The Pharmacy Guild of Australia

Community Pharmacy Roadmap Program Development Template

Program/Service	**Opioid Dependence Treatment**
Quadrant	**A – Prescribed Medicines – Services and Programs**
1. Program/Service Description	
a) Background	Illicit and licit drug abuse is a serious and complex problem that impacts on individuals, families, communities and the economy. The estimated cost of drug abuse in Australia was $56.1 billion in 2004-05, with illicit drugs accounting for $8.2 billion (14.6%)[1]. Harm reduction strategies aim to directly reduce drug-related harm to individuals, families and communities based on principles of public health and human rights[2]. It is recognised that the provision of treatment services for people who are drug dependent reduces drug use and prevents drug-related harm[3]. The broad goal of treatment for opioid dependence is to reduce the health, social and economic harms to individuals and the community arising from illicit opioid use[3]. In Australia, Opioid Dependence Treatment (ODT) programs are funded by a mixture of State, Territory and federal governments, as well as user-pays, with each jurisdiction differing in the ways in which ODT is provided based on regulatory requirements and funding structure[4]. It is estimated that 80% of clients pay a dispensing fee which varies depending on the pharmacy and treatment type[4]. Dispensing can occur in a public clinic, community pharmacy, private clinic, prison or hospital, with almost 80% of clients dispensed in community pharmacies and private clinics[4]. Treatment is generally provided in a supervised setting on a daily basis, with the provision of take away doses for stable clients authorised by the GP and within regulations for each jurisdiction[4]. The Australian Government funds the cost of buprenorphine, buprenorphine + naloxone and methadone, under a section 100 program of the Pharmaceutical Benefits Scheme (PBS), supplied through clinics and pharmacies approved by State and Territory governments. At June 2008 there were more than 41,000 people receiving pharmacotherapy treatment, 72% on methadone maintenance, 22% on buprenorphine and 5.5% buprenorphine + naloxone[4]. Methadone was introduced in Australia for the treatment of opioid dependence in 1969 and has been found to be more effective than no treatment, placebo, detoxification alone, and drug-free treatment in retaining people in treatment and reducing heroin use[3]. Buprenorphine has been used to treat opioid dependence in Australia since 2000, with buprenorphine + naloxone approved in 2005[3]. The effectiveness of buprenorphine is similar to that of methadone in terms of reduction of illicit opioid use; however may be associated with lower rates of retention in treatment[3]. The Guild commissioned a study to collect a wide range of data that could be used to investigate the health, social and economic benefits of best practice funding model options for the provision of methadone and buprenorphine[5]. This was followed by a trial of a nationally consistent funding model for the provision of pharmacotherapy treatment in community pharmacy, comprised of a subsidy for client treatment costs and improved incentives for pharmacists[6].

[1] 'Australian Drug Strategy Beyond 2009 – A Consultation Paper' (November 2009) Intergovernmental Committee on Drugs National Drugs Strategy Working Group

[2] Anex Australia – promoting drug harm reduction (website: http://www.anex.org.au/)

[3] 'National Pharmacotherapy Policy for people dependent on opioids' (2007) Intergovernmental Committee on Drugs

[4] 'Polygon – the many sides to the Australian opioid pharmacotherapy maintenance system' (2009) Australian National Council on Drugs

[5] 'Development, Implementation and Evaluation of Funding Model Options for Dispensing of Pharmacotherapies for Opioid Dependence in Community Pharmacy' (2007) 3CPA Research & Development Program

[6] 'A National Funding Model for Pharmacotherapy Treatment for Opioid Dependence in Community Pharmacy' (2010) 4CPA Research & Development Program

b) Brief Description	Due to the jurisdictional differences and multilayered dispensing options, a nationally subsidised scheme and the formalisation of case-conferencing to allow for greater support for the client and dispensing-fee payment to the pharmacist is strongly supported by various key stakeholders within the sector. This would encourage more community pharmacies to become involved in ODT and improve access to treatment for clients.
c) Alignment with Government Policy	Any ODT program will need to align with the National Medicines Policy. A nationally subsidised ODT scheme would align with the National Drug Strategy 2004-2009 (currently under review), which provides a coordinated approach to drug issues in the Australian community. It is also consistent with the National Pharmacotherapy Policy for People Dependent on Opioids (2007).
d) Expected Outcomes for Government and Community Pharmacy	Expected outcomes for government of a nationally subsidised program are improved coordination between the Commonwealth Government and State and Territory governments, and improved consistency and availability of service delivery. In addition, the literature suggests that dispensing fees discourage treatment uptake[4], so a subsidised program would increase treatment uptake rates and reduce the burden associated with illicit opioid dependence. Form a community pharmacy perspective, this initiative would lead to a greater number of pharmacies being involved in ODT. Community pharmacy will have the opportunity to develop a viable business involving service provision as an adjunct to product supply.
e) Consumer Benefits	A nationally subsidised scheme for ODT programs, operated by community pharmacies, would provide an affordable and accessible treatment program for clients. Such a scheme would also create a financial safety net for those entering the program and protect the whole community. Increased ODT providers within community pharmacy would provide clients with the necessary support to effectively manage their opioid dependence through accessible and professional management of their pharmacotherapy. The service would contribute to improved adherence and improved quality of life for the individual. Moreover, services of this type through community pharmacy, as opposed to those provided through specialised treatment centres, provide patients with a more community-based setting for management of opioid dependence. This allows continuing community contact, which can allow for better outcomes in terms of re-integration into the workforce and general societal contact/relationships.
f) Who Performs the Service	Pharmacists
g) Collaboration with Other Health Care Professionals	*Is the service likely to require any formal collaboration with other health care professionals?* Yes - collaboration will be required with GPs and other health professionals within the alcohol and other drug sector as part of case conferencing.
2. Implementation and Enablers	
a) Stakeholder Consultation	*Representative bodies from the following areas will need to be consulted in order to fully develop and implement the program:* • Consumer organisations • Pharmacy organisations • GP organisations • Government • Pharmacy software vendors • Alcohol and Other Drug Organisations • Funders • Professional Insurers

b) IT Requirements	*Is pharmacy software required to deliver this program?* Yes - IT solutions may assist in the delivery of this service. Program software needs to integrate service consultation with pharmacy software, be streamlined for ease of use and consistent with pharmacy workflow. Documentation and claiming software needs to be available for programs that support subsidised services.
c) Infrastructure and Staffing	*Is a private consultation area required to deliver this program?* Yes. *Is the program within the pharmacist's/pharmacy assistant's normal scope of practice?* Yes - some additional training may be required. *Will an additional pharmacist likely to be needed?* Individual pharmacies will need to assess their workload capacity according to the volume of clients on ODT they support and the extent of pharmacist consultation involved. There may be a need for another pharmacist to manage other professional activities within the pharmacy, such as the supply of Pharmacist Only Medicines.
d) Training	*What additional formal training be needed?* With the development of any specific ODT program, initial familiarisation on any standards and legislative and administrative requirements will be necessary. *Does any suitable training exist?* Yes - a number of programs designed to enhance the knowledge and skills of pharmacists in providing ODT programs are available.
e) Supporting Standards, Procedures and Templates / Checklists	*Will a QCPP standard be required?* Yes *Will professional guidelines and/or standards be required?* Yes. *Are there any national guidelines which need to be taken into account in developing the program to ensure consistency with best practice?* Yes. Therapeutic Guidelines – Analgesic Edition 5 (2007) covers the special problems with the use of opioids. A number of local (State/Territory) jurisdictions have prepared guidelines for ODT pharmacotherapies in addition to the 'National clinical guidelines and procedures for the use of buprenorphine in the maintenance treatment of opioid dependence' (2006) and the 'National clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence' (2003).
f) Legislation / Regulation Implications	Nil
3. Funding	
Funding Options	Possible funding options include: • Alternative Commonwealth Program (National Drug Strategy; Medical Benefits Scheme) • State/Territory Government *Has any funding for this program been secured?* Yes - ODT is currently funded under the PBS, with some States and Territories subsidising dispensing fees. Additional funding at the national level will need to be explored for any expansion of the program.

4. Timelines	
Timelines	√ Established community pharmacy practice √ Immediate to short-term implementation (< 30 June 2015) ☐ Medium-term implementation(1 July 2016 to 30 June 2020) ☐ Longer-term implementation (> 1 July 2020)