

SURVEY OF NEW SOUTH WALES OPIOID TREATMENT PROGRAM PUBLIC CLINICS SWAT REPORT 3

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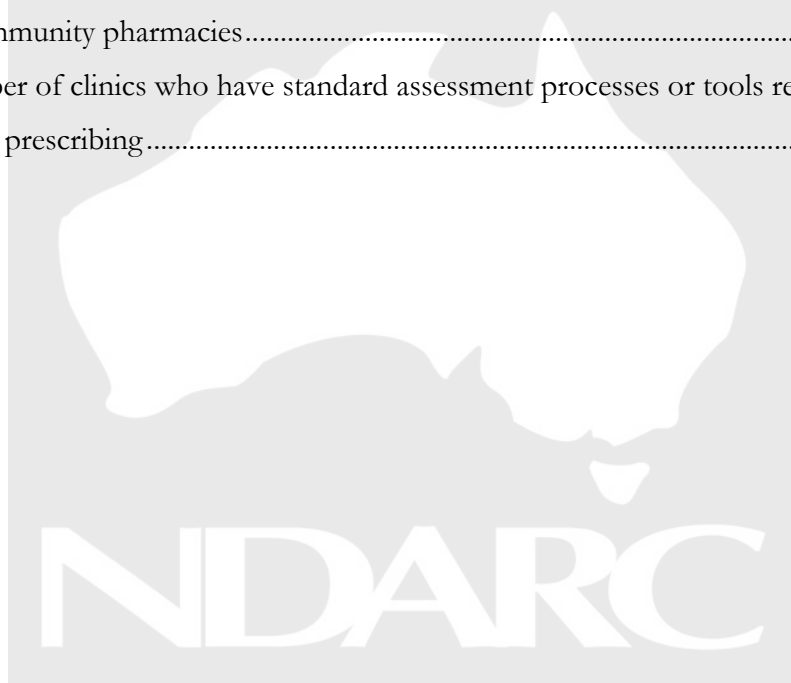
Contents

List of Tables	iii
List of Figures	iv
Abbreviations	v
Acknowledgements	vi
Summary	vii
Recommendations	xi
1. Introduction	1
1.1 Context of the survey	1
1.2 Current opioid treatment provision in NSW	2
1.3 State-Wide Advisory Team (SWAT): Drug Health Streamed Shared Care.....	4
1.4 Streamed Shared Care.....	4
2. Method	7
2.1 Clinic sample.....	7
2.2 Measures and procedures.....	7
2.3 Statistical analysis	8
3. Results and recommendations	9
3.1 Response rate.....	9
3.2 Clinic descriptors.....	9
3.2.1 Number of public clinics in each AHS.....	9
3.2.2 Location and description of facilities.....	9
3.2.3 Private clinics.....	13
3.2.4 Range of on-site services provided	14
3.2.5 Staffing.....	16
3.2.6 Medical officers.....	17
3.2.7 Number of clients managed by public clinics.....	18
3.2.8 Public clinic capacity	19
3.2.9 Opening and dosing hours	20
3.3 Pharmacotherapy provision.....	22
3.3.1 Dispensed pharmacotherapies	22
3.3.2 Methadone takeaway provision and charges	22
3.3.3 Proportion of methadone and buprenorphine clients managed at public clinics	24
3.3.4 Where are public clinic managed clients dosed?	27
3.3.5 Who prescribes to public clinic managed clients?	30

3.4 Clinic capacity.....	36
3.4.1 Clients managed per FTE clinic staff.....	37
3.4.2 Transfers from correctional facilities.....	38
3.4.3 Minutes per dosed client.....	38
3.4.4 Medical sessions.....	41
3.4.5 Medical sessions per client numbers.....	42
3.5 Clinic practice.....	44
3.5.1 Case management (care planning).....	44
3.5.2 Waiting lists.....	45
3.5.3 Prescriber review.....	46
3.5.4 Time-limited public clinic dosing.....	47
3.6 Shared care practice.....	47
3.6.1 Community pharmacy shared care practice.....	47
3.6.2 Standard assessment processes for pharmacy transfer.....	50
3.6.3 Pharmacist clinical placements.....	51
3.6.4 GP shared care practice.....	52
3.6.5 Divisions of General Practice and GP clinical placements.....	53
4. Conclusions.....	55
5. References.....	58
6. Appendices.....	62
Appendix A: Opioid Treatment Program Public Clinic Survey.....	63
Appendix B: NSW Public OTP Clinics Contact List.....	67
Appendix C: Stability Assessment Flowchart; Supportive notes; and Tips for clinicians.....	68
Appendix D: Example of benchmarking.....	77
Appendix E: Sample GP letter/agreement.....	81
Appendix F: SWAT GP Public Clinic Audit Form.....	82
Appendix G: Example of benchmarking Medical Clinic sessions.....	83

List of Tables

Table 1. Public clinics in each AHS and clinics that participated in the survey	9
Table 2. Clients considered to be ‘managed’ by a public clinic	18
Table 3. Clinics classified according to their defined maximum client capacity	19
Table 4. Weekday methadone and buprenorphine dosing hours.....	20
Table 5. Weekend methadone and buprenorphine dosing hours	21
Table 6. Number of clinics in each AHS providing takeaway methadone doses	23
Table 7. Determinants of client capacity by clinics with a defined maximum capacity	37
Table 8. Review frequency for a clinic offering 96 clinical review appointments per month.....	44
Table 9. Proportion of clinics providing case management to different client groups.....	45
Table 10. Number of clinics who have standard assessment processes or tools regarding transfer of clients to community pharmacies.....	51
Table 11. Number of clinics who have standard assessment processes or tools regarding transfer of clients to GP prescribing.....	52



List of Figures

Figure 1. Clients in opioid treatment in NSW by dosing site	3
Figure 2. Referral pathways – public clinic, community pharmacy, and GP prescriber	5
Figure 3. Location of public clinics in NSW	10
Figure 4. Example formula used to calculate number of OTP dosing places at public hospitals..	13
Figure 5. Proportion of public clinics providing on-site services other than opioid dispensing....	14
Figure 6. Total number of clients managed at public clinics	19
Figure 7. Total clients managed at public clinics according to pharmacotherapy type.....	25
Figure 8. AHS breakdown of total clients managed at public clinics according to pharmacotherapy type.....	26
Figure 9. Proportion of public clinic managed clients dosed at a public clinic or community pharmacy/private clinic.....	27
Figure 10. AHS breakdown of the proportion of public clinic managed clients dosed at a public clinic or community pharmacy/private clinic	28
Figure 11. Proportion of public clinic managed clients with a public clinic prescriber or private prescriber	32
Figure 12. AHS breakdown of the proportion of public clinic managed clients with a public clinic prescriber or private prescriber	33
Figure 13. Mean number of clients per FTE clinic staff according to which clients clinics provide case management for	38
Figure 14. Mean minutes per dosed client combined for methadone and buprenorphine according to dosing hours per day.....	39
Figure 15. Minutes per dosed client according to pharmacotherapy type for the five clinics with separate methadone and buprenorphine dosing times	39
Figure 16. Number of four-hour medical sessions provided at public clinics each week	41
Figure 17. Clients per four-hour medical session at public clinics.....	42

Abbreviations

ACT	Australian Capital Territory
ADIS	Alcohol and Drug Information Service
AHS	Area Health Service(s)
CNC	Clinical Nurse Consultant
FTE	Full-time equivalent
EPC	Enhanced Primary Care
GP	General Practitioner
GPET	General Practice Education and Training
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user(s)
MHDAO	Mental Health and Drug & Alcohol Office, NSW Health (formerly Centre for Drug and Alcohol)
NGO	Non-government organisation
NSP	Needle and Syringe Program
NSW	New South Wales
NUM	Nursing Unit Manager
OTP	Opioid Treatment Program
PBS	Pharmaceutical Benefits Scheme
PSA	Pharmaceutical Society of Australia
PSB	Pharmaceutical Services Branch, NSW Health
SD	Standard deviation
SSC	Streamed Shared Care
SWAT	State-Wide Advisory Team: Drug Health Streamed Shared Care
TCA	Team Care Arrangement
NSW Area Health Services	
GSAHS	Greater Southern Area Health Service
GWAHS	Greater Western Area Health Service
NSCCAHS	Northern Sydney/Central Coast Area Health Service
HNEAHS	Hunter/New England Area Health Service
NCAHS	North Coast Area Health Service
SESAHS	South East Sydney/Illawarra Area Health Service
SSWAHS	Sydney South West Area Health Service
SWAHS	Sydney West Area Health Service

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Summary

The State-Wide Advisory Team (SWAT): Drug Health Streamed Shared Care was established in 2005 by NSW Health and Drug Health Services, Sydney South West Area Health Service for the purpose of mapping, consulting and supporting opioid pharmacotherapy services across NSW. Specifically SWAT had the objective of building capacity within existing specialist and community facilities for the management of those with drug and alcohol problems, with an initial focus on those with opioid dependence.

To assist in the attainment of the goals of the SWAT project, it was decided to undertake a study to identify the range of work practices, clinical referral pathways and supporting policies currently in place in public clinics providing treatment for opioid dependence across NSW. In addition, the possible utility of benchmarks for staffing, capacity and service delivery was investigated. This report presents the findings of the *Survey of NSW Opioid Treatment Program Public Clinics* conducted by SWAT.

Initial consultations with Area Health Services (AHS) revealed wide variation in culture and priorities as well as in staffing levels, resources, and operational practices at public clinics across NSW. However, one of the few consistencies across the state was that many public clinics had a limited capacity to take on new-to-treatment clients and there appeared to be an under-utilisation of available community pharmacy dosing places.

Between April and September 2006 a questionnaire was sent to all public clinic Nursing Unit Managers (NUMs) across NSW. A response rate of 100% was achieved. Data was collected on a range of clinical and resource variables including staffing levels, client numbers, provision of takeaway doses, and the utilisation of community service providers such as community pharmacies and GP prescribers, and relationships with these service providers. Where appropriate, results have informed the development of recommendations for clinical practice and in some areas suggestions are made for benchmarking clinical activity and staffing to client ratios. Associated rationales and suggested ways of achieving these recommendations have also been developed. A full list of recommendations is provided in the section following this summary.

Clinic characteristics

Thirty-five public clinics across NSW participated in the survey. The number of clinics in each AHS, as defined by the AHS, varied between one and seven. The majority were located on

hospital grounds. Fourteen clinics reported having a private clinic in their local area (none of which were rural). All clinics except one provided both methadone (74% Methadone Syrup, 50% Biodone Forte, 24% both) and buprenorphine, with most not reporting either separate dosing times or areas. On average, 80% of those dosed at public clinics were on methadone. Forty-one percent of clinics (n=14) provided takeaways, of which eight clinics provided these at no charge.

All clinics provided case management and in all but three clinics this was delivered onsite. In terms of other on-site services, half the clinics reported providing other medications and approximately 40% providing services for other drug or alcohol problems. There was limited access to other on-site services, notably only 29% having a hepatology service, 23% a dental service, and 11% an on-site psychiatrist.

Client numbers, opening hours, clinic capacity

The mean number of clients managed at each clinic was 159 (range: 18-364). Only 21 clinics had a defined maximum capacity (with determinants including clients per full-time equivalent (FTE) case manager, FTE prescribers, number of medical session and dosing hours available).

In terms of opening hours, generally, the bigger the clinic the longer the opening hours. However, there was wide variation in dosing hours between clinics (two to eight hours/day) and there was generally very limited availability of early and late dosing. All but three clinics were open seven days a week. The majority of clients managed by a public clinic (59%) received their doses at a public clinic. The overall split between public clinic dosing and community dosing, however, varied widely between individual services. For example, the proportion of clinic-managed clients dosed at community pharmacies varied from 22% to 63% across the different AHS. The majority (80%) of clients managed by a public clinic had a public prescriber, regardless of where they were dosed (range: 57-100% across the AHS).

Staffing (nursing, medical, other) and clinical activity (including prescribing and case management)

Thirty-three clinics had a dedicated NUM position, and three-quarters had a dedicated administrative support position. The mean number of FTE clinical staff at each clinic was four. Just under half of the clinics reported having at least some non-nursing clinical staff. Taking into account case management activity, the mean number of clients per FTE case manager was 28 (range: 10-50).

Ninety-four percent of clinics reported having on-site medical officers, with 54% having staff specialist medical cover. The mean number of four-hour medical sessions was 4.3 per week (range: 0.25-12). The mean number of clients seen per four-hour medical session varied between four and 25. Three-quarters of clinics reported having minimum periods for prescriber reviews, with only 50% setting this at three months or less.

Waiting lists

Nine clinics reported having a waiting list (although interpretation of this term was inconsistent). These findings should not be interpreted as meaning that the remaining clinics had available capacity. The findings only suggest that the majority of clinics do not keep a formal record of their inability to provide treatment to all those who present for treatment.

Shared care activities

The vast majority of clinics reported routine transfer of stable clients to pharmacies and 75% reported that they monitored available capacity within their local pharmacies. Two thirds of clinics reported the use of standard assessment tools for identifying stable clients for transfer. Less than half reported the transfer of stable clients to GPs and only two-thirds reported they had contact with any of their local GP divisions. Although many clinics recognised the utility of transferring patients to community providers, many AHS, particularly those located in rural areas, reported difficulty in accessing both GP prescribers and dosing community pharmacies.



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