

**Project Aim:  To establish a sustainable model of shared care for people experiencing opioid dependence in Brisbane North.**

**Role (please circle): MO/Nurse MO Speciality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

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

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

To develop *the framework* appropriate for MNMH-ADS, clinicians of the Service are being asked to provide feedback on the proposed elements of *the framework*. This questionnaire has been developed incorporating components of shared care models used within Queensland, NSW and internationally. The questions ask you to consider these elements as part of a framework for MNMH-ADS. The collective responses to the following questionnaire will be used to refine *the framework* and generate other elements for consideration. It is intended that you will then complete two further questionnaires in this process until *the framework* has been developed from consensus of the Service clinicians.

For each question, please answer yes or no and provide any comments as necessary. There are no right or wrong answers – the aim of the questionnaire is to elicit the opinion of expert clinicians. Your responses will remain anonymous. You can speak with the Shared Care for Opioid Treatment (SCOT) Project team directly for any further clarification of points, to ask any questions or provide further feedback.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Questions** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Should shared care participation be voluntary? |  |  |  |  |
| 1. Should shared care participation be expected? |  |  |  |  |
| 1. Should clients receiving methadone be considered for shared care? |  |  |  |  |
| 1. Should clients receiving sublingual buprenorphine be considered for shared care? |  |  |  |  |
| 1. Should clients receiving sublingual buprenorphine/naloxone be considered for shared care? |  |  |  |  |
| 1. Should clients receiving long-acting injectable buprenorphine be considered for shared care? |  |  |  |  |
| 1. Should there be medication dose maximums to be considered for shared care? |  |  |  |  |
| 1. Should there be a minimum length of time on QOTP before consideration of shared care? |  |  |  |  |
| 1. Should there be a minimum length of time at clinic before consideration of shared care (think transfers)? |  |  |  |  |
| 1. Should a ‘fast-track’ option be available for clients, referred from their GP, experiencing pharmaceutical opioid dependence in the absence of injecting drug use? (Fast-track = medically stabilised on OTP and referred back to GP for ongoing care) |  |  |  |  |
| 1. Should clients, transferred from prison, have different criteria for consideration of shared care? |  |  |  |  |
| 1. Should shared care be available to authorised prescribers other than GPs? (e.g. psychiatrist, nurse practitioner) |  |  |  |  |
| 1. Should a portfolio be created at each clinic to manage shared care clients? |  |  |  |  |
| 1. Should a nurse navigator/clinical nurse consultant position be created for ongoing shared care coordination? |  |  |  |  |
| **Client stability**:  A key feature of a shared care model, and one essential for the success of the model, is the identification of a stable client. The following questions will help to define what is considered a stable client. | | | | |
| **Questions** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Should the number of take away doses received by the client be used to determine stability? |  |  |  |  |
| 1. Should appointment attendance be used to determine stability? |  |  |  |  |
| 1. Should continued substance use be used to determine client stability? |  |  |  |  |
| 1. Should regular alcohol consumption be used to determine client stability? |  |  |  |  |
| 1. Should ongoing legal issues be used to determine client stability? |  |  |  |  |
| 1. Should child-safety orders be used to determine client stability? |  |  |  |  |
| 1. Should diagnosed mental health conditions be used to determine client stability? |  |  |  |  |
| 1. Should stable personal functioning be used to determine client stability? |  |  |  |  |
| 1. Should having stable relationships be used to determine client stability? |  |  |  |  |
| 1. Should employment be used to determine client stability? |  |  |  |  |
| 1. Should engagement in counselling be used to determine client stability? |  |  |  |  |
| **Other assessment**:  Once a client is deemed stable, other elements may be considered for shared care suitability. Please consider the following: | | | | |
| **Questions** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Should there be a multidisciplinary review as part of assessment for shared care? |  |  |  |  |
| 1. Should there be a mandatory psycho-social assessment when considering shared care? |  |  |  |  |
| 1. Should shared care be considered if a client is considered medically stable but requiring psycho-social support? |  |  |  |  |
| 1. Should input from the client’s pharmacist be sought when considering shared care? |  |  |  |  |
| 1. Should shared care be considered if the client has a pharmacy debt? |  |  |  |  |
| **Community prescriber responsibilities**:  While a shared care client remains registered with an alcohol and drug service, the community prescriber manages many of the tasks associated with case management. Please consider the following elements of case management which may be transferred to the community prescriber. | | | | |
| **Questions** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Should community prescribers be able to change take away dose arrangements (i.e. change days)? |  |  |  |  |
| 1. Should community prescribers be able to change number of take away doses? |  |  |  |  |
| 1. Should community prescribers be able to change to double/triple dosing of included sublingual buprenorphine products? |  |  |  |  |
| 1. Should community prescribers be able to increase a client’s dose after consultation with the shared care clinic medical officer/nurse practitioner? |  |  |  |  |
| 1. Should community prescribers be able to increase a client’s dose after consultation with the shared care clinic case manager? |  |  |  |  |
| 1. Should community prescribers be able to decrease a client’s dose after consultation with the shared care clinic medical officer/nurse practitioner? |  |  |  |  |
| 1. Should community prescribers be able to decrease a client’s dose after consultation with the shared care clinic case manager? |  |  |  |  |
| 1. Should community prescribers consult with the shared care clinic medical officer/nurse practitioner before prescribing medications of concern (e.g. benzodiazepines)? |  |  |  |  |
| 1. Should pharmacy reports be provided to the shared care clinic case manager in addition to the community prescriber? |  |  |  |  |
| **Psychosocial support**:  It is important to consider psychosocial support when developing a shared care model for treatment. Timely access to psychosocial support remains a priority of a shared care model of treatment. | | | | |
| **Questions** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Should ongoing allied health support be referred to NGO agencies/private practice if client agreeable? |  |  |  |  |
| 1. Should the client identify their choice of psychosocial support as part of the treatment plan when entering shared care? |  |  |  |  |