

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

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

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

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

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

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

**Results from the second questionnaire:**

Responses have been collected and collated and continue to support model and procedure document development. A detailed table outlining accepted and rejected elements has been provided to all Team Leaders and Executives and is further provided as an attachment to this questionnaire.

**Questionnaire 3**

Whilst the preceding questionnaires have clarified many elements required for policy development there remains several that require further discussion and clarification before a final draft document can be completed. Responses regarding these elements will be sought through a stakeholder discussion with participation invited from of MNMH-ADS clinic Team Leaders, Senior Medical Officers and Executive Management.

The below topics have been identified as requiring further discussion. Information on the element is given with suggested discussion points italicised. The notes section is intended for participants to jot any pre-meeting thoughts and not as a feedback/answer box (as in previous questionnaires). It is hoped Team Leaders will discuss these topics with their teams prior to the stakeholder meeting to ensure all concerns/points of view are addressed.

Participants of the discussion meeting may attend in person or via teleconference and should note that the meeting will be recorded and transcribed in line with research requirements.

**Discussion topics:**

1. When asked what an acceptable maximum methadone dose would be for the purposes of a shared care agreement with an approved prescriber (AP), responses were received with the following outcome:
   1. 100mg (40%) b. 120mg (35%) c. 150mg (25%)

When considering this further it is important to understand that clients will be assessed as psychosocially and medically stable after being reviewed by the multi-disciplinary team (MDT), and the client’s dose cannot be independently altered by the approved prescriber (AP).

Discussion:

*Suggested discussion points: Should a dose maximum be removed and instead emphasis placed on individual client stability considerations? Should there be specific criteria for clients prescribed methadone?*

Pre-meeting notes:

1. Whilst it is very clear ADS clinicians are concerned about the concurrent prescribing (with MATOD treatment drugs) of benzodiazepines, gabapentinoids, antipsychotics and antianxiolytics, questionnaire 2 feedback suggests how we define this monitoring needs further clarification. Some comments indicated AP may be reluctant to take on a client if the Service is seen to be limiting the ability to holistically treat a patient or that it may be disrespectful to ask a medical professional to “ask permission” to prescribe certain drugs.

Discussion:

* *Suggested discussion points: should there be a drug specific list rather than drug classes? Should the model require consulting, reporting or advising of prescription? Should this be only on commencement or for all dose adjustments? When should this occur – at time of prescribing? dose changes just or on 3 monthly review?*

Pre-meeting notes:

1. It was largely agreed that a nursing shared care portfolio at each clinic would be advantageous in establishing and maintaining the shared care model of care. How do you see a shared care portfolio position working?

Discussion:

* *Suggested discussion points: should the position manage all shared care clients? Solely be a clinic liaison/support for AP? Should this be flexible for each clinic?*

Pre-meeting notes:

1. A Nurse Grade 7 (Nurse Navigator) role was also seen to be an important component of the shared care model, noting that this would be a created position and requires approval. What do you see as the role of a Nurse Navigator (if approved)?

Discussion:

* *Suggested discussion points: should the position manage all shared care clients? Be more a model of care support and driver? Include GP education/support? Be a community representative (eg PHN meetings, AOD service meetings)? provide prison liaison services for clients entering or discharging prison?*

Pre-meeting notes:

1. Should an alert be placed on ATOD-IS/CIMHA to identify shared care clients?

Discussion:

* *Suggested discussion points: Progress note sharing/reporting to Case Manager and/or portfolio holder/Nurse Navigator if applicable.*

Pre-meeting notes:

1. The responses received from the second questionnaire highlighted different practices in referring clients to the psychosocial teams across the MNMH-ADS.

Discussion:

* *Suggested discussion points: How does your team refer to the psychosocial team? Are these pathways relevant to SCOT clients? How will we provide a consistent approach to referral of SCOT clients?*

Pre-meeting notes: