting drug use	No evidence recent high risk injecting (groin, neck) or related harms (e.g. systemic infections linked to possible TAD injecting)	Past history (past 6-12 months) but no evidence recent (past 3 months) high risk injecting or related harms,	Evidence recent (past 3 months) high risk injecting or related harms

Table 6. SESLHD OTP Framework for TAD schedules

	Low Risk	Moderate Risk	High Risk
Methadone	6 TADs per week	1-5 TADs per week Generally initiate with small number TADs (e.g. 1-2 per week), increasing to 5 TADs per week as client demonstrates safe TAD use and no clinical deterioration. Aim to minimise multiple consecutive TADs as much as possible (e.g. 1+1+2 TADs is safer than 4 consecutive).	No TADS unless exceptional circumstances
Suboxone	6 day; 13 day or 27 day TADs Generally initiate with 6 TADs per week, increasing as client demonstrates safe TAD use and no clinical deterioration	3-6 TADs per week Generally initiate with small number TADs (e.g. 2-3 TADs per week), increasing to 5 TADs per week as client demonstrates safe TAD use and no clinical deterioration	No TADs unless exceptional circumstances

Risk mitigation strategies

There are multiple strategies that aim to minimise potential harms associated with takeaway and unsupervised dosing. These include:

- Clear communication with the client and relevant others (e.g. carers, family members) regarding the conditions for unsupervised doses, and their responsible storage and use of their medicine - between service providers, particularly where there are concerns regarding the safety of unsupervised doses - regarding the roles and responsibilities of each person. Client, doctor and pharmacist responsibilities regarding TADs are shown in Table 7. These are documented in the Safe Storage and Use Medication Agreement and Client Information Pack regarding Safe Use of TADs
- Use of safer opioid preparations. The use of depot buprenorphine preparations avoids potential harms associated with unsupervised doses (see Table 3) and should be prioritised where the client does not want regular supervised dosing but has persistent risks that limit their suitability for TADs. Takeaway doses of SL buprenorphine-naloxone are generally associated with fewer safety concerns than methadone, due to the lower risks of overdose and respiratory depression, the greater flexibility of dosing (e.g. safety of 'double dosing' with buprenorphine), and the fewer concerns regarding interactions with other drugs. Clients with a history of methadone injecting may have this risk mitigated by dilution of takeaway doses (the prescribing doctor is to discuss this with the client and pharmacist). SL buprenorphine-mono preparations (Subutex®) have higher misuse potential and should be avoided for TADs.
- Limiting the number of consecutive takeaway doses. Multiple consecutive doses of methadone, especially higher doses of methadone (e.g. >80 mg methadone daily) carry significant risks if used non-medically by a client or if diverted to others not in opiate agonist treatment. Limiting the number of consecutive takeaway doses provided in any week may be an appropriate way to reduce risk of poor adherence or non-medical use.
- Regular clinical reviews and appointments. Clients receiving takeaways should have a formal clinical review at least every 3 months by their prescribing doctor. They will also have at least 2key worker appointment between doctor appointments. Clients with more complex treatment needs will have more frequent reviews and appointments. Urine drug screens should also be conducted periodically to confirm client self-reported substance use. Conducting some keyworker appointments by telehealth may facilitate clients who are dosing at pharmacy and have barriers to attending face to face appointments (eg. Work) to engage and participate in the program.
- Regularly assessing for non-medical use of TADs and other medicines. Clinicians have a responsibility to assess and document the use of TADs and use of other medicines (BPMH). This should include assessing if medicines are not taken as prescribed (such as missed doses, running out of medications early, using additional doses than prescribed, lost or misplaced medicines, diversion to others, unauthorised routes (e.g. injecting) or intoxicated presentations).
- Responding to non-medical use of TADs and other medicines. Generally, 'lost' TADs should not be replaced. The client should be informed that lost medicine will not be replaced prior to receiving takeaway doses. However the doctor may, when clinically appropriate, decide if situations occur where replacement of lost doses is warranted. These may be supervised doses,

additional monitoring of the client may also be indicated. Non-medical use of TADs or other relevant incidents (missed doses, intoxicated presentations, not attending appointments) require a review of the client's dosing conditions, and are generally markers of the need for greater levels of support through supervised dosing and monitoring.

- Take Home Naloxone interventions. Ensuring all clients (and carers) have access to THN, are familiar with overdose risks, and how to respond to a (suspected) overdose, including administration of naloxone.
- Clear documentation in medical records regarding the indications, risks and strategies put in place to mitigate identified risks.

Shared Information:

Easy to understand explanation to clients should be provided as to potential benefits and harms associated with TADs, our TAD framework (including number of TADs available and criteria), how decisions are made and reviewed.

The relevant clinical decision-making matrix should be shared with clients in the high-risk category, not yet eligible for TADs, in a way that promotes for easy understanding. Even where clients are not currently eligible for TADs, clients should be intentionally supported to plan and work towards this goal if this is desired. It should be stressed that the decision for TADs is based on clinical indicators and not a tool of reward and punishment.

Table 7. Responsibilities of clients and workers re: TADs

Prescribing doctor responsibilities	Client responsibilities	Dosing staff responsibilities	Key worker responsibilities
Authorising TADs and clearly documenting dosing instructions on the prescription and communicating with dosing sites Regularly reviewing dosing conditions for each client, involving regular assessment and documentation of the indications, risks and risk mitigation strategies Communication and collaboration with key worker and dosing staff to ensure decision making regarding TADs is informed by clinical presentation. Communicating takeaway guidelines and conditions to clients, enabling clients a clear understanding of decision-making processes regarding access to takeaway or unsupervised doses Regularly communicating with the client regarding safe use and storage of TADs	Using medicine as prescribed and according to the instructions on dispensed medicine Safe storage of medicine, and ensuring that medicine is kept out of reach of children Notifying treatment providers of any issues or concerns regarding medicine (including lost or misplaced doses, consumption by others, or use of the medicine not as prescribed) Seeking emergency medical assistance in the event that medicine is consumed by others, particularly children or adults with low opioid tolerance, due to the risk of overdose and death	Ensuring supervised and unsupervised doses are administered and dispensed as per prescription, unless there are safety concerns (such as providing unsupervised doses to intoxicated clients, or where clients have been routinely missing doses), in which case they should communicate with the doctor Keeping accurate records regarding dispensed medicines Regularly communicating with the doctor or other members of the MDT regarding factors that impact upon the safety of unsupervised doses, including intoxicated presentations, missed doses, attempts at not consuming supervised doses, or evidence of diversion to others Regularly communicating with the client regarding safe use and storage of TADs	Regularly communicating with the doctor and other members of the MDT regarding factors that impact upon the safety of unsupervised doses. Consistently reinforcing the decision making guidelines for takeaway doses. Consistently reinforcing information about safe use and storage of TADS. Incorporating client's goals/preferences for future medication/dosing location/takeaway doses into the Global Care Plan and collaborating with the doctor and client to develop a plan to achieve these.

3.2.4. Program Orientation and information

Ensuring clients are oriented to the Opioid Treatment Program and are provided with regular information throughout their engagement is critical to the model of care.

Program orientation and the provision of information is a responsibility of core team (key worker, doctor, dosing staff), and can be supported by consumer workers and other members of the MDT. Information needs to be provided in a timely manner (relevant information at the right time), suited to the client's cultural background, cognitive status, language, and literacy skills.

A **Program Navigation Map** should be provided to each client that outlines:

- Program principles (see Section 2)
- Medication options, including usual dosing schedules (e.g. frequency of attendance for dosing, capacity for TADs), effects and potential side effects, drug-drug interactions, and likely costs of treatment (e.g. dosing fees at pharmacy)
- Likely duration of treatment (the 'big picture' as well as within SESLHD program) and conditions for successful withdrawal from opioid agonist treatment
- Core elements of the OTP, including clinical care processes (care planning, regular monitoring of outcomes and risk, and transfer of care), medical reviews and dosing conditions. This should include how clients' transition core elements of their treatment, including transitions in dosing and prescribing conditions
- Roles and identity of the client's core OTP team (key worker, medical practitioner, dosing provider), and how they can be accessed by the client
- Elective elements of the OTP, including the types of supports available, how these are tailored to each individual client, and how we communicate with other service providers. This also requires information regarding privacy and confidentiality
- The role of consumer workers in supporting clients in accessing services and achieving their treatment goals, and information regarding telephone support services for OTP clients (e.g. peer line, OTL line).
- Service expectations of attending services, including attendance at appointments, engaging with the care standards and behavioural expectations; this includes the codesigned DAS clinic prinicples (See Appendix A)).

The program Navigation Map should be presented in formats that are easy for the client to understand and use as a tool to help navigate their service engagement. It is discussed and copies are offered at the start of treatment; the Map is then reinforced and re-presented throughout treatment.

3.2.5. Transitions

The OAT Model of Care promotes planned, coordinated, and supported transitions across the program components. Transition Points are relevant to all SESLHD OAT clients.

Clients are often navigating transitions within the OAT program. SESLHD's clinical role is to proactively work with clients to plan, provide information and support to ensure the transitions are smooth and sustainable. Key Workers should consider working with the peer workforce to support clients in support of the transition work.

Transition Points (Figure 6) occur when:

1. Dosing location changes
2. Medication changes occur
3. Clients disengage from the program (unplanned)
4. Clients transfer their opioid treatment to other providers (e.g. to community or other public clinics, residential rehabilitation)
5. Entering and exiting other services (including custody, hospital), and
6. Withdrawing from OAT.

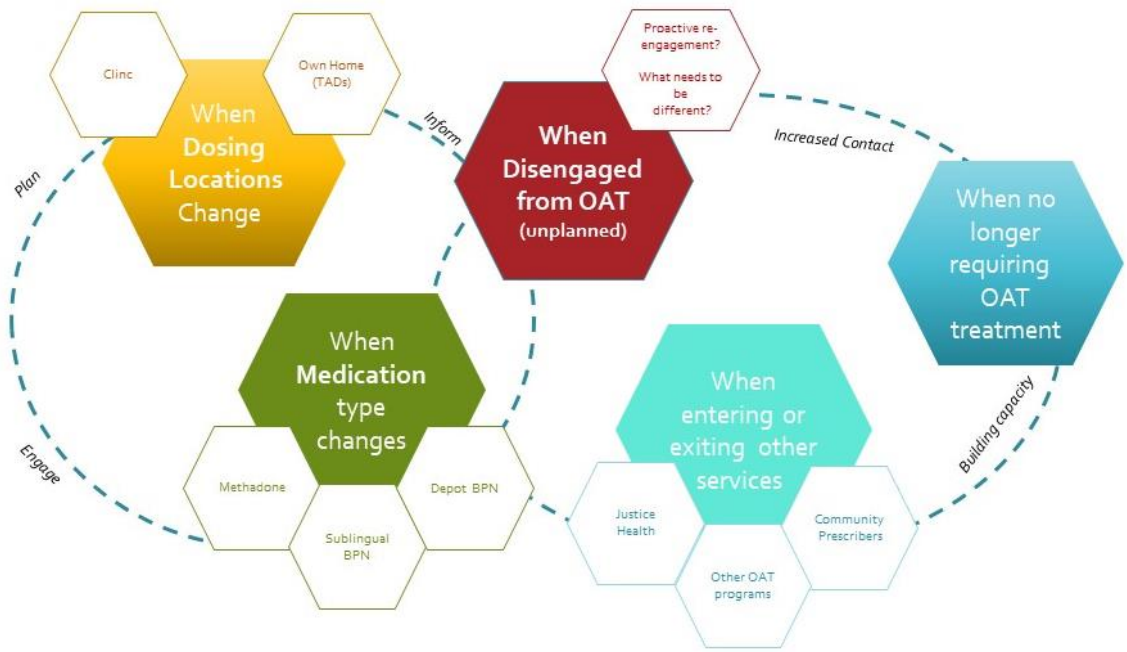

Figure 6: SESLHD OAT Program Transition Point

At these transition points (Figure 7), **Key Workers and doctors** will:

1. Work with clients through the SESLHD OAT Program Navigation Guide to assist them in understanding the need or purpose of each transition point
2. Plan for upcoming transitions with clients and relevant stakeholders, identifying potential barriers (e.g. no prior experience of pharmacy dosing, anxiety, pharmacy fees) and enablers (e.g. financial assistance scheme, support from consumer workers)

3. Tailor frequency of contact with clients to provide extra support. Transition support can be reduced once the client has successfully navigated the challenges presented in the transition
4. Provide relevant information regarding transitions. This should include written consumer information for each type of transition
5. Engage and involve peer support workers to support clients in their transition if requested.
6. Coordinate with other service providers (e.g. community pharmacists or doctors) as necessary.

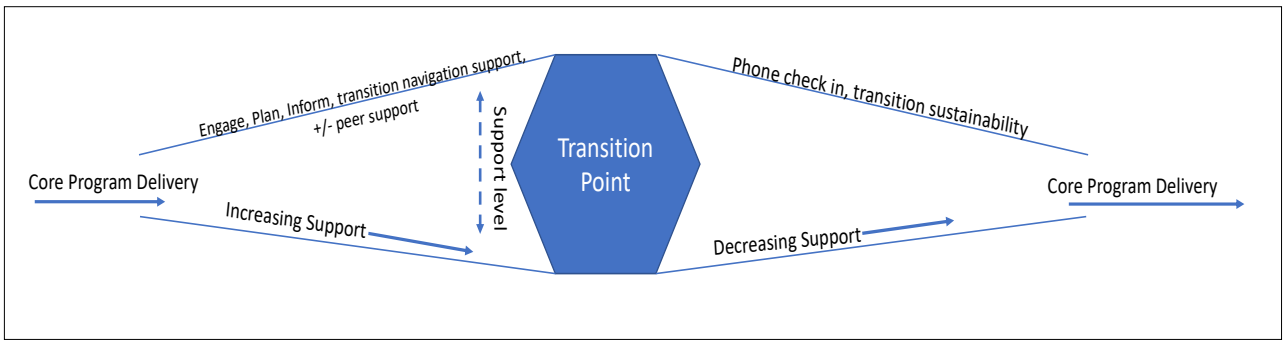

Figure 7: Transition Point increased and decreased supports

3.3 Elective elements of OTP

Elective elements are additional supports and services that are coordinated or provided by the Key Worker and medical practitioner according to each client's needs, strengths and goals, and documented in the client's Global Care Plan (figure 7). Key workers should work with clients to determine the best combination of services to

(i) support clients to identify and address their current needs and goals

(ii) develop further client capacity and,

(iii) support clients to sustain gains. The OAT program should not automatically duplicate a service response being provided by another provider but ensure ongoing communication and coordination with the client and that provider.

If significant risk or vulnerability is identified (e.g. overdose risks, domestic violence, housing, child protection, mental health concerns) then Key Workers and doctors should address this as part of Core program components and duty of care. Some of resource options outlined in the elective elements of care may be relevant to supporting clients in mitigating their risk and vulnerabilities.

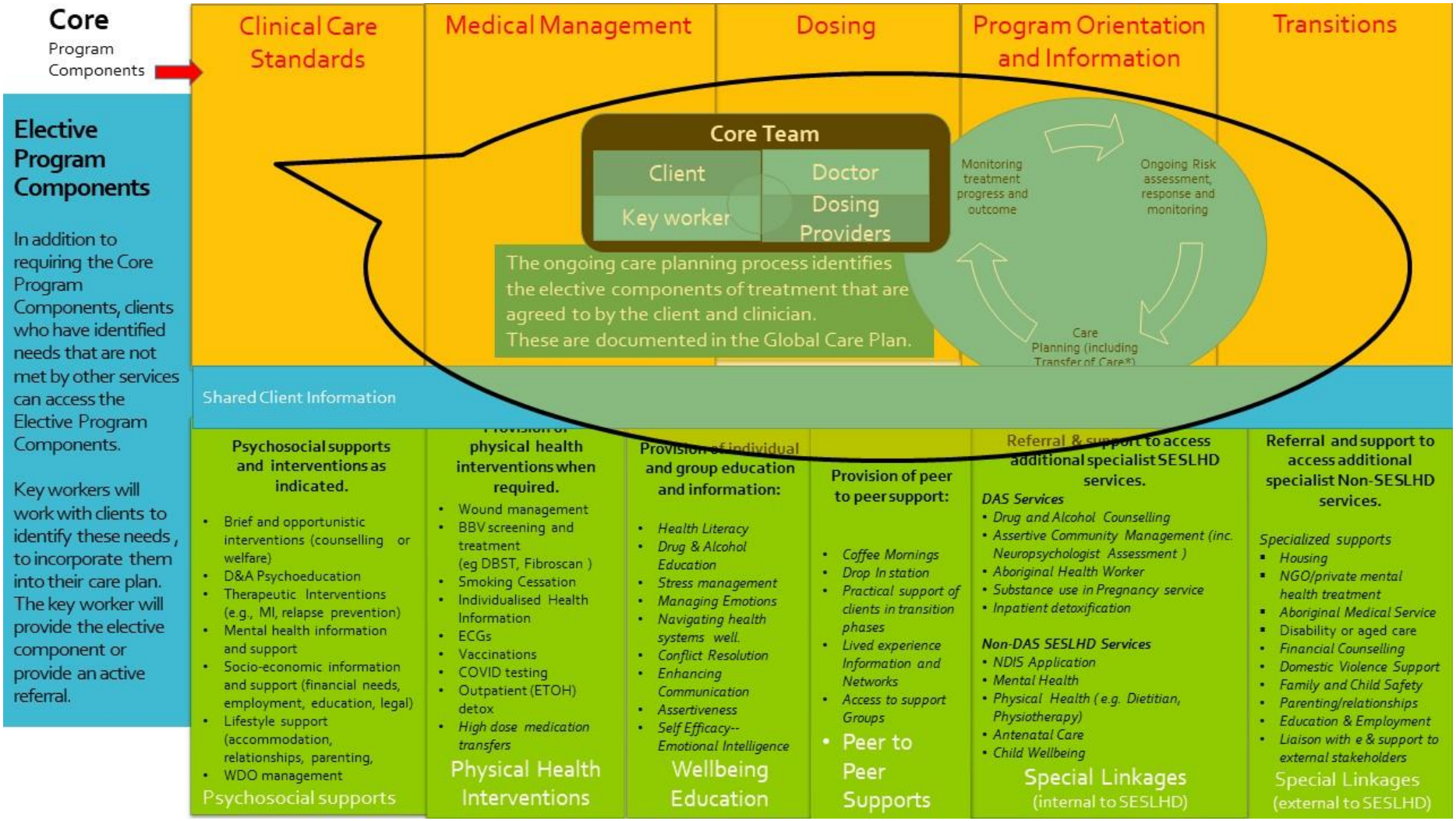

Figure 8: Elective program components

3.3.1 Psychosocial supports & Interventions

Psychosocial supports and interventions can be broadly categorised as 'counselling interventions', and 'social and welfare supports'.

Counselling interventions. Counselling can cover a broad range of interventions. Basic psychoeducation (e.g. information about specific diagnoses) is relevant for most clients, whilst brief interventions (relaxation techniques, smoking cessation, problem solving, sleep hygiene) may be targeted at specific issues arising. Therapeutic interventions (CBT, ACT, DBT, relapse prevention) may be appropriate for some clients, and all clinicians should be familiar with basic behaviour change approaches, such as motivational interviewing. Clinicians working in OTP services have different skills, scope of practice and capacity to deliver different types of 'counselling' interventions. In many cases, workforce development can assist clinicians to be better equipped to deliver psychoeducation, brief interventions and behaviour change approaches appropriate for this client population. Where a key worker does not have the requisite skills to deliver a particular intervention (e.g. THN intervention), they should engage other members of the OTP team to do so. Where key workers identify they do not have the necessary skills or capacity to deliver psychotherapeutic interventions, they can refer or liaise with relevant counsellors – either within SESLHD DAS (particularly where the focus of the counselling relates to substance use issues), or to external counselling providers (particularly where the focus may be addressing other issues such as managing an anxiety disorder, parenting skills).

Social and welfare supports: Many OTP clients experience problems relating to their social circumstances, including problems with housing, employment, education or (health) literacy skills, legal or financial problems, food security, domestic violence, or child welfare issues, and many clients need assistance with Work and Development Orders. The skills and capacity of key workers within an OTP team will vary, and where a key worker feels ill-equipped to address these issues, they should seek assistance from other members of the team with more relevant expertise (e.g. social workers), or working with external providers (e.g. NGOs) to assist clients to access the services they require. OAT Program social workers may provide support and advice to the key worker and for more complex problems may directly assist the client. Clients who identify as Aboriginal may choose to engage with the Aboriginal Health worker to support their treatment. Referrals may also be made to the Assertive Community Management Team (ACM), where required. Workforce development approaches should also develop the skills of all key workers in these areas.

The range of psychosocial services for clients should be identified as part of regular care planning and risk management, and are likely to change over time.

3.3.2 Physical health interventions

Clients in OTP often have a range of concurrent physical and mental health problems, which may or may not be related to their substance use. Part of the comprehensive assessment and ongoing medical management is to identify these issues, and develop appropriate management plans with the client – often in consultation with other health providers (e.g. GP, other specialist services), and for these issues to be documented in the client's Global Care Plan. Given the high prevalence of problems such as smoking, BBVs, mental health, pain, perinatal care and unwanted pregnancy.

Particular attention should be given to systematically screening and assertively managing these conditions, often in collaboration with other health care providers.

3.3.3 Supporting client wellbeing

An increasing emphasis in healthcare is to better empower consumers to better manage their own health and well-being. This can be achieved through health promotion activities (e.g. health eating, exercise, stress management, drug and alcohol education, smoking cessation, safer alcohol use) but also through equipping clients to better manage their own health and navigate the 'health system'– through enhanced health literacy, communication skills, assertiveness (including providing feedback and making complaints), and how to access supports.

3.3.4 Peer to Peer supports

Peer support is an important aspect of care for many clients experiencing substance use issues, particularly in OTP services where clients often develop, or benefit from, connections with other clients and peers. Clients often have different preferences regarding peer supports, including peer-based programs such as NA or Smart Recovery, support from external peer support services such as Peerline or OTL, peer groups held within SESLHD services (e.g. coffee mornings), or individual one to one support from Consumer Workers. SESLHD Consumer Workers can play an important role in orienting new clients to the OTP service, assisting clients to engage with relevant workers in the OTP team, in advocating for clients regarding aspects of their care, and in assisting clients at transition points (e.g. transfer to community pharmacy or community prescriber). Clients should be informed of the range of options available, and be provided with relevant assistance to access these supports.

3.3.5 Linkages with other health and service providers (internal and external to SESLHD)

The principles of integrated health care and the AoD Clinical Care Standards highlight the importance of working with clients to address a broad range of health and social wellbeing issues – and not restricting our focus to 'Drug and Alcohol' issues, and to work collaboratively with the client and other service providers to optimize health and social outcomes. This often requires engaging with a range of services and service providers to address the needs of the client.

Services may be provided by other teams

- within SESLHD D&A Services (e.g. Substance Use in Pregnancy service, inpatient admissions for withdrawal or medication transfers, counselling teams, forensic teams, Assertive Community Management, Neuropsychologist assessment),
- by non-DAS SESLHD Services (acute hospitals, Mental Health, Pain services, Chronic care teams, Child Wellbeing Teams, PARVAN services, NDIS Application), or
- with services external to SESLHD (e.g. Housing, Financial Counselling, Domestic Violence Support, Family and Child Safety, vocational services, NDIS workers, and other healthcare providers (e.g. GPs, allied health providers (e.g. psychologists), other medical specialists), other D&A Service providers (e.g. NGOs, private providers).

In addition to working collaboratively with clients to identify when a referral is required and to where, key workers and doctors also need work with clients to determine how the referral will be

made (active, facilitated, or passive) and to follow up on the outcome of the referral. Often active or facilitate referrals will be the most appropriate, where a doctor or key worker either assists the client to make contact with the other service or does so on their behalf. The clinician will then follow up with the client on the outcome of the referral and whether they attended the other service. Active referral are particularly important during transfer of care either to pharmacy dosing or to a private practitioner. Clients should be made aware that privacy laws allow for health professionals to communicate about their treatment without explicit release of information. Clients should be made aware of what is being communicated to whom; and the information exchanged should be consistent with privacy principles by being necessary, relevant, accurate, not excessive and non-intrusive.

4. Program Support Functions

The program model is supported by robust support functions. These program support functions assist in operationalising the model of care, so that it becomes an embedded way of working that provides consistency across the program, is connected to the broader SESLHD direction, and is efficient and effective.

The team support functions are cluster into five areas: (1) Governance, (ii) Workforce, (iii) Communication, (iv) eMR and Documentation, and (v) Value Based Health Care

4.1 Program Governance

Corporate Governance: The existing corporate governance structures within SESLHD and DAS SESLHD ensure that the service is complying with legal and ethical requirements and is achieving the goals of the Model of Care.

Clinical Governance: Ensuring accountability for the delivery of safe, effective, integrated, high quality and continuously improving treatment within our Model of Care.

Guiding Documentation: The Model of Care incorporates and is consistent with local, state and national guidance and legislation, including:

- NSW Ministry of Health (2020) Clinical Care Standards: Alcohol and Other Drug Treatment
- NSW Ministry of Health (2018) NSW Clinical Guidelines: Treatment of Opioid Dependence – 2018
- NSW Depot BPN guidelines
- NSW Ministry of Health – Co Morbidity Framework for action- NSW Health Mental Health/ Drug and Alcohol
- SESLHD Drug and Alcohol Service Clinical Service Plan 2017
- SESLHD Policies, Procedures and Business Rules
- National Quality Framework for Drug and Alcohol Treatment Services
- Evaluation and Quality Improvement Program (EQuIP) (via Australian Council on Healthcare Standards (ACHS))

- Interim National Guidance for providing OTP in response to COVID (RACP 2020)

3.4 Workforce

The workforce program support function ensures that we have the right staff with the right skills and support to deliver the Model of Care. This is grouped into:

People and Culture. Ensuring our teams have the right skills and professional mix to maintain the Model of Care.

Workforce Development. Enabling our staff to maintain or develop the clinical competency required for the Model of Care.

Supervision. Supporting our staff to reflect on and develop further skills in relation to the Model of Care.

3.5 Communication

The Model of Care relies on effective communication within the core team, with clients as a group, between clinical teams, with external providers, and across the organisation. Some of the key communication groups are listed below, however this is not exhaustive:

Clinical communication between the Core Treatment Team.

Group communication with clients to discuss general aspects of the program or for health promotion.

Business communication within and between SESLHD OAT teams.

OAT Working Group provides a mechanism for quality assurance and improvement.

Clinical Communication between internal and external providers.

Stakeholder Relationships and Liaison with external stakeholders and coordinated with other SESLHD DAS external partnership projects.

3.6 eMR and Documentation

The Model of Care is supported by the eMR system and documentation package. The eMR forms are consistent with the Model of Care and the eMR functionality supports communication between providers.

3.7 Value Based Health Care

Better Value Health Care is focused on determining whether clients are receiving care that results in outcomes that matter to them using the available resources most efficiently. It requires that our Model of Care identifies measurable outputs, outcomes and measures of experience, program inputs and costs, and can categorise clients groups based on their treatment complexity. It also involves feedback mechanisms to clients, clinicians, and managers to facilitate quality assurance and improvement. See Appendix C for the MoC Evaluation Framework.

Appendices

Appendix A Clinic Principles

Appendix B Safe Storage of takeaway doses of Methadone

Appendix C Draft Evaluation Framework

Appendix A SESLHD DAS Clinic Principles

CLINIC PRINCIPLES

Health
South Eastern Sydney
Local Health District

Building a Respectful Culture at Drug and Alcohol Services

At this Drug and Alcohol Service we want the treatment experience to be the best it can be.

These Clinic Principles were developed with clients and the people who work here, and outline the behaviour expected in this clinic.

We hope that this respectful culture will create a better experience for everyone.

Staff agree to:

- Be respectful to you.
- Be friendly and professional.
- Be transparent and open about decisions regarding your treatment.
- Work as a team to help you reach your treatment goal.
- Help you to take greater control of your wellness goals and link you in with external opportunities where possible.
- Communicate changes and reduce waiting times as soon as possible

Clients agree to:

- Be respectful to:
  - each other
  - the people who work here
  - the neighbours of the clinic
- Take it easy while waiting for appointments and /or medications.
- Not be aggressive with each other.
- Respect that people are here for treatment - no drug using, sharing or dealing near the clinic.
- Keep noise at reasonable levels in and around the clinic and put rubbish in the bins provided.

CONSUMER

If you have any concerns about your treatment here please ask to speak to any Manager.

We value your opinion
so please continue to share any ideas on how to improve this service using the feedback box in the client waiting area or talk to one of the Consumer Workers.

Appendix B: Safe Storage of takeaway doses of Methadone

Health
South Eastern Sydney
Local Health District

PATIENT INFORMATION SHEET:
SAFE STORAGE OF TAKEAWAY DOSES OF METHADONE / BIODONE

- Methadone can be fatal in overdose, especially when taken by those who are not used to the effects of opioid-type drugs [drugs like methadone or heroin].
- Note that Biodone is a brand name of Methadone
- ***Methadone - even very low doses such as 1ml [5 mg] can cause death in children***
- For this reason your prescriber or case manager has a responsibility to discuss the issue of safe storage of takeaway doses with you.

If you receive takeaway doses, please take note of the following:

1. **Methadone takeaway doses should always be stored in a locked place.**
   They must be kept in a location where they are unlikely to be stolen or accidentally taken by another person, and must always be out of reach of children. The fridge is not a safe place for storing methadone, nor is it necessary to keep your methadone cold
2. **Takeaway doses must not be given lent or sold to anyone.**
   Even you think you are helping someone out, do not give lend or sell them your methadone. Selling your methadone can result in criminal charges.
3. Takeaway doses are dispensed in a labelled and child-resistant container.
   Do not transfer the medication into another bottle.
4. **Takeaway doses must be taken on the date specified on the medication label and in the appropriate manner**
   – that is, taken orally, not injected, and the full dose must be taken within 24 hours.
5. **For your confidentiality and safety, rinse your empty methadone bottles and remove the label or cross out your name with a pen.**
6. **Return all of your empty bottles to the OTP clinic as we will need to re-use them.**
7. **Lost, misplaced or damaged takeaway doses will not be replaced.**
8. **If anyone, particularly a child, accidentally takes your takeaway dose of methadone, an ambulance should be called immediately by dialling 000.**
   This is a free call and can be contacted even if your phone is out of credit.

I have read this and understood the above.

Patient's Name: _____ **Signature**: _____ **Date:** _____

Witness's Name: _____ **Signature** _____ **Date:**_____

Signed photocopy given to client ☐ Yes ☐ No

File this sheet in client's notes ☐ Yes

DRUG AND ALCOHOL SERVICES

The Langton Centre
591 South Dowling St, Surry Hills
(02) 9332 8700

St George Hospital
2 South Street, Kogarah
(02) 9113 2944

Caringbah Community Health Centre
The Sutherland Hospital, The Kingsway Caringbah
(02) 9540 7464

Appendix C: OAT Model of Care Evaluation Framework.

DRAFT

The Alcohol and other Drug (AoD) Treatment
Clinical Outcomes and Quality Indicators (COQI) Framework.

The COQI framework aims to improve the clinical outcomes and quality of care for people in drug and alcohol treatment through the use of routinely collected clinical information. It seeks to establish systems to identify and routinely measure, analyse, and report on process oriented quality indicators and clinical outcomes, providing a mechanism to:

1) describe the clinical profile of clients who attend their treatment services at entry to treatment and at points throughout their treatment (currently within a single LHD), and

2) describe and quantify the treatment provided to patients including

1) Your text here

a) whether treatment delivered meets the standard of care outlined in the AoD treatment services Clinical Care Standards, and

b) treatment activity including number, type and duration of service contacts, designation of treatment providers, etc., and

3) quantify clinical outcomes.

The framework incorporates the NSW AoD Treatment Clinical Care Standards as the foundation of AoD treatment and outcome monitoring, and facilitates services to report on care standard achievement and clinical outcomes. Outcome measurement is incorporated within the clinical care standards, providing as a structure for collecting and using patient reported outcome measures throughout the treatment journey. The ATOP is the core drug and alcohol Patient Reported Outcome Measure (PROM) employed by the project. As a clinical tool the ATOP supports standardised review appointments through identifying the key areas to be covered during a review, the information captured can then be used for treatment service planning, evaluation and improvement.

The primary focus of the framework is community drug and alcohol treatment in NSW for the most common treatment modalities (withdrawal, counselling, case management, pharmacotherapies) for the most common Principal Drugs of Concern (alcohol, opioids, cannabis and amphetamines) treated within the community.

The PRINCIPLES of the Framework are that

1) clinical outcomes and quality of care are measured through information that is recorded in the Clinical Information System in the course of delivering high quality routine clinical care.

2) the data required for analysis is predominantly extractable from the clinical information system, with some minimal clinical auditing.

3) the analysis and interpretation of the clinical outcome and process oriented quality indicators is conducted in partnership with treatment services.

4) it is consistent with patient centered care.

It is to be anticipated that treatment models and the clinical information system will change over time, and that the data items within the CIS that allow us to apply the COQI framework will change. The current elements of the COQI dataset are outlined tables below, but it should be noted that the COQI project team continues to work on defining the COQI data asset for LHDs and data governance.

Figure 1 shows the relationship between the COQI framework and the NSW AoD Treatment Clinical Care Standards, the framework dependencies and the possible outputs of the framework. As noted above, the framework assists us in reporting on who our clients are, the treatment they receive and their clinical outcomes. This framework is supported by the Core Treatment Processes which have been developed into the NSW AoD Treatment Clinical Care Standards. The clinical care standards are the sector agreed standards of care for clients accessing drug and alcohol treatment in NSW. When services are delivering care aligned to the Clinical Care Standards there is the opportunity to collect the information that the COQI framework is based on. For NSW government services, this is incorporated in their Clinical Information Systems. A COQI Data Asset is being defined and will address the data governance issues associated with the use of routinely collected clinical information. The information can then be used for a range of activities including Continuous Quality Improvement, Research and Performance Management. The application of the framework is dependent on having a workforce competent in delivering treatment as described in the clinical care standards and services that have the capacity to utilise the information, including service managers who can interpret and apply the quality and outcomes information, data management resourcing, sector wide leadership and opportunities for collaboration between services.

The COQI Framework collects the information to measure clinical outcomes and the information required to make meaning of those outcomes. This includes describing the clinical profile of clients who attend their treatment services at entry to treatment and at points throughout their treatment (currently within a single LHD) (see Table 2), describe and quantify the treatment provided to patients (see Table 3), measure whether treatment is delivered in line with the NSW AoD treatment services Clinical Care Standards (see Table 4).

Table 1: COQI Framework measurement of Clinical Outcome

Patient Reported Outcome Measure				
Goal/Indicator	**Context**	**Measure**	**Data source**	**Analysis of outcome**
Substance use decreased or remained at low frequency.	Change in frequency of substance use for the principal drug of concern is the primary substance use outcome measure. Given the prevalence of polysubstance use amongst people seeking Drug and Alcohol treatment, change in the frequency of the non-principal drugs of concern are also outcomes of interest. Not all clients entering treatment are using their PDOC at treatment entry, therefore maintaining no or low frequency use may be a goal of treatment.	**Principal Drug of concern identified at the start of a treatment episode.** **Past 28 day substance use reported on ATOP.** • Alcohol • Cannabis • Amphetamine type substances (ice, MDMA etc.) • Benzodiazepines (prescribed & illicit) • Heroin • Other opioids (not prescribed methadone/buprenorphine)	DATS-NMDS Initial and Follow-up* ATOP	As per the COQI Outcome metric. Details of the metric are pending publication (see Table 2)

		• Cocaine • Other substances • Tobacco		
Improved or stable good self-rated psychological health.	• Psychological health, Physical Health and Quality of Lifer are secondary outcomes of interest given the prevalence of co-occurrence of substance use disorders and problems in these domains • The simple self-ratings of these domains have been chosen as the patient's perception of their health and QoL is the key consideration, and the 0-10 scales adequately measures this.	Self-rating of psychological health on the ATOP 0-10 scale.	Initial and Follow-up* ATOP	As per the COQI Outcome metric. Details of the metric are pending publication (see Table 2)
Improved or stable good self-rated physical health.		Self-rating of physical health on the ATOP 0-10 scale.	Initial and Follow-up* ATOP	
Improved or stable good self-rated quality of life		Self-rating of Quality of Life on the ATOP 0-10 scale.	Initial and Follow-up* ATOP	
Decrease (or maintained no BBV risk) in BBV risk behaviours	Injecting drug use can be associated with BBV risk, particularly if equipment is shared. Harm reduction strategies should aim to reduce injecting and equipment sharing.	Injecting in the past 28 days. Sharing injecting equipment in the past 28 days.	Initial and Follow-up* ATOP	Change in proportion reporting no shared equipment
Increase in work or study participation	Secondary outcomes of treatment for drug and alcohol problems due to the impact of substance use disorders on work and study participation.	In past 28 days: Days paid work. Days at school, tertiary education, vocational training.	Initial and Follow-up* ATOP	Change in proportion reporting study and/or work
Stability in housing	Secondary outcomes of treatment for drug and alcohol problems due to the impact of substance use disorders on housing stability.	In past 28 days: Homeless. At risk of eviction.	Initial and Follow-up* ATOP	Change in proportion reporting housing problems

Reduction in violence and/or involvement in criminal activity.	Secondary outcomes of treatment for drug and alcohol problems due to the impact of substance use disorders on arrests and violence.	In past 28 days: Arrested Experienced violence Patient violent towards another	Initial and Follow-up* ATOP	Change in proportion reporting violence

*determining which follow-up ATOP to use is dependent on the evaluation questions that is posed, which could include (but is not limited to) the ATOP administered at end of treatment, 12 months, 3mths, etc.

Table 2: COQI Algorithm for Clinically Meaningful Change in Substance Use Frequency and the Psychological, Physical and Quality of Life items.

Frequency of substance use in previous 28 days at measurement A	**Relative change in frequency of substance use in previous 28 days at measurement B**	**Treatment outcome**
Low (≤ 12 days in previous 28)	Increased by ≥ 4 days used in last 28 days compared to measurement A	Unsuccessful
	Reduced by ≥ 4 days used in last 28 days compared to measurement A	Successful
	Increase or decrease of < 4 days used in last 28 days compared to measurement A	Successful
High (> 12 days in previous 28)	≥ 30% increase in days used in last 28 days compared to measurement A	Unsuccessful
	≥ 30% decrease in days used in last 28 days compared to measurement A	Successful
	< 30% increase or decrease in days used in the last 28 days compared to measurement A	Unsuccessful
Rating of health/wellbeing at measurement A	**Relative change in rating of health/wellbeing at measurement B**	**Treatment outcome**
Poor (score of ≤ 5 on 0-10 scale)	Score increase of ≥ 2 from score at measurement A	Successful
	Score decrease of ≥ 2 from score at measurement A	Unsuccessful
	Increase or decrease of < 2 from score at measurement A	Unsuccessful
Normal-well (score of > 5 on 0-10 scale)	Score increase of ≥ 2 from score at measurement A	Successful
	Score decrease of ≥ 2 from score at measurement A	Unsuccessful
	Increase or decrease of < 2 from score at measurement A	Successful

Table 3. COQI Framework measures of Clinician Reported Outcomes

Clinician Reported Outcome Measure				
Goal/Indicator	**Context**	**Measure**	**Data source**	**Analysis of outcome**
Successful completion of treatment according to the clinical team.	Clinician rating of treatment episode success.	MDS reason for cessation codes:	MDS reason for cessation	

Table 4. SESLHD MoC Specific Outcomes

Service Level Measures			
Goal/Indicator	**Context**	**Measure**	**Data source**
Proportion of clients dosed at pharmacy	Community pharmacy is the appropriate location for many public OAT clients to dose to support individual progression in treatment and maximise access for new or returning clients.	Proportion of clients dosed at pharmacy of total clients receiving sublingual BPN or Methadone. Six monthly reporting.	OST Module
Proportion of clients transferred to GP	To maximise access for clients who require specialist AoD treatment, clients need to be transferred to private practitioner to continue their OAT treatment.	Proportion of clients transferred to private practitioners for OAT treatment. Six monthly reporting	Discharge Summary
Proportion of clients ranked by methadone and suboxone TAD risk categories:		Proportion of clients on methadone and suboxone ranked by TAD risk categories: High Med Low	OST Module

High Med Low			
Proportion of client on depot buprenorphine		Proportion of client on depot buprenorphine	OST Module
Patient experience	Patient experience of the OAT program	YES Survey for AoD when available.	YES.

Table 5. COQI Framework measures of patient descriptors

Patient descriptors Information describing who the patients are at the start of their treatment episode are important indicators for services planning, provide the baseline data for				
Variable	**Context**	**Measure**	**Data source**	**Analysis**
Age	To describe the demographics of the patients attending the service	Age	MDS (beginning episode)	
Sex		Male, Female, Not stated, inadequately described	MDS (beginning episode)	
Aboriginal or Torres Strait Islander Status		Aboriginal, Torres Strait Islander Both Aboriginal and Torres Strait Islander Neither Not adequately described.	MDS (beginning episode)	
Postcode		Postcode	MDS (beginning episode)	
Usual accommodation		Usual accommodation	MDS (beginning episode)	
Source of income		Source of income	MDS (beginning episode)	

Living arrangements		Living arrangements	MDS (beginning episode)	
Primary drug of concern	To describe the Drugs of Concern for the patient and their lifetime injecting drug use status.	Primary drug of concern	MDS (beginning episode)	
Other drugs of concern (up to 3)		Other drugs of concern (up to 3)	MDS (beginning episode)	
Injecting drug use status (lifetime)		Injecting drug use status (lifetime)	MDS (beginning episode)	
Past 28 day substance use	To describe the substance use frequency of patients entering treatment and record their baseline scores for outcome measurement.	• Alcohol • Cannabis • Amphetamine type substances (ice, MDMA etc.) • Benzodiazepines (prescribed & illicit) • Heroin • Other opioids (not prescribed methadone/buprenorphine) • Cocaine • Other substances •	ATOP start of encounter/episode	Median (range) days used Histogram (0, 1-4, 5-8, 9-12, 13-16, 17-20, 21-24, 25-28 days) % abstinent for each drug
		• Tobacco	ATOP start of encounter/episode	% used.

Injecting drug use & BBV risk past 28 days.	To describe the injecting frequency patients entering treatment and record their baseline scores for outcome measurement.	Number of days injecting in the past 28 days. Sharing injecting equipment in the past 28 days.	ATOP start of encounter/episode	Median (range) days injected % shared equipment
Days participation in work or study	To describe work and/or study participation.	In past 28 days: Days paid work. Days at school, tertiary education, vocational training.	ATOP start of encounter/episode	Proportion reporting involvement in work and/or study
Stability in housing Children in residence Violence and/or involvement in criminal activity	To describe: - housing stability. - Children in residence - Violence and/or involvement in criminal activity	Psychosocial factors • Homelessness • At risk of eviction • Caring for or living with child/ren under 5yo. • Caring for or living with child/ren 5-15. • Arrested • Violence towards you • Violent towards someone	ATOP start of encounter/episode	Proportion reporting: Housing problems; Caring for child under 5; Caring for children 5-15; Arrest; Violence.
Client self-rating of physical health	To describe the proportion of clients entering (or currently in) the treatment service with self-rated	• Client self-rating of physical health	ATOP start of encounter/episode	Mean (SD)

Client self-rating of their psychological health Client self-rating of their quality of life	significant problems with their psychological health, physical health, or quality of life.	• Client self-rating of their psychological health • Client self-rating of their quality of life		% of clinical cases (ie score 5 or below on the 0-10 items).

Table 6: COQI Framework Measures of treatment provided

What treatment was provided? Measures of service activity.		
Purpose	**Measure**	**Data source**
To describe and quantify the treatment inputs	Number of episodes of care opened &/or closed	MDS
	Types of episodes of care opened &/or closed	MDS
	Number of clients	MDS
	Direct occasions of service.	NAP
	Indirect occasions of service	NAP
	Professional staff providing the OOS	NAP
	Time of each OOS	NAP
To describe the referral source	Source of referrals	Intake Form, CHOC Assessment form CHOC

Table 7: COQI Framework measures of clinical care standard attainment

Was treatment delivered in line with the clinical care standards?

Proposed measures based on the NSW AoD Treatment Clinical Care Standards – these are the interim treatment quality indicators.

Standard Statement		Interim Indicator
Intake	A person seeking information or treatment for alcohol and other drug use will have access to advice, referral and appropriate treatment options.	i. The proportion of patients registered with a specialist AOD treatment service who have an AOD Intake form completed on the day of registration.
Comprehensive Assessment	A patient presenting to an alcohol and other drug service will have a comprehensive assessment.	i. The proportion of AOD clinicians who have been assessed as competent in conducting Comprehensive Assessments. ii. The number of days between intake (date of registration) and the comprehensive AOD assessment within a specialist AOD treatment service. iii. The proportion of encounters with a comprehensive assessment iv. A measure of the quality of the comprehensive assessments (method of measurement to be determined)
Care Planning	A patient in alcohol and other drug treatment will be engaged in collaborative care planning to develop a comprehensive care plan which is tailored to their individual goals and needs.	i. The proportion of AOD clinicians who have been assessed as competent in collaborative care planning. ii. The proportion of patients registered with a specialist AOD treatment service who have a collaborative care plan. iii. A measure of the quality of the collaborative care plan (method of measurement to be determined)
Identifying, responding to, and monitoring of risk	A patient entering alcohol and other drug treatment will have substance use related risks identified, responded to and monitored throughout treatment.	i. The proportion of patients who are screened at assessment for: ii. - risk of harm to self or others iii. - child wellbeing, and iv. - domestic violence
Monitoring Treatment Progress and Outcomes	A patient is engaged in ongoing alcohol and other drug treatment monitoring, that provides opportunity for joint reflection on progress and priorities and to inform ongoing care planning.	i. The proportion of AOD clinicians who have been assessed as competent in monitoring treatment progress and outcome.

		ii. The proportion of patients registered with a specialist AOD treatment service who have an initial and subsequent ATOP or alternative standardised clinical review measurement.
Transfer of Care	When a patient is discharged or their care transferred to another service, a detailed transfer of care summary is provided to the patient and all relevant ongoing care providers. It will provide a comprehensive summary of all the treatment provided, outcomes and ongoing treatment needs with a focus on patient safety. The process should facilitate access to a range of professionals and agencies, as required.	i. The proportion of AOD clinicians who have been assessed as competent in transfer of care processes and documentation. ii. The proportion of patients registered with a specialist AOD treatment service who have a Transfer of Care/Discharge Summary. iii. A measure of the quality of the transfer of care/discharge process and documentation.

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