PURPOSE

To ensure that tāngata whai ora / service users are admitted appropriately to the Te Whatu Ora – Health New Zealand Hauora a Toi Bay of Plenty Opioid Substitution Treatment (BOPOST) Service. This protocol should be read in conjunction with the CPM.M9.4 Opioid Substitution Treatment (OST) Pathway.

STANDARDS TO BE MET

1. Referral to OST Service

1.1. Walk-in service: self-referral

a) Where resources permit, tāngata whai ora / service users are able to directly access BOPOST service for assessment. In this case, relevant initial screening information (see below) should be gathered by the OST service.

1.2. Referrals through other Te Whatu Ora Hauora a Toi Bay of Plenty services – e.g. AOD, pain, crisis

a) Comprehensive pre-referral assessment is generally unnecessary. The referrer should ensure that they:
   i. Have tāngata whai ora / service user agreement for referral
   ii. Have current demographic details e.g. name, date of birth, NHI, ethnicity, iwi affiliation, current phone and address.
   iii. Document any contact alerts e.g. whether voicemail messages are unsuitable.
   iv. Complete initial assessment and screening (see below)
   v. Have referred the tāngata whai ora / service user formally
   vi. Have discussed with the tāngata whai ora / service user what to expect e.g. that the OST service will contact them.

1.3. External referral

a) Written (letter / fax / e-referral) or telephone referral to BOPOST service should include the following information, which the BOPOST service should then scan into the file:
   i. Demographics: any tāngata whai ora / service user details available, particularly contact details
   ii. Screening: any recent reported substance use, including opioids
   iii. Referrer's contact details

b) Advise the tāngata whai ora / service user that the BOPOST service clinician will contact them (usually within 24 hours of the clinician's receipt of referral).

1.4. Initial assessment and screening

a) The following information is required before proceeding further with tāngata whai ora / service user referral / assessment:
   i. Triage assessment has been completed
   ii. Tāngata whai ora / service user substance use history should demonstrate consistent opioid use
   iii. Risk assessment is completed, and any appropriate follow-up managed until the BOPOST service sees the tāngata whai ora / service user.

1.5. Priority admission criteria

a) Priority admissions include, for example, tāngata whai ora / service users who:
   i. are pregnant
   ii. have serious co-existing medical and mental health problems
   iii. are established on OST programmes overseas

2. Principles

2.1. Ideally, recovery-oriented practices related to assessment for OST include the use of global assessment tools, assessment as a continual process, is family / whānau inclusive and supports the transition from treatment planning to recovery planning (*White and Torres 2010 pp.76-77*).

2.2. The principles of good assessment:

a) Maintain an empathic, non-judgmental approach

b) Discuss tāngata whai ora / service user strengths: individuals are the experts on their own recovery. Prior challenges present a learning experience for current and future well-being.

c) Ask what has worked in the past. Incorporate these ideas into the recovery plan.

d) Involve support people where appropriate. Consider the potential strengths and resources within the tāngata whai ora / service user's support networks.

e) Provide information for informed decision-making, so that the tāngata whai ora / service user can appreciate the benefits and risks of treatment

f) Ensure culturally safe practice including the use of karakia, whakawhanaungatanga, invitation to include the whānau voice in assessment, and clear communication of support available in iwi and kaupapa Māori providers.

3. Clinical assessment

3.1. <u>Tāngata whai ora / service user contact</u>

a) Before making contact (immediately or within 24 hours of referral) ensure:

i. Tāngata whai ora / service user has consented to referral, if not self-referred

ii. Ensure any privacy requirements stated are met with an alert on the tāngata whai ora / service user file if needed (e.g. if voicemail messages are declined or if the tāngata whai ora / service user declines to have their file audited in quality audits).

b) Discuss with tāngata whai ora / service user:

i. Date, time and duration of nurse assessment appointment (usually occurs between 0 – 7 days of referral)

ii. That significant others are welcomed and encouraged to attend the assessment or any appointment. Is the emergency contact / next of kin registered by tāngata whai ora / service user on the registration form aware of the person attending the service? If not, discuss the implications of this e.g. are they able to support changes being made by the tāngata whai ora / service user?

iii. Request a form of identification (e.g. driver's licence) be brought to the appointment (note may need to provide proof of eligibility of treatment if new to the District)

iv. Discuss the need and purpose of taking a tāngata whai ora / service user photograph

v. Explain the need for follow-up laboratory tests

vi. Advise the tāngata whai ora / service user that OST treatment admission depends on treatment suitability and occurs in that case on or after the medical appointment

vii. Explain the general timeframe to medical appointment (usually 0 – 14 days after nursing assessment)

viii. Confirm postal details for any follow-up appointment confirmation letter

3.2. Assessment preparation
- a) Administrative tasks on presentation:
  - i. obtain tāngata whai ora / service user photograph (see above)
  - ii. copy of tāngata whai ora / service user identity document (see above)

3.3. Nursing / clinician assessment
- a) Discuss the limits to confidentiality and that the BOPOST service is obliged to contact relevant third parties including other prescribers if there is risk to their own or other's health.
- b) Obtain any relevant background information to inform about GP enrolment, medical treatment and other health issues. Sources include historic files, Regional Clinical Portal (RCP), including details of any concurrent prescribers where available. Any historic BOPAS files must be reviewed before stabilisation phase.
- c) Key assessment information includes pattern of use e.g.
  - i. when the tāngata whai ora / service user last used
  - ii. when the tāngata whai ora / service user last went without any opioids
  - iii. whether any withdrawal symptoms occurred when without opioids
  - iv. what, if any, withdrawals the reports having experienced at these time
  - v. details of any other substance use, especially central nervous system (CNS) depressants
  - vi. any other relevant Diagnostic and Statistical Manual of Mental Disorders (DSM) IV criteria
- d) Complete the comprehensive assessment and if not already obtained
  - i. Family violence screening
  - ii. Gambling screening
  - iii. Smoking cessation (may be deferred)
  - iv. Emergency contact person and details

3.4. Informed consent to treatment
- a) Assess for intoxication as this may result in consent being deferred
- b) Ensure the tāngata whai ora / service user has read and understood information about OST.
- c) Reiterate the following before obtaining the tāngata whai ora / service user's signed consent:
  - i. a description of the tāngata whai ora / service user pathway including shared care
  - ii. a discussion of treatment risks and benefits
  - iii. a discussion of alternative treatment options
- d) Give tāngata whai ora / service user a copy of:
  - i. OST and you booklet
  - ii. BOPOST handbook
  - iii. Methadone and Buprenorphine / naloxone information leaflet

3.5. Tāngata whai ora / service user Plan
- a) Ensure the following is done, before their medical appointment:
  - i. **Laboratory and onsite-tests** (see medical assessment, step 3 and step 4).
    - Encourage the tāngata whai ora / service user to undertake Hepatitis C / Blood-borne viruses (BBV) testing and provide the tāngata whai ora / service user with a laboratory form for this. Advise tāngata whai ora / service user these tests must be completed prior to medical appointment.

- Consider benzodiazepine levels (diazepam / clonazepam) if the tāngata whai ora / service user history, presentation and / or urinalysis indicate significant or problematic use.
- Breathalyser on the spot if any indication of frequent / regular alcohol use or presents under the influence of alcohol at assessment.
- Urine drug screen - consider sending to PathLab for further analysis if use of substances such as tramadol, Zopiclone or others not picked up on routine testing, reported.

ii. **Information**: any relevant information the tāngata whai ora / service user has not yet received, e.g. Your Health Information.

iii. **Primary care**

- explain that the GP will be contacted prior and during OST treatment. If the tāngata whai ora / service user has no GP,
- explain that they need to become enrolled and actively engaged in primary care with a view to eventual shared care. Some tāngata whai ora / service users will require key worker assistance to engage with a GP. It is a requirement for a tāngata whai ora / service user to have a GP for general physical health and specific needs, e.g. referral to specialist health services, and may affect progress through OST such as takeaways and shared care if not enrolled.

iv. **Appointment card** for medical assessment, key worker contact details

v. **Written admission treatment plan** including service expectations and tāngata whai ora / service user's own immediate goals with:

- Tāngata whai ora / service user's brief overall goal
- Practical action plan where required for follow-up appointment, post-dose checks, pharmacy consumption e.g. transport, childcare
- Risk and harm reduction plan e.g. needle exchange
- Support plan for managing substance use and withdrawal prior to clinician's appointment e.g. reassurance of coping in the interim, advise tāngata whai ora / service user to be in mild withdrawal at time of clinician's appointment
- Driving advice and the tāngata whai ora / service user's plan to manage this
- Any immediate social network recovery supports
- whānau goals and action plan

3.6. <u>Service Plan</u>

a) The nurse / clinician contacts the tāngata whai ora / service user's primary health care practice to confirm any other health treatment and conditions to consider in preparation for the medical assessment.

3.7. <u>Poly-drug Dependent Referrals</u>

a) If the tāngata whai ora / service user is using significant amounts of alcohol or other (non-opioid) drugs, the MDT should consider:

i. What harms would be reduced and what gains made for the tāngata whai ora / service user, with OST?

ii. What obstacles may be presented to OST treatment goals?

iii. How safe is it to provide this tāngata whai ora / service user with OST, in terms of responsibility for the dose and / or potential for overdose?

iv. What non-opioid options could be considered with or before admission?

v. What is the tāngata whai ora / service user's motivation to address their alcohol or other drug use?
vi. What other treatment options are there? (e.g. in-patient stabilisation)

4. Medical Assessment

4.1. Admission to the Programme

a) Tāngata whai ora / service users eligible for OST meet the diagnostic criteria of the DSM IV for opioid dependence and consent to treatment.

4.2. Young People

a) Where there is evidence that OST might be a beneficial treatment option for a person under 18, this will be carefully considered on a case-by-case basis and may involve consultation with family / whānau and other healthcare providers, including the Clinical Director.

4.3. Diagnostic Uncertainty

a) Multi-disciplinary team (MDT) discussion:
   i. Where, even after a comprehensive assessment, questions remain about primary dependence or the appropriateness of OST, further assessments might be required.
   ii. Further outcomes may be explored (e.g. to seek a second opinion).

4.4. Clinician's Assessment Actions

a) The medical assessment should take particular note of:
   i. Substance use assessment, including:
      - historic and recent opioid and other substance use
      - opioid use in the days preceding the assessment
      - opioid use on the day of assessment
   ii. Risk assessment:
      - historic and current drug use complications(eg overdose, DVT)
   iii. Medical assessment, including:
      - family history of heart problems
      - use of prescribed / over the counter (OTC) medication
   iv. Mental health assessment, including:
      - any current and historic risk / treatment
   v. Legal history, including:
      - any current and historic risk / treatment

b) Review laboratory test results, particularly the following tests, which will have been requested prior to doctor assessment:
   i. Full blood count
   ii. Urea, creatinine and electrolytes
   iii. Liver function tests including ALT / AST
   iv. Urinalysis drug screen, including methadone, other opioids, amphetamines, benzodiazepines and any other relevant drug following assessment
   v. Tests for HIV, Hep C and Hep B

   Note: opioids are metabolised in the liver. If liver function is significantly impaired, care must be taken with early opioid substitution treatment, to avoid overdosing. In general, initial doses should be reduced if significant liver impairment is established or suspected

c) Other investigations:
   i. If other investigations are indicated (e.g. ECG, serum diazepam and / or clonazepam), discuss this with the tāngata whai ora / service user. Preferably, these should be completed in advance of the clinician's assessment. Consider benzodiazepine levels (diazepam / clonazepam) if the tāngata whai ora / service user history, presentation and / or urinalysis indicate significant or problematic use.
   ii. Always do serum levels before initiating any prescribing for benzodiazepine dependence, but commencing treatment does not need to be delayed waiting for results if there is a clear clinical rationale.

d) Check for multiple dependency:
   i. Assess tāngata whai ora / service user dependency on other drugs / substances particularly alcohol, benzodiazepines and other CNS depressants, CNS stimulants and hallucinogens.
   ii. Consider tāngata whai ora / service user needs where there is co-existing significant alcohol or other substance use as well as opioid dependence.

e) Primary care liaison:
   i. Write to the tāngata whai ora / service user's primary care provider. Make clear the expectation that BOPOST service communicates with primary care.

4.5. Treatment Choices

a) Once opioid dependence is diagnosed, the tāngata whai ora / service user's options are considered. Support the tāngata whai ora / service user to make the decision that best fits their presentation, circumstances and aims, such as:
   i. Admission to OST with the BOPOST specialist service
   ii. Admission to BOPOST and / or referral to the inpatient bed where problematic poly-substance use might be a concern
   iii. Referral to BOPAS for counselling without OST
   iv. Discharge from the BOPOST service

4.6. Deferred admission or decision not to admit

a) **MDT discussion**: The clinician, stabilisation nurse and Clinical Lead discuss the plan if the tāngata whai ora / service user is assessed as not suitable for OST, or if admission is deferred.
b) The tāngata whai ora / service user and their support people are informed of the reason and of any appropriate alternative options and services. Where possible, the referrer should also be informed, and an explanation provided as to why the tāngata whai ora / service user not deemed suitable for OST.
c) The relevant team members are informed of the outcome.
d) A letter will be uploaded on the patient management system to indicate rationale for not admitting to OST.

4.7. OST Options

a) OST options are considered by the tāngata whai ora / service user, in consultation with the admissions nurse and clinician. Medications indicated for treatment of opioid dependence in NZ are methadone (primarily Biodone™) and buprenorphine / naloxone .

b) Rarely, other opioids may be considered for OST, following consultation with the Clinical Lead and Clinical Director. The fact that this medication is being used outside of its indications should be discussed with the tāngata whai ora / service user. There will need to be a clearly documented rationale, and plan attached to this decision. This plan needs to be reviewed within the MDT at least annually, and documented within the tāngata whai ora / service user notes why it is still felt appropriate to continue in spite of the fact it is against the recommendations of the National Guidelines.

4.8. Initial Dose and Titration Protocol

a) The tāngata whai ora / service user must attend in the morning to commence OST, to allow for post-dose checks. Ideally this process should be at the start of the week, to allow for plenty of opportunity to review the tāngata whai ora / service user before the weekend.

b) When assessing the appropriate OST starting level, consider and record the tāngata whai ora / service user's presentation for withdrawal or intoxication. Consider also:
   i. The tāngata whai ora / service user's substance use is self-reported i.e. not clinically observed
   ii. The tāngata whai ora / service user's substance use may be for intoxication rather than the minimum amount to prevent withdrawal and cravings
   iii. The quality of the tāngata whai ora / service user's supply is unknown
   iv. The tāngata whai ora / service user's current symptoms of withdrawal or intoxication

c) Select a starting dose (usually between 10 and 40 mg when methadone is used.) See further down for buprenorphine commencement. The first dose (of methadone) should generally be in the range of 20 – 40 mg, and not higher than 40 mg." National Guidelines (2014) p13.

d) Write an initial prescription. Dose changes can be considered following the peak dose review on day 3 or 4 for methadone, however with Buprenorphine / naloxone increases can be actioned on a daily basis. Do not increase the dose during the first 3 days for methadone, unless in exceptional circumstances, and after a review of the tāngata whai ora / service user . With Buprenorphine / naloxone the clinician can write a prescription allowing for a daily increase within a specified range, up to a specified maximum dose if deemed appropriate.

e) The Pharmacist needs to understand the importance of careful assessment in this initial treatment stage.

f) If assessed by the clinician 24 hours or more before the first dose, the nurse or clinician must review the tāngata whai ora / service user's situation before the clinician releases the prescription to the Pharmacy, including:
   i. Assessment of the tāngata whai ora / service user for withdrawal and / or intoxication
   ii. Review of the tāngata whai ora / service user's current reported substance use against that reported at the time of initial assessment. If the tāngata whai ora / service user's substance use has reduced in the interim, consult with the clinician before releasing the prescription.

g) Treatment Plan
   i. The tāngata whai ora / service user's risk plan is the main focus for support at this time, with managing the risks of illicit use during the OST peak build-up

ii. Treatment is focused on planning the next appointment, the tāngata whai ora / service user plan to get to the appointment and the required BOPOST service response if unable to be seen for post-dose check(s)
iii. General information is helpful e.g. AOD helpline, TXT / pain / emergency contact cards, and how to contact the key worker.

h) Post-dose Checks
   i. Assess the need for post-dose checks

i) 30-minute post-dose check
   i. This may be unnecessary in a tāngata whai ora / service user that is not naïve to treatment – decision made between clinician and Stabilisation Nurse. It is done where indicated to review risk of anaphylaxis. If completed the following is recorded in the clinical notes:
      - Time at which the tāngata whai ora / service user consumed
      - Observations: speech, gait, pupil size and pulse rate
      - Any other evidence of intoxication / withdrawal
      - Any risk plan updates
      - Harm reduction information and plan, particularly regarding time to and hours following peak dose, and coping strategies through to the next session
   ii. The agreed next step, e.g., post-dose check / session
   iii. 3 – 4 hour post dose check:
      - this is done to review the tāngata whai ora / service user's level of comfort / intoxication / withdrawal at peak plasma level concentration. All tāngata whai ora / service users who have not had prior, recent methadone / buprenorphine treatment should complete this check.
      - Tāngata whai ora / service users who are exempted from this check must be known to be able to tolerate much larger doses than the initial dose prescribed – these tāngata whai ora / service users will still require a phone call from the nurse to check on their wellbeing.
      - The following is recorded in the clinical notes:
        - Time at which the tāngata whai ora / service user consumed
        - Observations: speech, gait, pupil size and pulse rate
        - Any other evidence of intoxication / withdrawal
        - Review of any substance use in the interim
        - Harm reduction information and plan, particularly through to the next session
        - The agreed next step, e.g. awareness of Pharmacy opening hours and plan to complete 4-day post-dose check.

j) Buprenorphine / naloxone titrations:
   i. All tāngata whai ora / service users started on Buprenorphine / naloxone, have to be called on the morning of day 2, 3 and / or 4 (unless seen for post-dose check on day 4).
   ii. During this phone call the nurse has to enquire as to how they felt on the dose of Buprenorphine / naloxone dispensed the previous day, and discuss suitability for an increase as is allowed on the prescription written by the clinician on day 1.
   iii. If the nurse feels an increase will be suitable, the tāngata whai ora / service user can then request this from the Pharmacy when dosing, as per instructions on the script.

iv. The nurse must consult with the clinician if there are any concerns with the tāngata whai ora / service user increasing, or additional guidance is required.

4.9. 3 – 4 Day Post-dose Check

a) All tāngata whai ora / service users have a post-dose check between 3 – 4 hours after consuming on the 3rd or 4th consecutive day on OST (with methadone this will be on the same dose as initially started) , to review their level of comfort at the current dose and ensure the is sufficiently tolerant of the current dose before further planned increases. This is especially relevant in relation to the peak plasma level and steady state of methadone which occurs after 4 hours on day 3 – 4. The nurse will assess whether the dose the tāngata whai ora / service user is currently taking is suitable to continue, or if they can safely be allowed an increase that might be allowed on the script by the prescriber. If the nurse feels the dose needs review, this needs discussion with the prescriber before the next dose is due.

b) Record the following in the clinical notes:
   i. Time at which the tāngata whai ora / service user consumed
   ii. Observations: speech, gait, pupil size and pulse rate
   iii. Any other evidence of intoxication / withdrawal
   iv. Review of any substance use in the interim
   v. Harm reduction information and plan, particularly through to the next session
   vi. Plan next pose-dose check / session

c) If the tāngata whai ora / service user fails to present for this review, place the dose on hold at the Pharmacy for the next day, and the tāngata whai ora / service user must attend a review with the nurse before any further doses can be released. The tāngata whai ora / service user must then attend the 4-hour check on that day, or the dose needs to be held again the following day until this check has been completed. This could mean that a tāngata whai ora / service user is not able to dose over a weekend, and will need a review and discussion with the clinician after the weekend.

4.10. Dose Increases Methadone

a) Increases are usually dependent on consistent daily consumption and completion of the 3 – 4 day post-dose check. The prescription incorporates the following:
   i. Begin titration to a comfortable methadone dose from day 4 of treatment onwards where indicated with a maximum of 10 mg increase in the first 7 days
   ii. Where appropriate, increase the methadone dose by a maximum of 10 mg every 4 days until reaching a dose at which the tāngata whai ora / service user feels comfortable. Write a maximum methadone dose on the script. This is the expected dose needed as assessed by the clinician and tāngata whai ora / service user in discussion.

b) The tāngata whai ora / service user attends weekly review with the Stabilisation Nurse whilst the dose is changing. If the does not attend appointments their dosing may be reviewed e.g. hold the increase / dose.

c) The tāngata whai ora / service user attends a review with the clinician and nurse, ideally within 30 days of starting OST – usually about a week after they have achieved the dose assessed as their likely required dose, or a week after reaching their maximum prescribed dose, whichever is sooner.

d) Further increases in methadone dose are considered, if clinically indicated. Recording the time of the tāngata whai ora / service user's last reported consumed dose and the tāngata whai ora / service user's presentation in relation to this can be useful.
e) If a methadone dose of 100 mg or more is being considered, an ECG is required for increasing the dose (see *Medical Conditions and End of Life Care SOP 13.3 risk analysis*).

5. Commencing Buprenorphine

5.1. Consider the following when selecting the OST options:
a) The tāngata whai ora / service user's preference
b) The tāngata whai ora / service user's desire to continue to use other opioids
c) Clinical suitability e.g. it is unsuitable in pregnancy and with chronic pain needing opioid analgesia, but may be preferable for tāngata whai ora / service users taking medications which interact significantly with methadone
d) Factors relating to safety e.g. reduced risk of fatal accidental child ingestion; known significant users of other CNS depressants

5.2. Formulation
a) The formulation of buprenorphine licensed for use in addiction treatment in New Zealand is in combination with naloxone namely Buprenorphine / naloxone.

5.3. Information and consent
a) The tāngata whai ora / service user needs to be fully informed about buprenorphine including its mechanism of action, how it contrasts with methadone, its side effects, risks and benefits, with written information .
b) Ensure the tāngata whai ora / service user understands the importance of best practice for sub-lingual consumption e.g. do not roll the tongue.

5.4. Transition from methadone to buprenorphine
a) The tāngata whai ora / service user, clinician and key worker should attend a review appointment to discuss the suitability for transition and arrange the transition plan. The key worker should liaise with the nurse to plan the transition date with the tāngata whai ora / service user.
b) Transition from methadone may be useful if the tāngata whai ora / service user experiences dangerous or intolerable side-effects or sub-optimal cognitive functioning on methadone, or as a choice for OST withdrawal or continuity.
c) The tāngata whai ora / service user needs to be assessed for current substance use, level of support and co-existing medical and mental health problems.
d) Transitions from methadone doses below 60 mg, are considered lower risk for complications. If an inpatient day-stay is an option, a higher dose transition may be considered in the community setting. A higher-dose transition can be done in a community setting provided it is agreed within the MDT, and plan for support for the tāngata whai ora / service user is put in place.
e) The tāngata whai ora / service user must be informed of the likely length of time needed after their last dose of other opioids, including any OTC use, before buprenorphine can commence and the rationale for this.
f) The tāngata whai ora / service user is asked to present for their first dose of buprenorphine in moderate withdrawal.
g) The tāngata whai ora / service user is asked not to drive to the commencement appointment as the withdrawal symptoms may affect their driving ability and because of the possibility of precipitated withdrawal after dosing.

h) Tāngata whai ora / service users who wish to transfer from methadone to Buprenorphine / naloxone, can also be offered a micro-induction regimen. The tāngata whai ora / service user needs to be provided with the information leaflet, and an explanation of the process. The tāngata whai ora / service user needs to be advised that this is a new method of transition in New Zealand. The tāngata whai ora / service user should be allowed to decide and consent to their preference of transition method = i.e. as above, or by using micro-induction.

5.5. Initial dose and titration

a) Buprenorphine will displace other opioids from opioid receptors … (and) can precipitate withdrawal symptoms if given whilst other opioids are active. Buprenorphine can be titrated quickly and is safe when rapidly increased to higher dose levels in response to withdrawal symptoms. *National Guidelines, 2014.*

b) Tāngata whai ora / service users ~~s~~ need to attend in the morning for their first dose so that any withdrawal symptoms that occur can be managed.

c) Objective signs of opioid withdrawal should be in place. This is usually:
   i. 8 – 12 hours after the last IV dose of morphine or home bake
   ii. 12 – 24 hours after the last oral dose of morphine or oxycodone
   iii. At least 24 hours after the last dose of oral or IV methadone (between 40 – 60 mg)

d) The Clinical Opiate Withdrawal Scale (COWS) helps to assess the tāngata whai ora / service user's readiness for buprenorphine.

e) Moderate withdrawals (usually a score of between 10 – 12) are required with objective physical evidence of withdrawal. Providers should not attempt the transfer if the COWS score is less than 8. If the COWS score is less than 8, and there is service availability, the tāngata whai ora / service user can be asked to wait, and re-assessed in a few hours. If this is not possible, consideration can be given for the to return the following morning, and be assessed again.

f) Tāngata whai ora / service user education is key to avoiding precipitated withdrawal.

g) The following commencement schedules can be used:

i.

Day	**Dose (mg)**
1	2 – 8
2	Increase by 2,4 or 8 mg, maximum 16 mg
3	Increase by 2,4 or 8 mg, maximum 24 mg

h) If a higher dose is required by day three, the clinician and nurse should discuss this option.

i) The maximum recommended daily dose, as per Medsafe, and National Guidelines, should not exceed 32 mg. The effective daily dose range for buprenorphine is 12 – 24 mg per day for most tāngata whai ora / service users, however due to the variation in sublingual absorption, a dose as low as 4 mg could be effective in some tāngata whai ora / service users.

j) The tāngata whai ora / service user is assessed by the nurse or clinician before consuming on day 2 and day 3 for evidence of toxicity, such as headaches and dizziness. The induction is slowed if toxicity occurs. The assessment may be face to face or by telephone as assessed appropriate by the stabilisation team.

k) The tāngata whai ora / service user should be seen face to face by the nurse on day 3 or 4, ideally also 4 hours after the last dose, as the clinical effect peaks after 4 hours. As the dose increases this opioid effect plateaus (ceiling effect) and the duration of action lengthens.

5.6. Precipitated withdrawal

a) If precipitated withdrawal occurs the prescriber should continue buprenorphine dosing and use symptomatic medication if necessary.

5.7. Commencement regimen

a) Day 1

i. Tāngata whai ora / service user attends the Pharmacy (Stabilisation Nurse accompanies for support). Pharmacist (+/- clinician) observes first dose of buprenorphine. Tāngata whai ora / service user reviewed by Stabilisation Nurse at 1 hour post-dose.

ii. *Increased withdrawal*: Provide additional doses of buprenorphine, review regularly until tāngata whai ora / service user is without withdrawal symptoms for one hour.

iii. *Unchanged or improvement of withdrawal*: After a minimum of 4 hours the tāngata whai ora / service user consumes another 2 – 4 mg of buprenorphine. In some instances this may be given as a takeaway dose.

b) Day 2 and 3

i. Tāngata whai ora / service user is reviewed by Stabilisation Nurse prior to dosing as above.

- If the tāngata whai ora / service user is responding well continue with planned induction regimen.
- If the tāngata whai ora / service user shows signs of intoxication (headaches, dizziness) the clinician adjusts the induction schedule accordingly.

6. Tāngata whai ora / service user admission to BOPOST from out of area

6.1. Temporary or permanent admissions, without referral

a) The process for these tāngata whai ora / service users is as for new admissions.

6.2. Temporary or permanent admissions, on referral

a) Referral information should be provided by the current prescriber, to support the tāngata whai ora / service user admission and confirm dosage. This is necessary for continuity of their current OST dose.

b) Full assessment information is required, with consent to treatment as for new admissions. At minimum, in order for the BOPOST service to prescribe the tāngata whai ora / service user must provide identification, a physical local address, and attend a face-to-face assessment with the BOPOST clinician.

c) The tāngata whai ora / service user must be informed that there may be a cost for treatment if they have no proof of right to free treatment.

REFERENCES

- Tondora J and L Davidson. 2006. Practice Guidelines for Recovery-Oriented Behavioural Health Care. Connecticut Department of Mental Health and Addiction Services: USA.
- White W. and L Mojer-Torres. 2010. Recovery Oriented Methadone Maintenance. Great Lakes Addiction Technology Transfer: Chicago.

ASSOCIATED DOCUMENTS

- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.1.1 Informed Consent
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.2 Health Records Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 4.1.0 Infection Prevention and Control Management
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.2 Pharmacist Dispensing Opioid Substitution Treatment (OST)
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.3 Admission to Opioid Substitution Treatment (OST)
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.4 Opioid Substitution Treatment (OST) Pathway
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.5 Opioid Substitution Treatment (OST) Managing Co-existing Conditions
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M9.6 Opioid Substitution Treatment (OST) Prescribing and Dispensing
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services OST Overseas Travel Letter template

Appendix 1: BOPOST Admission Flowchart