clinic Rx
respect empathy dignity

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Dear Pharmacist

I will be away from work for two weeks. This will affect five clinic days in Lismore on the following dates – 18, 19, 25 and 26 of September. I will next be seeing patients again on Tuesday October 3.

I have contacted all patients booked in for those days and provided them with new appointments and I will send prescription extensions to their respective dispensing pharmacists over the course of this week.

This break is not a holiday as such, so I can contacted by phone – 0428 890 021. I can respond by SMS for simple queries, or take and return calls for more complex matters. I can then fax prescriptions and provide phone orders as required for any urgent matters.

If you make any changes to clients takeaways for urgent travel, sickness or other emergencies, then I will always provide a prescription to cover when I get back, so feel free to use your discretion in that regard. The vast majority of patients are pretty stable right now and I'm sure everyone knows that my preference is for dosing continuity. A patient needing to self medicate with black market opioids because of my oversight on a script expiration date would be a clinical failure from my perspective to say the least.

Phone or SMS 0428 890 021
email dr.paul@opioid.com.au

I have attached detailed information to this letter outlining my usual decision making process in situations that would normally require a phone call to me, they could almost be thought of as standing orders. It is the approach I would take if you phoned me in five identified areas of urgent presentation. If you were to adjust a clients dosing regime accordingly (if I could not be contacted) then I would always send an appropriately dated prescription as soon as I was back at work.

It is a detailed outline, but clinical procedure in these five presentations can be critical in terms of reduction of harm and mortality. Some of you already have this, and apart from minor updates it is largely unchanged. Read, file, refer to later or shred now as time and energy allows :)

I imagine it will be a trouble-free time away but I am always happy to take calls to clarify any situation..

Thank you and all the best,

Paul McGeown

Urgent Dosing Policy

We don't have many true emergencies or “urgencies” in pharmacotherapy although many situations seem earth-shatteringly critical to some of our patients. In general I believe there are five. Here are my usual approaches to these situations, bearing in mind my bottom line decision is always the one that the pharmacist on the spot thinks is the best course of action and is most comfortable with.

1. **Script inadvertently expires**
2. **Urgent travel out of town**
3. **Missed doses.**
4. **Lost or stolen doses.**
5. **Patient conflict.**

1. **If an opioid prescription expires** while I am away and I have overlooked this then I would be grateful if you could continue to dispense for the patient and I will send an appropriately dated prescription as soon as I get back from leave. My prescriptions always expire on the day of the next appointment (I put the time and date on each prescription), but rarely the next appointment is not logged in and therefore the prescription extension is overlooked when I take leave.

   Diazepam staged supply. There is good recent evidence ** to show that the co-dispensation of benzodiazepines and opioids for clients with chronic anxiety on an OTP program actually leads to safe and positive outcomes, with ***less*** morbidity and mortality than if benzodiazepines are declined and withheld. This may seem counter-intuitive but many factors such as “positive therapeutic alliance”, “retention in treatment”, reduction in self medicating and “benzodiazepine tolerance induction” lead to safer outcomes. There seems to be a secondary independent long-term anxiolytic effect of benzodiazepines that persists despite tolerance to the obvious primary BZD-induced anxiolysis/sedation. Patients reliably report this effect. I try and arrange seamless staged supply for all such patients. If because of some oversight on my behalf a routine benzodiazepine prescription fell short during my absence I would be very grateful if the patient could be dosed and I will provide a prescription as soon as I am back at work. I also respect your decision to not do this of course especially if you feel the patient's overall stability is impaired.

** **Benzodiazepine maintenance in opiate substitution treatment: Good or bad? A retrospective primary care case-note review**
Adam Bakker, Emmanuel Streel British Medical Journal 2017

2. **Urgent out of town travel where I cannot be contacted**. Please dispense the maximum number of takeaways allowed. If the person is stable, my usual practice is to allow 7 consecutive takeaways for out of town or interstate travel – if you were comfortable to provide that then I would always send a script to cover as soon as I returned. I am a Queensland prescriber so I can get a patient dosed in virtually all areas of Vic, NSW and QLD easily if they need to be away for longer than a week.
   If a person needs to access illicit drugs in a new city without reliable contacts they are forced to associate with the most unpredictable and dangerous sources. Voluntarily entering withdrawal and using nothing is not an option for 90% of people despite what they tell us when they get back. Eventually at some point a patient will usually tell me what they had to do to get the opioid they needed and it can be pretty degrading and hellish. In 20 years I literally cannot recall a patient who got into trouble with takeaways provided for them to travel for a family emergency. But I can think of dozens of disasters for people who were forced to "score" while they were away because they weren't given any.

3. **Missed doses:** Below is the regime that I use for missed doses. Making sure that someone returns to dosing after they have missed some days is crucial. It is the most humane and safe thing we can do. A short relapse can be a hiccup or it can be a death sentence depending on what happens here.
   The guidelines say that after a period of missed doses the person needs to be reviewed. I interpret this to mean that the review can be done by a dosing pharmacist who is ideally placed to check if the person is too intoxicated to dose (methadone) or not sufficiently in withdrawal to dose (buprenorphine). For virtually all missed doses this and a dose adjustment is all that needs to be done for safe continuation in the program. .
   It does not need to be a doctor or a nurse who does the review. In fact dispensing pharmacists who know the clients are **by far the best clinicians for this job**. It embarrasses me how naive most doctors are to the realities of dosing – the states our patients are in when they turn up to dose, their behaviour, the things you over-hear and witness. We see our patients at their most squeaky clean, polite and charming best... you get to see them at both ends of the spectrum – from hanging out after takeaway days to bleary-eyed and borderline intoxicated on pay day.
   My return-to-dosing approach is based on sound and safe evidence and is a good balance of safety and practicality. It is also liveable and acceptable to clients. The "miss three days and you're off" approach is not necessary and we are leaving that behind. Dosing saves lives, it really is as simple as that and even irregular dosing induces and maintains tolerance (overdose protection), and reduces crime at a level that eclipses any

law enforcement action.

Missed doses

For methadone:

- if there are three or less days missed then assess intoxication and continue as normal.
- If 4 – 7 days are missed then please provide a half dose for one day then continue as normal the next day. Please try to contact me before that is given, but If I am unavailable and it looks like a further day may be missed because of that ***and*** you feel comfortable then my preference would be to give the half dose and I will send the script ASAP. Most patients will tell us that they have used nothing in the past four or five days or so, but this is rarely the case, and their tolerance does not drop that quickly in any case. I absolutely respect your preference to wait for a verbal or faxed order as well if that is the case of course.
- If more than seven days are missed then it is something we would need to discuss prior to dosing. A stepped re-induction beginning at 40mg is required but I do not need to visually reassess the patient once you have already talked to them and we can arrange the re induction by phone and faxed prescriptions. Unless, of course, their instability is such that they require formal assessment by me. I will always make an urgent early appointment for any patient who is drawn to my attention by a pharmacist, this goes without saying.

Suboxone has a much larger safety margin. Try to contact me, but if I am not available and you wanted to avoid another missed day, feel free to dose accordingly as below then I will send a prescription as soon as I am able. I will make an early appointment if it looks like the missed doses are a sign of instability. I stress to suboxone patients to dose on the day they are due NOT when their films run out... sometimes the two do not always match because patients try to "cut down" and end up with extras which they see as a sign that they are doing well..... but we see it as a sign that they are non-adherent to the program.

- if seven days or less are missed then dose as normal, regardles of dose.
- if 8 – 14 days missed and dose is less than 16mg then continue as normal and reduce TA to four per week (2 plus 2) until I can see them.
- if 8 – 14 days are missed and the dose is greater than 16mg then half dose for one day then continue on normal dose the next day. Reduce TA to four per week (2 plus 2) until I can see them.
- if more than 2 weeks, ask the patient to see me.

Lost or stolen prescriptions are a serious matter. The guidelines are harsh and do not give much support to replacing TA. My approach is a compromise – if a person can provide a receipt or a phone screen shot of a police report for the theft or loss of the takeaways then I will replace them but not as takeaways – I will prescribe them as supervised daily doses in the pharmacy. This is not something I repeat, it is a once-only salvage. I tell patients that if they lose their takeaways or they are stolen and I cannot be contacted then they must consider the likelihood of being re-dosed is very low. However if I am away and a trusted client provides you with evidence of police reporting AND you assess the client as reliable and stable then I would furnish a prescription for daily dispensation of a dose to replace the takeaways as soon as I am able.

Thefts and losses do happen in the real world and condemning someone to opioid withdrawal in addition to the theft is not something I do lightly And because it involves interfacing with the police it is not something our patients do lightly either, as a result I have not felt that that re-dosing compromise has been taken advantage of.

Patient conflict or behavioural problems

If you experience any behavioural issues that are a sign of clinical instability or mental health issues then I will see the client on **the next available work day** and attempt to sort things out for them. I am very understanding and proactive with these patients. If however it is just repeated bad behaviour, verbal abuse, non verbal disrespect, intimidation of any kind, problem behaviour outside or near your pharmacy, constant breaking of limits or pharmacy requirements then I support your decision to stop dosing the patient. I stress to clients that we are private businesses and we can decide who we treat or not, we do not have to adhere to standards of judicial proof or even natural justice. We have a medico-legal responsibility to make sure they are appropriately referred to the public service but if their behaviour is threatening or abusive then we do not even have that responsibility. If that happens when I am away then they have no options, their dosing will cease and cannot be prescribed anywhere else if I cannot do the prescription. The waiting time for the public clinic is at least 4-6 weeks usually.

My patients know that I will always back-up and support a pharmacist-decision in any situation and that I expect polite and respectful behaviour towards dispensing pharmacists - the same politeness and respect they get from me. Hopefully that translates into decent behaviour in your pharmacies, please let me know if that does not happen and I will address it at an individual level

Paul McGeown Sept 2017