

# **OST and you**

**A guide to Opioid Substitution Treatment**

## **Acknowledgements**

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National Addiction Workforce Development

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# Your guide to OST

## *Welcome to the first client guide to Opioid Substitution Treatment (OST).*

It has been put together by people with experience of opioid substitution treatment and aims to give clients and their support people access to information that is used by the people who provide opioid substitution treatment. It describes the aims of treatment, the process or stages of treatment (assessment, induction, ongoing and completing treatment), the role of GPs (general practitioners) and community pharmacists, and other issues related to OST.

The information in this booklet is from the New Zealand Practice Guidelines for Opioid Substitution Treatment 2014, referred to here as the national guidelines. The aim of the national guidelines is to guide services and doctors providing OST and to help ensure clients receive a standard approach to treatment no matter where they live in Aotearoa/New Zealand.

For more information see: Ministry of Health. 2014. *New Zealand Practice Guidelines for Opioid Substitution Treatment*. Wellington: Ministry of Health. Available at [www.moh.govt.nz](http://www.moh.govt.nz).

Previous national guidelines focused on methadone maintenance treatment but, now that buprenorphine<sup>1</sup> is available, the focus and name has changed to opioid substitution treatment (OST).

Although the terms 'opioid' and 'opiate' are often used interchangeably they do mean different things. An opioid is a substance that is synthetic or partly synthetic, meaning the active ingredients are manufactured. An opiate is a substance derived from an opium poppy, so the active ingredients are natural. The term 'opioids' is currently used to refer to all opium-like substances (natural and manufactured), and the term 'opiates' is used only to refer to natural opium poppy derived drugs like morphine.

Opioid substitution treatment is highly regulated, but is underpinned by concepts of person- and family- and whānau-centred treatment, recovery, wellbeing and citizenship.

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<sup>1</sup> Buprenorphine refers to Suboxone which contains both buprenorphine and naloxone, the only formulation currently available in Aotearoa/New Zealand.

Individual services may develop their own policies, protocols and procedures specific to treatment in that service. Even so, those policies etc must be consistent with the underpinning concepts and with the national guidelines. They must also meet legislation and standards including the Health and Disability Services (Core) Standards (2008), the Privacy Act (1993), the Health Information Privacy Code (1994) and the Code of Health and Disability Services Consumer Rights Act (1996)<sup>2</sup>.

To be effective and relevant to Māori, services need to recognise cultural factors and processes and work with these to improve tangata whaiora and whānau health and wellbeing.

If there is anything here you don't understand or would like more information about please speak with a peer (someone else with experience of opioid treatment) or someone at the service (your key worker, doctor, peer support worker, etc). You may find it more useful to access particular sections at relevant times in your treatment and you can go to [www.matuaraki.org.nz](http://www.matuaraki.org.nz) and download the sections you want.

# Your rights when receiving Opioid Substitution Treatment

*“Consumers receive safe service of appropriate standard, complying with consumer rights legislation; services respect consumer rights, facilitate informed choice, minimise harm and acknowledge people’s cultural and individual values and beliefs.” Ministry of Health and Standards New Zealand Health and Disability Services (Core) Standards NZS 8134.1:2008*

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<sup>2</sup> Services should also have a plan in case of civil defence emergencies.

All clients must receive information about:

- their rights under The Code of Health and Disability Services Consumers' Rights 1996
- peer support and consumer advocacy contacts
- limits of confidentiality, that is, situations where the service may need to break confidentiality (services need to let you know who they might share your information with and under what circumstances, if the service is going to share information about you they need to let you know unless it would be a risk to do so)
- the range of treatment options and psychosocial interventions and supports available
- how OST medications work, their side effects and interactions with other drugs/medications
- the service's policies and procedures including their complaints procedure.

All health services including OST services must have a complaints system that is easily accessible to clients and which complies with legislation. This information should be displayed prominently (see page 39 for more information on complaints).

Sometimes services operate differently to what is suggested in the national guidelines. This might be service-wide, for example all of a service's clients may be expected to attend appointments more or less often than recommended in the guidelines. Or it might be individual, for example a client may be prescribed a higher dose of medication than the recommended maximum

dose of 120mg. When this happens, services need to explain to clients that the treatment varies from the national guidelines.

When a service is considering doing something outside the national guidelines, they will sometimes seek a second opinion from another service or they will discuss the issue with other services at the National Association of Opioid Treatment Providers meeting. All services providing OST are expected to regularly attend these meetings.

The service will also be required to explain any variations from the national guidelines to the Director of Mental Health at the Ministry of Health. OST services have to report regularly to the Director of Mental Health with information about the number of people receiving OST, waiting times, discharges and so on. This information is not about you as an individual, it is statistical information so is confidential<sup>3</sup>.

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<sup>3</sup> You can access the Director of Mental Health's Annual Report at [www.health.govt.nz/publication/office-director-mental-health-annual-report-2012](http://www.health.govt.nz/publication/office-director-mental-health-annual-report-2012)

# Opioid Substitution Treatment

Opioid dependence requires treatment and care much like any other chronic (long-term) health problem. The key objectives of OST in Aotearoa/ New Zealand are to improve the physical and mental health and wellbeing of people who use opioids through:

- reducing or stopping illicit opioid use
- reducing or stopping injecting and associated risk of blood borne virus transmission
- reducing the risk of overdose
- reducing substance related criminal activity
- promoting and supporting client, family and whānau recovery journeys and access to recovery support systems and networks.

Change takes time and what this is and how it happens will be different for every client. Some people will require more support and input than others. Some will aim for abstinence and some will not. Treatment needs to be individualised - one size does not fit all.

# OST services

Opioid treatment services are expected to:

- assess people for substance use and related issues
- plan treatment for and with each client with a focus on supporting recovery and wellbeing
- ensure each client is stabilised on an adequate dose of opioid substitution medication
- provide a range of interventions<sup>4</sup> to minimise the harms associated with drug use
- provide appropriate psychosocial support so that clients and their families and whānau can build and maintain personal, social and community resources (see recovery capital page 8)
- support stabilised clients into shared care with a GP
- support people with co-existing physical and/or mental health problems, for example, referring you to other appropriate health professionals
- consult with and refer to other services including peer support and advocacy
- assist clients to withdraw from OST medication as appropriate.

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<sup>4</sup> The term 'intervention' is used in addiction services to mean something that will bring about change, for example, some of the interventions used to reduce harm associated with injecting are providing clients with information on safe injecting, referring clients to the local needle exchange and providing wheel filters.

## The OST team

Addiction services are focused on people's biopsychosocial wellbeing, meaning they are concerned about your physical, emotional/mental and social wellbeing. Doctors working in OST tend to focus on the 'bio' ie. your physical health, while key workers tend to focus on your 'psychosocial' situation i.e. your living environment, your relationships and supports, and their impact on your psychological wellbeing.

**Key workers** (also known as case managers) coordinate and support each client's treatment and recovery.

**Pharmacists:** all services utilise pharmacists in the community to support opioid treatment. A very small number of services employ their own pharmacists as well. Pharmacists are part of the treatment team and liaise with service staff and your prescriber (the service doctor or your own GP). They will often pass urine drug screen requests and other information on to you from

the service (for more info on urine drug screens see page 32).

**Doctors** attend to all the prescribing and medical aspects of your opioid treatment.

**Clinical team leaders:** most OST teams have a leader who supports and oversees the work of the team. The team leader is often involved in discussions about clients and client issues.

**Your clinical/treatment team:** the people directly involved in your care. Discussions and decisions usually involve your key worker/s and doctor and can include the team leader and pharmacist.

OST teams may also include a manager, social worker, consumer advisor, peer support worker/s, clinical nurse educator and/or nurse practitioner. Services which do not employ peer support workers to work alongside clients need to help clients access this type of support from outside the service.

## Working with 'recovery capital'

Recovery capital is made up of aspects of who you are and the resources available in your whānau and community that can contribute to your wellbeing and recovery. These resources can be considered as being social, community and personal.



**Support networks**

**Education**

**Attitude**

**Skills**

**Financial health**

**Friends**

**Workplace**

**Goals and aspirations**

**Family/whānau**

**Employment**

**Self-awareness**

**Leisure & recreation**

**Partner**

**Housing/shelter**

**Physical & mental health**

**Social activities**

**Social resources**

**Personal resources**

**Coping strategies**

**Non-using friends**

**Emotional health**

**Groups & networks**

**Community resources**

**Spirituality**

**Core beliefs**

**Access to education/training**

**Faith groups**

**Personal values**

**Community assets**

**Local community**

**Coping in community**

**Community activity**

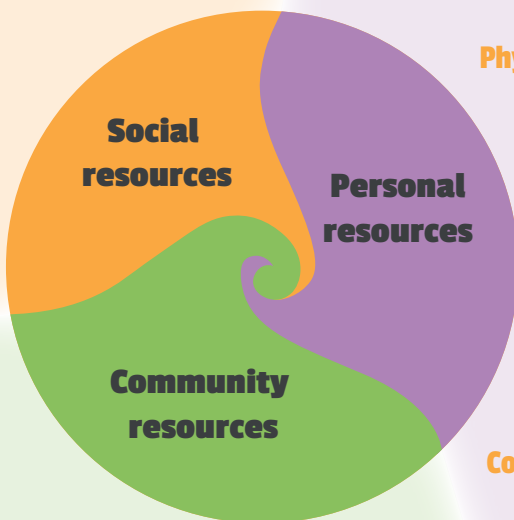
**Community attitudes**

**Mutual aid**

**Belonging**

**Community values**

**Local recovery community**



# Recovery-orientated OST

*“Recovery is worked on and experienced by the [client]. It is not something services can do to a person. The contribution of specialist service staff is to support the person in their journey towards recovery.” (Slade 2009<sup>5</sup>).*

Recovery is an individual process or journey rather than a predetermined destination. ‘Recovery’ doesn’t mean abstinence. It means gaining a sense of control over our own lives, our problems, the services we receive, and building a life away from active addiction whether we’re abstinent or not. Medication like methadone and buprenorphine can play a significant part in supporting recovery.

Services are there to help you build the life you want away from active addiction. Key workers can help you identify your strengths, the things you want to let go of, and the resources and relationships you want to develop or maintain. Most importantly, services need to communicate hope.

Recovery-orientated services:

- are person-centred (rather than being service-centred)
- provide treatment focused on your strengths not just your problems (strengths based treatment)
- involve you in your own care
- involve people with lived experience in providing services
- involve your family and whānau in the process
- offer you a choice of OST medications
- have strong relationships with other recovery-orientated services and the broader community.

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<sup>5</sup> Slade, M. (2009). 100 ways to support recovery:

A guide for mental health professionals. Rethink recovery series: volume 1. Available online:

[www.mentalhealthrecovery.com/recovery-resources/documents/100\\_ways\\_to\\_support\\_recovery1.pdf](http://www.mentalhealthrecovery.com/recovery-resources/documents/100_ways_to_support_recovery1.pdf)

# Assessment for OST

You should be assessed for suitability for OST within **two weeks** of first contacting a service for help. Most OST services conduct their own initial assessment but in some parts of Aotearoa/New Zealand the initial assessment is done by another service. Regardless of where the assessment takes place it must be carried out by an appropriately trained and supervised clinician.

## What to expect at the assessment

At the assessment you'll be asked about your health and your drug use and other personal circumstances relevant to OST. It's really important to give accurate information about your drug use so you receive appropriate treatment.

Some of the questions will be about 'risk'. When services talk about risk they mean things like unsafe injecting practices, overdose, use of other substances (including alcohol and tobacco), impaired driving, and the broader risks related to self-harm, or harm to others, especially dependent children.

- You will also receive forms for you to complete blood and/or urine tests.
- It's a good idea to take some form of identification with you as you will need to provide this either at assessment or before you receive your first dose.

## Information to help with your decision

The service needs to provide you with written information that you and your support people can take away and read. You should receive written and verbal information about:

- treatment options (although OST is the appropriate treatment for most people dependent on opioids you might want to consider managed withdrawal/detox or a residential treatment programme)
- your rights
- your obligations/responsibilities to the service
- how your health information is stored and shared
- the side effects, benefits of and limitations to opioid substitution medications
- the difference between methadone and buprenorphine
- the potential effects of OST medications on driving and operating machinery
- how OST medication interacts with alcohol and other drugs (including prescribed medication)
- what you need to do to prepare for your first dose
- the process for making complaints

- where to get in touch with consumer advocacy and peer support services.

If you are with a service that requires you to have an electrocardiograph (ECG) before commencing OST, you need to receive information about this, too (see page 35).

### Before you provide consent

It's really important that you understand what's required of you if you're thinking about going onto OST and especially before you sign any form that indicates you consent to treatment. ***If you have any questions about the consent form, ask!*** Informed consent is an ongoing process and you need to be fully informed throughout OST of any changes in the way the service is provided and any proposed changes to your own treatment plan.

### Eligibility

To be eligible for OST you need to be a New Zealand citizen or permanent resident diagnosed as opioid dependent. You also need to consent to treatment and agree to comply with treatment expectations. Some people may be eligible for priority access to treatment, for example pregnant women, people with serious medical and mental health problems, and people arriving in Aotearoa/New Zealand from overseas who are already on OST. People under 18 years old can get OST, though parental/caregiver support may be required.

Anyone assessed as being unsuitable for OST needs to be told, in person (wherever possible) and in writing, of the reasons and offered appropriate alternatives.

Although the use of other substances at the same time as opioids is not a reason to deny people access to opioid treatment, risks are increased if people are using a lot of other different

substances. It is the role of OST services to work with clients on reducing additional drug use.

### Medications used

In Aotearoa/New Zealand, buprenorphine and methadone are the two medications used for opioid substitution treatment (OST). Both have been proven to be safe and effective in treating opioid dependence. However, they may not be suitable for people with:

- liver disease - as they may contribute to the worsening of brain function when the liver is no longer able to remove toxins from the blood (hepatic encephalopathy)
- acute asthma or other respiratory/lung problems
- severe mental illness
- people who have had allergic reactions to other opioids.

## Admission to OST

Admission to the OST service should occur as quickly as possible (within two weeks) after you have been assessed as eligible for OST. If the service can't admit you within two weeks, they need to tell you how long you have to wait (Health and Disability Code of Consumer Right 7(b)) and they may be able to offer you interim prescribing (see page 38).

## Induction - starting treatment

'Induction' refers to the process of starting on an OST medication.

The purpose of induction is to get the dose of medication to a level that eliminates or greatly reduces cravings and prevents withdrawal symptoms starting. The goal is to do this as quickly and safely as possible.

If induction is too slow, cravings persist and people may top up with other opioids, alcohol or benzodiazepines, which can be fatal. If induction is too fast, the build-up of methadone in your system can cause overdose. Fatal overdoses when starting buprenorphine (see page 29) are less common.

### FIRST DOSE OF METHADONE OR BUPRENORPHINE

You will probably get your first dose early in the week so there is time for you and the service to communicate about how you are doing – it's very difficult for most services to manage that on weekends.

It is also likely that you will receive your first dose in the morning rather than the afternoon. This is so the doctor or key worker can see how you are after 30 minutes and again a few hours after the first dose.

### STARTING ON METHADONE

The first dose is generally in the range of 20-40mg and no higher than 40mg. On average it takes four days to achieve a steady blood level so dose increases during this time may be slow (5-10mg at a time) or non-existent depending on how you are feeling. The methadone will be accumulating in your system so even on the same dose you may feel considerably better on day four than on day one. The doctor or key worker may want to see you on day four to assess the dose and make any dose changes.

During this early stage of treatment people often feel uncomfortable and may be tempted to 'top up' with additional opioids. This of course increases the risk of overdose. If you do 'top up' you should use small amounts several hours *after* the peak effect of the prescribed methadone; methadone blood levels generally peak at about four hours.

For the first two weeks the service should see you often (eg. at least daily for the first three days and then every two to four days until a stable dose is reached) especially if you haven't previously been on methadone.

Although dose increases are tailored to what you need most people end up on doses between 60 – 120mg though some need more – and some need less. Whatever dose you are on, it should be enough to allow you to function well and to minimise withdrawal symptoms.

## STARTING ON BUPRENORPHINE

Induction onto buprenorphine is quite different than induction onto methadone. With methadone the rule is to start low and go slow whereas buprenorphine doses can be rapidly increased to manage withdrawal symptoms.

### What is buprenorphine and how does it work?

Buprenorphine is a partial agonist meaning it binds to the opioid receptors in the brain but doesn't activate them as much as full agonists like methadone, heroin and morphine. Buprenorphine (with naloxone) also binds to the receptors more 'tightly' than other opioids so, if there are opioids already on the brain's receptors, buprenorphine will 'kick them off' and bind in their place.

### What happens if I have withdrawal symptoms?

This is why it's so important that you are in moderate withdrawal before your first buprenorphine dose. Services may use something like the Clinical Opioid Withdrawal Scale (COWS) to 'measure' your withdrawal symptoms.

If you still have a significant amount of opioids in your system that are then kicked off and replaced by the buprenorphine, you'll go into 'precipitated withdrawal' – this is when withdrawal symptoms are caused very quickly by the medication. Sometimes the first day's dose will be split to reduce the risk of this happening.

In some cases (where there are other health issues or there is significant risk of precipitated withdrawal) the induction might take place in a hospital or similar setting so support and symptom relief is readily available.

Induction onto buprenorphine is usually 2-8mg on day one, up to 16mg on day two and 24mg on day three, though this varies between individuals with some people needing less or more by day three.

### How often should I see my doctor or key worker?

You will need to be seen by the doctor or key worker regularly every two to four days during the induction phase. After the first three days the dose can generally be increased, or decreased, by between 2mg and 8mg per day.

### How do I take buprenorphine?

Buprenorphine is sublingual, meaning you dissolve it under your tongue. It can take 3-10 minutes for the tablets to dissolve depending on the dose. Pharmacists often crumble the tablets to reduce the time. Crumbling the tablets has no effect on their effectiveness but if swallowed (instead of dissolving under your tongue), buprenorphine won't work.

### What is the typical dose of buprenorphine?

The typical dose by the end of the first week is 12-24mg per day though this will vary between clients. Some people are comfortably maintained on a dose of 8mg a day while others require 32mg or more.

For more information about buprenorphine see [www.medsafe.govt.nz/consumers/cmi/s/suboxone.htm](http://www.medsafe.govt.nz/consumers/cmi/s/suboxone.htm)

## SIDE EFFECTS

Methadone and buprenorphine have the same side effects as all opioids and commonly include:

- excess sweating
- reduced saliva leading to dental cavities
- constipation
- sleep apnoea (shallow or infrequent breathing when asleep)
- nausea
- drowsiness
- osteoporosis (bones become more likely to fracture)
- reduced sexual function through loss of libido or impotence.

Services can provide you with information and advice about side effects and treatments available.

## Your treatment plan

Every client has an individualised treatment plan. You need to be involved in developing this plan and you can also involve your support person/s if you want to. You can involve support people at any stage of your treatment.

The treatment plan needs to include the priorities you and the service have for your treatment as well as your recovery and wellbeing goals, recognising that recovery is a personal and unique process for each individual. Treatment plans can include things that are meaningful to you like your physical health, mental health, and parenting and employment goals.

Early in treatment, key workers can help you set immediate short-term goals and support you to achieve them. As you progress in treatment they can support you with your longer-term goals. The plan may also include the expectations and processes for moving into a shared care arrangement with a GP. If you don't have a GP the service can support you to find one.

## Stabilisation - getting to a stable dose

After being inducted onto methadone or buprenorphine the goal is 'stabilisation'. That is, getting you to a point where you are comfortable on a consistent regular dose without the need for constant dose review and you have reduced or stopped using other (not prescribed) opioids. A stable dose is usually reached within one to three months, but it may take some people longer.

Deciding what dose is okay for you is a decision made by you, the doctor, and your key worker though it may also include other members of the OST team. Within services it is common for there to be regular multidisciplinary team (MDT) meetings about clients. These meetings might also include input from the pharmacist, your GP and, when you have given permission, your support people.

Until you reach a stable dose you will probably be seen by a nurse or key worker at least once a week. After that, you will probably be seen fortnightly to monthly at least for the first six months. Clients who are not stabilising or progressing well will be seen more often.

# Ongoing OST

Once you're on a stable dose of medication you move into what's termed 'ongoing' treatment<sup>6</sup>. How long you stay in ongoing treatment is largely up to you.

After stabilisation of your dose the focus goes onto your treatment plan. Some questions you might like to consider are:

**What is your main goal for ongoing OST, withdrawal and abstinence or staying on OST for a while?**

**What do you want to achieve and how can the service support you?**

**What are your strengths, the things that help you stay on track, and who are the people you find most supportive?**

**What are the events or 'triggers' that might lead to opioid use?**

**What commitments do you have that would be made easier with takeaway doses of medication?**

**How is your physical health? Is there anything that needs addressing (eg. Hepatitis C)?**

**What new things would you like to do in life and how can others help you achieve this?**

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<sup>6</sup> It used to be called 'maintenance' but many clients disliked the term as it implied being 'parked' on medication without any other type of support.



## SEEING YOUR KEY WORKER AFTER STABILISATION

How often you need to see your key worker will depend on your circumstances but you should see them every three months at least for the duration of treatment with the OST service.

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You'll need to see the prescribing doctor, often with the key worker, at least once in a three to six month period. When you've been stable (see page 21) for a while (the length of time varies between services and between individuals) your care should move to a GP.

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If you're on a methadone dose over 120mg or take split doses the service may want to see you more often; you may get less takeaways, and you may be required to have ECGs and methadone serum level tests (see pages 32-33 and 35).

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If you're taking buprenorphine there's the possibility of less than daily dispensing because of its long action. This will of course depend on how your treatment is going and won't happen until you're stabilised on an adequate daily dose.

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With buprenorphine it is possible to take double the daily dose on alternate days (though no more than 32mg is given in a single dose). The national guidelines recommend that clients taking their dose on alternate days consume in the pharmacy on four consistent days per week (for example double dose Monday, Wednesday and Friday and single dose Sunday). Not all clients like alternate day dosing so if it doesn't work for you let your prescriber (the service or your GP) know.

## TRANSFERRING FROM METHADONE TO BUPRENORPHINE

If you're stable on methadone there is little advantage to transferring from methadone to buprenorphine, though some people report they prefer the clear-headed feeling that buprenorphine provides especially if they are employed or studying.

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In general, transfer to buprenorphine is only recommended for people who experience significant or dangerous side effects from methadone and some people use it to help withdraw from OST.

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To avoid precipitated withdrawal, you should be on less than 60mg of methadone (preferably 30mg or less) for at least one week before transferring. You need to be showing visible signs of withdrawal before your first buprenorphine dose. This usually happens 20-28 hours after your last methadone dose.

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You will need to be observed frequently for 4-6 hours after receiving your first buprenorphine dose and over the next three days or until you reach a stable dose. People often feel uncomfortable with mild withdrawal symptoms for the first two to five days and the service can provide symptomatic relief if it's necessary.

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If you are transferring from a higher dose (more than 100mg methadone), have unstable medical or mental health problems, or lack social support it may be better to do the transfer in a hospital setting.

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The service will provide you with more detailed information about the transfer process.

## **TRANSFERRING FROM BUPRENORPHINE TO METHADONE**

Transferring from buprenorphine to methadone is usually less complex than transferring from methadone to buprenorphine. Sometimes people transfer from buprenorphine to methadone because they don't like the clear-headed feeling it gives or are experiencing side effects such as dizziness, headaches, nausea and vomiting.

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You can take the first methadone dose 24 hours after the last buprenorphine dose. The first dose of methadone will probably be no more than 40mg. However, if you're transferring from more than 12mg of buprenorphine per day, your first methadone dose may be up to 60mg.

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It will take 1-2 weeks for the buprenorphine to leave your brain's opioid receptors, so increases in methadone dose over this time will be gradual.

## Reviewing treatment

Reviews of treatment need to take place at least once every six months though services can set their own timeframes.

Scheduled treatment reviews should involve you, your support people (if you choose), the prescribing doctor and the key worker. They should include an overview of how you're doing in treatment, an updated risk assessment, and an updated treatment plan focusing on your recovery and wellbeing. Other things that may be discussed include (though aren't limited to):

- use of drugs including alcohol and use of tobacco
- results of any urine drug screens or blood tests
- dose and takeaway arrangements
- your expectations of the service and treatment and what the service expects of you
- lifestyle, relationships, education/employment
- physical and mental health
- your goals and hopes for the future
- links with other health and social service providers including peer support
- suitability for shared care with a GP (if not already receiving OST from a GP).

It is really important that you take part in these regular reviews. After all, it's your treatment. Remember that you can request a treatment review at any time.

Treatment reviews may happen outside of these scheduled times, for example, if the clinical/treatment team has concerns about a client, or a client has threatened or committed violence. In these cases clients may not be invited to take part though input may be sought from other people directly involved in the client's care.

## Psychosocial interventions

OST is about more than medication. Services are there to assist you with your physical, emotional, mental and social wellbeing. They can provide information, advice and support with practical issues such as finances, benefits, housing and accommodation, education and training, parenting and legal problems.

Many services also offer counselling or can assist you to access counselling services. They will also have information available about other psychosocial supports, relevant self-help and whānau support groups, and access to cultural and spiritual guidance.

*“Individualised treatment is about you getting your needs met. Let the workers in the service know what you need.”*

Getting these things sorted helps stability and wellbeing and recovery. The kind of support you get depends on your needs. Some people will need more support than others and some will want more than others.

Individualised treatment is about you getting your needs met. Let the workers in the service know what you need.

## Takeaways

'Takeaways' are individually measured and labeled daily doses of medication which are not consumed at the pharmacy. They can be given as a 'regular' thing (the same days each week) and for other perhaps unexpected circumstances.

Getting takeaways depends on agreement between you, your key worker, and prescribing doctor (and sometimes the pharmacist) that you are 'stable' and reliable, and can comply with the safety requirements of the service and the Ministry of Health. It's uncommon for clients to get takeaways early in treatment.

When services talk about 'stability' in relation to takeaways, going to a GP, etc. they mean things like:

- you're not using alcohol and/or other drugs in a harmful or risky way
- you schedule and attend appointments with your key worker and doctor
- you get your lab tests done on time and urine drug screens (see page 32) show positive for methadone and/or other prescribed medications but negative for other drugs especially alcohol, additional opioids, benzodiazepines and amphetamines
- any physical and/or mental health problems are well-managed
- your relationships with others, housing, employment/occupation etc. are stable
- there's no evidence of criminal activity
- you don't make frequent requests for changes to your dose or dispensing arrangements
- you can ensure that your takeaways will be stored safely
- you have a GP or are actively looking for one
- the potential for diversion of medication and overdose is limited.

These are the kinds of things the service considers before granting takeaways. You don't have to achieve each and every one - though the more that apply to you the more stable you'd be considered to be - rather they are used as 'indicators of stability' which give a picture of where you're at.

## HOW OFTEN YOU COULD GET TAKEAWAYS

Different services have different takeaway regimes. Usually clients start with just one takeaway dose of medication a week and as they progress through treatment they get more.

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If you are receiving more than 120mg methadone daily or more than 32mg buprenorphine daily or you're being prescribed other opioids or benzodiazepines you may face more restricted takeaway regimes than clients on lesser doses.

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Although the national guidelines state that clients should have no more than four takeaway doses at any one time, services should be flexible for clients who demonstrate consistent stability and in particular situations, such as, when people are living far from pharmacies in rural areas or their employment requires flexibility.

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Before moving to treatment with a GP clients should be attending a pharmacy on at least three non-consecutive days per week.

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Going to a GP for your OST doesn't necessarily mean you get more takeaways but less frequent and more flexible dispensing may be possible.

## KEEPING TAKEAWAYS SAFE

Each takeaway dose needs to be in a bottle with child resistant closures. Please note: child resistant doesn't mean child proof (see risks to children, page 30).

Sometimes the caps on bottles can leak. Check that your doses are intact before you leave the pharmacy. Once you've left the pharmacy the pharmacist cannot replace leaked bottles without authorisation from your prescriber. Also, any replacement doses have to be consumed on the premises – not taken away.

Always keep your takeaways bottles upright. It's a good idea to put them in a small zip-lock plastic bag – that way any leakage can be salvaged.

Store your medication safely and securely preferably in a locked cupboard or box.

Don't transfer your takeaways into any other bottles especially not drink bottles accessible to children (see see risks to children, page 30).

If you are physically unable to go to the pharmacy because of illness or injury and need someone else to collect your doses from the pharmacist you will need written notification from the prescribing doctor or service key worker that this has been approved. The pharmacist will want to check they are giving your meds to the right person so your 'agent' needs to take ID with them to the pharmacy.

# OST and your GP

OST in Aotearoa/New Zealand is provided in specialist treatment services and in the community by pharmacists and GPs. While you will start OST with a specialist service the expectation is that most clients will go on to have their treatment provided by a GP (though this is easier to achieve in some parts of the country than others).

As one of the aims of OST is to support people to live as normal a lifestyle as possible, within the constraints of treatment, it makes sense to have your opioid treatment integrated with your general health care.

The move to shared care with a GP generally happens when you are 'stable' in treatment. This will be determined by consideration of the 'indicators of stability' (refer to page 20). If you are already receiving takeaways your ability to manage your takeaways will also be taken into account.

General Practitioners (GPs) are 'authorised' to prescribe for opioid dependence by the OST service<sup>7</sup>. The GP is responsible for ongoing prescribing of your OST meds and taking care of your general health needs. However, the service still has overall responsibility for your care. The service is available to support and

<sup>7</sup> A small number of GPs are authorised by the Ministry of Health.

assist you (and the GP) to review your treatment at least once a year, and to accept back into the service any client who becomes 'destabilised' and can't be managed by the GP. So, your OST is 'shared' by the service and your own doctor (hence the term 'shared care').

## Shared care

People already in shared care say the benefits of going to a GP for continued OST include:

- receiving a more holistic approach to all your health care needs
- having less contact with other clients
- greater privacy and confidentiality ("nobody knows why I'm in the waiting room")

- being more convenient with less travel and the option of after-hours appointments
- allowing the service to focus on and provide more care to clients with the greatest needs

The main challenge clients have with shared care is the cost. Services should help you work out a way to manage the costs associated with shared care.

You must see the GP at least once every three months.

Please note that your GP, pharmacist, service doctor, key worker and perhaps other health professionals involved in your care, will liaise and exchange information relevant to your OST, health and well-being.

# OST and your pharmacy

Pharmacists are an integral part of the team providing community-based opioid treatment. In fact, you will see the pharmacist more often than any other person involved in your treatment so the relationship you have with your pharmacist is an important one.

Pharmacists are responsible for:

- providing a non-judgmental service (this applies to anyone working in the pharmacy)
- maintaining your confidentiality (eg. the pharmacist might serve everyone else before you because they are respecting your privacy)

- positively identifying each client (they may ask for photo ID if this hasn't already been provided by the service)
- supervising the consumption of OST doses (you will need to speak to the pharmacist after consuming your dose)
- liaising with the service or GP on a regular basis and particularly when a client:
  - » has missed collecting more than one dose
  - » is in withdrawal or is stoned/intoxicated when they go to pick up
  - » is abusive or threatening
  - » diverts or makes a serious attempt to divert their medication (you must leave used cups in the dispensing area)
  - » deteriorates in their physical, emotional or mental state

the reasons for the change must be sent to you via the pharmacy.

## DISPENSING ERRORS

Dispensing errors, while rare, can occur. Where a pharmacist has administered less than the prescribed dose the pharmacist must notify you immediately and ask you to return to the pharmacy that day for the remainder of the dose as the balance must be given on the same day or not at all.

Where a pharmacist has administered more than the prescribed dose, the pharmacist should immediately advise and inform you of the need to be medically assessed within four hours at the most.

## Cancelled or withheld doses

Doctors, key workers, and community pharmacists can cancel or withhold doses and can change or stop takeaways. This might happen if:

- there's a risk of a client taking double doses
- a client is stoned/intoxicated when they arrive at the pharmacy (see page 34)
- to ensure an accurate medication serum level is obtained (see page 32)
- to re-establish contact with a client where all other attempts have failed.

The service must try contacting you directly if doses are being cancelled or withheld or takeaways are being changed or stopped. If direct contact isn't possible, a letter outlining

## Making prescription changes

Services need to inform you of their protocols around requests for changes to prescriptions, such as dose and takeaway changes. Usually it is sufficient to give the service three days' notice of any required change, but whether it can happen or not will depend on things like the availability of a doctor to write a new script. If you're travelling overseas a longer period of notice will be required (see page 33).

Note: pharmacists cannot change your prescription without specific authorisation from the prescriber.

## Replacement doses

In general lost or stolen takeaway doses are not replaced unless the circumstances can be verified.

If you vomit within 30 minutes of consuming your methadone dose it is up to the prescriber to decide on replacing the dose. They may require you to prove that the dose has been vomited before they will replace or partly replace the dose. As a general rule 80% of a dose will be absorbed within 20 minutes of swallowing your methadone.

Repeated requests for replacement doses will lead to a review of takeaway arrangements.

Some vomiting of methadone doses can occur during pregnancy. This is usually managed by strategies like splitting the dose, changing the time of consumption, sipping the dose under observation and/or prescribing an effective antiemetic (see page 37).

There is no need to replace buprenorphine after vomiting because of how it is absorbed under the tongue (see page 14).

## Missed doses

If you repeatedly miss doses your tolerance may be reduced which can increase the risk of overdose when you then take the full dose.

As a general rule, you can be dispensed your usual dose if you've missed one or two days.

If three days are missed you will need to be assessed by someone at the service before a dose is given.

If you miss up to five days you will probably receive half your usual dose of methadone or buprenorphine

- » If you are taking methadone you will probably return to your usual dose within seven days, with daily increases of 10-20mg per day until that dose is reached.
- » If you're taking buprenorphine you will probably return to your usual dose within three days with increases of up to 8mg per day.

If you miss five days expect to go through the standard induction process all over again.

The pharmacist is expected to let the service know if you miss more than one dose or you are regularly missing a single dose.

On its own, missing doses is not a sufficient reason to withdraw someone involuntarily from OST. However, if you have significantly breached the safety requirements of treatment, or there is evidence that treatment is not reducing harms, then the service may initiate an involuntary withdrawal (see page 27).



# Completing OST

## Planned withdrawal

People start thinking about coming off opioid substitution for many reasons.

**Your life is stable and you've achieved the goals you set yourself**

**Pressure from others**

**The inconvenience of or dissatisfaction with treatment**

**'Liquid handcuffs'**

**Health concerns etc.**

"The doctor and key worker can work with you to set a suitable dose reduction that attempts to minimise symptoms and cravings, but ultimately the rate of reduction is up to you."

### THINKING ABOUT COMING OFF?

If you're having thoughts about coming off, ask yourself the following questions:

Have you been on a stable dose for six months or more?

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Have you achieved some of your treatment and recovery goals?

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Are many of your friends active drug users?

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Do you have good strategies for dealing with everyday stress?

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Do you know ways to prevent relapse?

If you relapse into unsafe drug use, do you have a plan to deal with this? Do you know how to access self-help groups in the community?

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Can you maintain your recovery without opioid substitution? For example:

- » will your physical health be okay?
  - » will things remain stable at home?
  - » can you avoid illicit drug use?
- 

If treatment is proving to be a hassle, are there other solutions to this?

It's a good idea to discuss these things with your key worker who can help you decide if this is a good time for you to complete treatment. If you decide yes, it's a good time, your key worker and doctor can also help you:

- clarify your reasons and fully assess your situation
- explore all your options
- identify and advise you of possible supports in the community
- determine a realistic rate of reduction
- decide which method you'd like to try:
  - » if you want to know the rate you're coming down at or not
  - » if you want the rate of reduction to be fixed or flexible
- co-ordinate your treatment plan with a focus on planning for completing treatment
- organise post-withdrawal follow-up.

### Planned and gradual withdrawal

People do best when their withdrawal is planned and gradual and they are able to control how often and by how much their dose is reduced, rather than 'jumping off' or reducing their dose rapidly.

Gradual dose reductions lessen the severity of withdrawal symptoms, although symptoms like anxiety and health problems (including any dental pain and other pain problems) can get worse or become more noticeable as the dose decreases.

The doctor and key worker can work with you to set a suitable dose reduction that attempts to minimise symptoms and cravings, but ultimately the rate of reduction is up to you. No one can force you to reduce at a rate faster or slower than the rate you choose (unless it's an involuntary withdrawal).

Relapse prevention and supportive counselling should be offered before, during and after OST withdrawal. You may find it helpful to give information about the withdrawal and aftercare process to your support people (partners, parents, friends etc).

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Ongoing support is particularly important during the first 3-6 months after completing a planned withdrawal as the risk of relapse or return to a pattern of harmful substance, including alcohol, use is very high during this period. The service can inform you of resources available to help you. Many people find it helpful to access support from people who have 'been there done that', so ask about peer support networks in your area.

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Before you complete treatment it's a good idea to negotiate a window period with your key worker so that after your last dose you know there is an agreed to 'window' if you feel you need to re-engage with the service and return to OST. Also, if you do relapse after a planned withdrawal you should be offered prompt readmission so it's a good idea to negotiate a timeframe for this too.

# Involuntary withdrawal off OST

Involuntary withdrawal of OST should be a last resort. The service should have explored and attempted other options before initiating an involuntary withdrawal. This includes seeking a second opinion from another addiction medicine specialist not within the same service or DHB.

## Considerations

The types of issues that may lead to a service considering involuntary withdrawal are when a client:

- Frequently overdoses or continues uncontrolled drug (including alcohol) use which makes the ongoing dispensing of opioid substitution meds unsafe. It is important to note that lapse and relapse are features of addiction, so do not alone justify involuntary withdrawal.
- Threatens violence or is violent towards staff, other clients, the prescriber or pharmacist. The service needs to review what happened that lead to violence or threat of violence before making any decision to withdraw a client from OST.
- Is repeatedly unable to keep to the safety requirements of treatment (eg. repeatedly diverts or loses doses, doesn't keep doses secure, or repeatedly misses appointments).

Injecting methadone or regular use of other drugs is not usually adequate reason for involuntary withdrawal from OST. Regular drug use is different than **continued** and **uncontrolled** drug use as mentioned above.

The clinical/treatment team needs to talk with the client if there are any concerns like those listed above, and the client needs to be given written notification before a decision is made to withdraw treatment.

## Following a decision

When a decision is made to withdraw the client involuntarily from OST, the service needs to:

- give the client, in writing, the reasons for the withdrawal
- caution the client about risks of overdose (due to reduced tolerance) and driving and operating machinery during the withdrawal process
- offer support, where appropriate, during the withdrawal process
- provide the client with a treatment plan
- inform the client of other treatment options and assist with a referral where appropriate
- provide the client with the service's complaints procedure for review of the decision.

Clients should be given the opportunity to present their case and to appeal against the decision to withdraw them from treatment and wherever possible should be retained in treatment until the appeal is resolved. Information about accessing a consumer advocate needs to be provided by the service.

When a client is being withdrawn involuntarily it is recommended that they have a gradual reduction as described for a planned withdrawal and the client needs to be informed about how they might re-engage in OST in the future. In some circumstances a gradual reduction may not be considered safe (eg. in cases of violence).

# Transferring your treatment

## Moving to another area and another OST service

If you move to another part of Aotearoa/New Zealand your OST should be transferred to the service in that area within three months. This is the expectation for anyone moving from a specialist health services in one area to another. The service you are moving from should tell you about:

- the need to be reassessed at the new service
- possible treatment differences between the two services (eg. number of takeaway doses prescribed, frequency of appointments)
- any dispensing restrictions in the new area
- any requirements you need to meet when being prescribed out of area such as returning to the service to see the prescriber or key worker
- the time limit of three months for your current service to prescribe you out of area.

If you are prescribed your medication by a GP you may need to be admitted to the new OST service for a period of time before you can move to a new GP. This is because the national guidelines do not support services authorising GPs outside their own area.

The service you are moving to will expect to receive a comprehensive assessment including a current risk assessment, a summary of your treatment, and a current treatment plan, before they see you so expect to attend an appointment or two with your current service before you move. If you are prescribed by your GP, the service still needs to gather this information from you or your doctor to pass on to the new service.

Communication between services is essential in the transferring process. **Your transfer could be delayed if the necessary information is not provided.** While you are waiting for admission to the new service, one of the team there will see you at least monthly or as often as they have been advised by your original service, and they will communicate with that service about how you are doing.

You can't be denied access to a service if you are still using other drugs, including prescribed benzodiazepines, nor can a service restrict access by requiring you to stop using licit or illicit drugs. However, once you have been transferred to the new service a routine review of all drug (including alcohol) use will occur.

## OST in prison

When a client is remanded in custody they will continue to receive their OST. If they are likely to be on remand for longer than three months, the service might authorise the prison doctor to prescribe, especially if the prison is outside their service area.

When a client receives a prison sentence the service may continue to prescribe OST or will authorise the prison doctor to prescribe. This is especially likely if the prison is outside their service area.

Clients receiving OST in prison should be reviewed by the prescriber at least once every six months. This will be organised by the OST service.

Services usually have a staff member or staff members who liaise with the prisons about remanded or sentenced clients and who provide psychosocial support to all people receiving OST in prison.

## Overdose

Anyone who uses drugs, from the first time user to the long-time veteran, can OD. The first two weeks of treatment, when people are being inducted onto OST, and the weeks after people have come off OST, when their tolerance has decreased, are the riskiest times for overdose.

Most of the deaths that occur during the induction stage involve the use of other substances particularly other opioids but can also involve alcohol, benzodiazepines and antidepressants. Accidental overdose on methadone is possible because of its slow onset of action and long half-life meaning it lasts in the body for a long time.

People with little or no prior experience of methadone may feel the starting dose isn't enough because it feels different than other opioids. In the hope of feeling better they may top up with more methadone or other opioids but their central nervous system (CNS) is already 'depressed' from the methadone; adding more opioids (or benzos) further depresses the CNS and can cause them to stop breathing (respiratory depression).

Three to four days after your first methadone dose is the time of greatest risk: by now the methadone has started accumulating in your body and there can be more methadone in your system than you think or feel. Using anything on top (especially alcohol or sedatives/benzodiazepines) greatly increases the risk of overdose.

## Other issues in OST

Although it's less likely with buprenorphine people can overdose if they use sedative drugs on top.

Deep snoring during methadone treatment can be a sign of your lungs shutting down or dangerous respiratory depression so it's a good idea to tell partners or family and whānau members so they know to watch or listen out for it. If it happens tell your doctor or key worker.

### SIGNS OF OVERDOSE INCLUDE:

- » the person is awake but can't talk or their speech is very slurred
- » their body is limp
- » their face is very pale (cold, clammy bluish skin means their body temperature is dropping)
- » heartbeat is slow, erratic or not there at all due to their heart rate decreasing
- » vomiting
- » unable to 'come-to'
- » choking sounds or a gurgling noise
- » slow and shallow or erratic breathing

Symptoms of overdose can last for 24 hours or more. Someone who's overdosing usually isn't aware of what's happening so they need help. If they stop breathing it only takes a few minutes for them to die.

## Risks to children

**Any child who consumes any amount of methadone or buprenorphine requires immediate medical attention. Children can die from consuming less than 10mg of methadone.**

## OST and driving

The Land Transport Amendment Act (2009) introduced new driving laws that include controlled drugs or prescription medicines as causes of possible impairment. The Act advises that: "persons may not drive or attempt to drive while impaired and their blood contains evidence of use of a controlled drug or prescription medicine."

Methadone and buprenorphine shouldn't affect your ability to drive once you're on a stable dose. However, driving may be affected:

- when you are starting treatment and your OST dose is being increased and especially if you are using 'on top' (if you have to drive you should avoid doing so for two to six hours after taking your OST meds and at least four hours after taking any other drugs including any alcohol)
- following dose increases or during rapid reductions
- if you have a medical or psychological condition that is likely to contribute to impairment
- when you are taking doses of more than 120mg of methadone or 32mg of buprenorphine.

Of course it's not sensible to drive if you are tired and/or have consumed alcohol or other medications or drugs (eg. sedatives, cannabis, other opioids, benzodiazepines, antihistamines).

Your driving ability will be affected more than it would in someone who is not on OST. The risk is increased when the blood level or effects of OST meds reach their peak, usually around two to six hours after consuming methadone and around one to four hours after consuming buprenorphine.

Buprenorphine has less effect on performance than methadone so may be preferable for people who need to drive or operate machinery regularly.

Although OST meds are safe if used as prescribed, OST services are still required to consider clients' driving risk.

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Any client considered medically unfit to drive must be informed of this verbally and in writing by the prescribing doctor and all discussions about driving must be noted in your file.

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If the doctor is concerned that your driving risk is increasing but they haven't actually witnessed you being intoxicated or stoned they are still obliged to respond; they might for example ask you to attend more appointments to focus on alcohol and other drug use, or they might request a treatment review. All discussions about driving must be noted in your file.

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If you continue driving or there is a risk that you will continue to drive the doctor is obliged (that is that they don't have a choice) to write to the NZTA Chief Medical Advisor as soon as is practicable stating the reason/s for their concern (Section 18 of the Land Transport Act 1998 subsection 1(a)).

You will also receive a letter advising that you have been declared medically unfit to drive. It should advise when and how you can expect your situation to be reviewed, and what you need to do to resolve the situation. To get your license back the doctor needs to write to the NZTA Chief Medical Advisor saying you are now okay to drive.

**Benzodiazepines and driving:** There is substantial evidence that using benzodiazepines (prescribed or illicit) increases the risk of motor vehicle accidents. All benzos (even the short acting ones) in combination with OST meds create a degree of risk. Alcohol and benzodiazepines together significantly increase the risk of accidents.

## Drug interactions

There are a number of medications that can cause a variety of unexpected, unwanted or potentially dangerous outcomes if taken with methadone. Using other drugs that depress the central nervous system (alcohol, benzodiazepines, other opioids, GHB, and medications with sedative side effects including some antidepressants, antipsychotics and antihistamines) can be very dangerous and sometimes fatal. Ask your doctor or pharmacist before using any other medicine, including over-the-counter medicines, vitamins, and herbal products. For more info on this ask your key worker or doctor.

## Drug screening

Services request urine drug screens (UDS) to assess client stability. The results are used in relation to takeaways, transfer to shared care and assessing general stability, though they should never be used in isolation; decisions about your treatment should always include an understanding of who you are and what is happening in your life.

How often you need to do UDS is determined by each service. You need to be informed of the procedure and reason for tests and whether there are consequences for your treatment if you not do the test(s) when requested. Also you have the right to know the result of any tests (Health and Disability Code of Consumer Right 7(f)).

Services have procedures in place to ensure the authenticity of the sample, such as testing the temperature and supervising the UDS. Anyone supervising UDS needs to be of the same gender as you and the process must take place in a private environment.

## Measuring methadone serum levels

When a steady dose of methadone is taken daily it should be present in the blood in levels sufficient for you to feel 'normal' over a 24-hour period. That is, you shouldn't feel stoned or have withdrawal symptoms during that time. However, people sometimes complain of problems like "My dose isn't holding me", "I get sleepy at work" or "I wake up feeling like I'm hanging out".

Serum level measurements may help explain why your response to your methadone isn't what would normally be expected with the dose you are receiving.

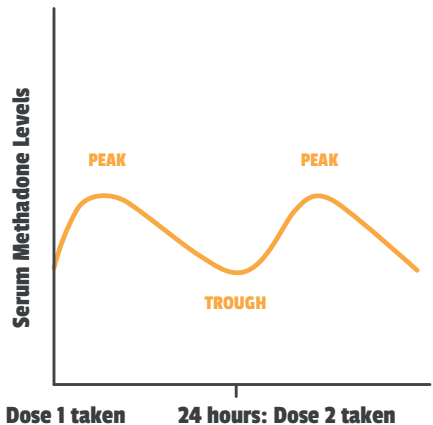
Services will sometimes request you do serum levels when:

- the service is considering a dose above 120mg or wants additional information to help in making a decisions about dose changes
- you are pregnant
- you are suspected of poor compliance or of diverting OST medication
- there is a suspected drug interaction
- you have serious liver or other physical disease.

### Types of serum levels

There are two types of serum methadone levels:

1. A peak level measures the highest amount of methadone in your blood. Typically, the blood level reaches a high point, or "peak," about three to four hours after taking your dose.
2. A trough level measures the lowest level of methadone in your blood. After the three to four hour peak, there's a gradual decline over the remainder of the 24-hour period to a low point or "trough" level.





## How the serum test works

If you need to do a serum level test you need to consume your methadone in front of the pharmacist at approximately the same time each day for four consecutive days. On the fifth day you have a blood sample taken before having your dose. If your veins are in a bad way making it difficult to get blood, capillary blood may be taken instead.

After the blood's taken, you go to the pharmacy and have that day's dose. If the doctor wants to check your peak level as well you'll need to return to the lab three or four hours after consuming your dose to have another blood sample taken.

Just as there's variation in how different people might react to the same dose of methadone there is also variation in the amount of active methadone between two people who have the same serum level.

## Split methadone doses

The need for split doses, that is having two separate doses of methadone in a 24 hour period, is uncommon and is mainly limited to people with a fast metabolism (estimated at less than 10 per cent of people) or for better pain management.

## Travelling overseas with opioid substitution medication

Organising opioid substitution medication for overseas travel can take up to six weeks to organise, sometimes longer if you're travelling to more than one country. So, to ensure your

medication supply throughout your overseas trip you need to plan ahead.

Even if you're just thinking about going overseas it's a good idea to give your key worker a heads-up so there is plenty of time to prepare.

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You need to find out if OST services are available in the country you're going to. Your key worker can help with this. Rather than having takeaways you may need to visit and get your doses dispensed via a service overseas.

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If there's no information available about the country you're going to, or the info available is outdated, contact the embassy of that country to find out if OST is available and if there's a service in the area you are visiting; whether that service will dispense to you; and whether there's any cost involved (in some countries you may also have to pay the pharmacist).

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If you're intending to carry takeaway doses, the prescriber (the service or your GP) needs to clarify with the consulate of that country their laws concerning opioid substitution meds. Some countries won't let you in if you have OST meds with you; others make entry really difficult (especially if you have a criminal record as well). The service will provide you with a letter stating that you are prescribed the medication; however it is possible, even with this letter, that OST medication could be taken from you at any border.

If you have a criminal record or any outstanding debts to New Zealand government agencies, chances are you will be stopped at the border.

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You should travel with methadone tablets rather than liquid in your hand luggage and the doses must remain in their original packaging with labelling.

## Using other drugs

Using a range of drugs is common amongst opioid users especially in the early part of treatment. Services (and GPs) are expected to help reduce or stop other drug use and to reduce the harms or problems associated with drug use (including alcohol).

If you are using other drugs which continue to cause problems or makes things like anxiety, depression, medical problems, or pain worse, services need to provide you (and your support people if appropriate) with advice and information to minimise these problems.

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If you have mental health problems, the service must ensure you have access to appropriate expertise and treatment.

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If you continue using other drugs (including alcohol) and/or regularly inject your prescribed medication, you are unlikely to get takeaways and are likely to be monitored more by the service. Continual injecting will lead to a treatment review (see page 19) and you (and your support persons) should be part of that process.

All health care providers involved in your care are obliged to communicate with each other so expect regular communication or correspondence between the OST service, the pharmacist, and your GP.

- If you appear to be stoned/intoxicated when you present at the pharmacy, the pharmacist may give you half the usual dose and instruct you to return later in the day. You will receive the other half only if you are no longer intoxicated. The pharmacist will inform the prescriber (the OST service or your GP) if this happens.
- If you are found to be using more than one prescriber it is likely that Medicines Control will be informed and a Restriction Notice issued so that you can only be prescribed by the service.

## BENZODIAZEPINES

Ongoing and problematic benzo use will lead to the services reviewing your treatment, particularly your medication dose and any takeaway arrangements. If there are concerns that you have an anxiety or mood disorder then other medication and psychological treatment should be provided.

## TOBACCO

OST services and GP prescribers are expected to promote and provide smoking cessation strategies including nicotine replacement therapy.

# Health issues

A key objective of OST is to improve the health of people with opioid dependence. Services are expected to assess clients' emotional, mental and physical health and if needed refer clients to appropriate health (and other) services.

## Methadone and your heart

Methadone can cause changes in the electrical system of some people's hearts: the heart beat may be too fast or too slow, regular or irregular. This is called 'arrhythmia'.

The type of arrhythmia identified as potentially risky for some people taking methadone is 'QT interval prolongation'. This is when the time it takes for the heart to contract and then recover is longer than normal (QTc interval prolongation is less likely with buprenorphine).

QTc interval prolongation can increase the risk for Torsade de Pointes (TdP) which, though rare, can be fatal. People with a family history of TdP, coronary artery disease and congestive heart failure may be more at risk of TdP. People with a history of blood chemical disorders related to eating disorders, vomiting, dehydration or other drugs known or suspected to increase the risk of TdP may also be more at risk of TdP.

## Noticing the symptoms

The symptoms are not always easy to spot. The person may experience palpitations (racing heart) or dizziness. In more severe cases the person may faint or have what appears to be a seizure. This often resolves on its own but further episodes may quickly follow and occasionally result in a heart attack (cardiac arrest) and death if the person is not resuscitated.

If you have any of these symptoms you should see your doctor or go to an emergency clinic for an assessment. You'll need to undergo an electrocardiogram (ECG) which will usually indicate whether there are significant changes in your heart's electrical conduction system. If there are doubts about what is causing the problem you may need further attention from a heart specialist.

## What to expect if your heart is affected

Expect closer monitoring by the service if you are one of the few people affected by QTc interval prolongation, you have unexplained fainting or seizure episodes, or are at risk of cardiac problems. Your GP and pharmacist will probably also be notified about it so that prescribing of medications that might prolong QTc can be avoided.

## Blood-borne viruses (BBV)

Hepatitis B and C are the most common blood borne viruses experienced by people with opioid dependence. Both can lead to scarring of the liver/fibrosis, cirrhosis and, in some cases, liver cancer.

All OST services and GPs should provide information and education about BBVs to clients and their support people and actively support people to get treatment for hepatitis C.

Some services offer or support people to get tests for hepatitis B, C and HIV though testing can only be conducted with your informed consent.

## Dental health

Dental problems are common for people who use opioids. While some people believe “methadone rots your teeth (and bones)” dental problems are commonly due to reduced saliva (which happens with all opioids), poor diet (eg. irregular mealtimes, increased intake of sugary foods) and poor dental care.

## Ageing on OST

As well as the usual health issues that come with getting older, people on OST can experience health issues related to past drug use or existing health issues can get worse.

Buprenorphine causes fewer adverse side effects than methadone (and morphine) in older people so some clients will choose to transfer to buprenorphine as they age.

Some of the problems faced by people taking methadone include:

- progressive liver damage
- progressive airways and chronic lung damage from smoking (cigarettes and/or cannabis)
- vein and/or arterial damage making IV access difficult for obtaining blood tests and in emergency situations
- heart problems, especially if they've previously had endocarditis
- kidney problems
- chronic pain related to past injuries and chronic illness
- osteoporosis particularly in men and probably in post-menopausal women
- altered sexual function and lowered testosterone levels.

Speak to your GP or OST doctor if any of these are causing you concern.

If clients are admitted to an aged care facility the OST service staff will liaise with the relevant nursing and medical staff at the care facility about ongoing OST.

## Managing acute and chronic pain

### Acute pain

The dose you are prescribed for addiction/dependence is unlikely to provide any pain relief (analgesia) for acute pain because of increased tolerance. Also effective pain relief won't be achieved for most OST clients with 'conventional' opioid doses - that is, the doses prescribed to people not receiving OST.

If you are planning to undergo surgical, medical or dentistry treatment you need to inform the

service or your GP (whichever is prescribing your OST medication) so they can liaise with hospital staff, dentists or other health professions about pain management and possible interactions with other medications.

Buprenorphine may partially block the effects of other opioids so it's important that consultation occurs between the prescriber and whichever health professional is managing your surgical, medical or dentistry treatment.

## Chronic pain

Chronic (persistent) pain problems can significantly affect people's stability in treatment. If you have chronic pain that affects your life this needs to be reflected in your treatment plan. The service can provide or arrange non-pharmacological pain treatment which might include consultation between the service and pain specialists.

## Pregnancy and breastfeeding

Pregnant women who are dependent on opioids are encouraged to enter OST as early as possible into their pregnancy as it is safer for mother and baby than the continuing use of other opiates such as morphine or heroin.

If you're already on methadone and become pregnant the service will provide you with extra attention during your pregnancy to help ensure your treatment is optimal for you and your baby.

Methadone is the preferred medication as there is much more evidence about its efficacy and safety for pregnant and breastfeeding women.

Also, anyone being inducted onto buprenorphine needs to be in mild to moderate withdrawal, which could place the foetus under unnecessary stress<sup>8</sup>.

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Some women think about coming off methadone when they are pregnant and while this might be a realistic goal for some, the World Health Organisation recommends women continue with methadone treatment until after the baby is born.

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Doses should not be reduced if the pregnancy is in any way unstable. Opioid withdrawal symptoms may induce a spontaneous abortion in the first trimester of pregnancy, or premature labour in the third trimester. If a dose reduction is required it should only occur in the second trimester and in small amounts.

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Nausea and vomiting are very common for any pregnant woman especially in early pregnancy. It is important that any nausea and vomiting is well managed because you need to maintain adequate blood methadone levels for you and your baby. Vomiting can usually be dealt with by altering your diet, splitting your dose, or changing the time of day at which you take your methadone. If vomiting becomes an ongoing problem your key worker and doctor will have strategies to help you.

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Like all opioids, methadone crosses the placenta to the unborn baby, so many of the babies born to methadone-dependent mothers go through withdrawal at birth.

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<sup>8</sup> Buprenorphine without naloxone (Subutex) is used overseas by pregnant women, but in Aotearoa/New Zealand neither buprenorphine formulation (Suboxone and Subutex) are licensed for use in pregnancy.

This is known as ‘neonatal abstinence syndrome’ (NAS). The symptoms of withdrawal vary in strength and length and are likely to be increased by antenatal smoking and benzodiazepine use. They are not related to the dose of methadone that the mother is taking.

- » Some newborns will manage with spending quiet time and sleeping in the same room with their mothers while others will need to stay in the hospital for a while so their withdrawal symptoms can be managed. Your key worker or maternity services can give you more detailed information about this.
- » Breastfeeding may also reduce the severity of NAS. Only low levels of methadone (and buprenorphine) transfer into breast milk so mothers on OST are usually encouraged to breastfeed because of the benefits to the baby’s immune system and the bonding that happens between mother and baby.

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After baby is born your treatment plan will probably be reviewed. This may include a serum level test to see whether your dose needs altering. If the dose has been increased, most women return to the dose they were taking prior to becoming pregnant.

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Getting support, information, and advice should help make pregnancy and new parenthood a positive time for you, your baby, and your whānau. Ask questions and ask for help when you need it.

# Interim prescribing

Where services are unable to admit people in the expected timeframe as set out in the national guidelines, they can provide “interim prescribing”. Basically this means people are prescribed, by the service or their own GP, a maximum dose of 60mg of methadone until they can be admitted to ‘full’ treatment.

- People on interim prescribing don’t need to do urine drug screens or undertake counselling.
- People on Interim Prescribing are not expected to have to take methadone every day.
  - » However, if they miss three consecutive doses the subsequent dose must be half the usual dose before they can return to the full dose the following day.
  - » If they miss five consecutive doses they must be reviewed by the prescriber.

The OST service should provide advice, support and information about addiction (or AOD) treatment services that may be able to offer additional support.

# Compliments and complaints

Services need to know what clients think. If your service has a suggestion box available you can use it to provide feedback to the service: compliments, suggestions, service improvements, frustrations etc. If your service doesn't have a suggestion box you could ask them to make one available.

If you are unhappy with your treatment and/or the service there are things you can do. For example:

- talk to someone who can help you work out your options, which could be a consumer advisor/liaison, peer advocate, or Health and Disability Advocacy Service ([www.advocacy.hdc.org.nz](http://www.advocacy.hdc.org.nz))
- ask to speak to the team leader or manager about your concerns
- request a treatment review
- make a complaint

Every service has a complaints procedure which you should know about. Most complaints procedures include:

- you receiving an acknowledgement that your complaint has been received

- an explanation of the process including the timeframe for the service to respond to your complaint
- an investigation of what has led to your dissatisfaction
- you receiving a response which, where appropriate, outlines any changes/improvements the service will consider or make as a result of your complaint
- the response should also include options for you if you are unhappy with the response, for example, writing to the Health and Disability Commissioner.

For more information on complaints go to or look at the website for your DHB (District Health Board) or service provider. Chances are that the complaint process will be available there and you may be able to make your complaint online.

# Matua Raki

National Addiction Workforce Development