Opioid Pharmacotherapy in Hospitals: Continuation, Withdrawal, Initiation and Discharge Arrangements Guideline

1 Purpose

The purpose of this Guideline is to assist clinicians in the consistent and appropriate management of patients admitted into the WA health system who are currently receiving opioid substitution treatment (OST) or who may be suitable for commencement on OST for the management of opioid dependency or withdrawal.

This Guideline provides information to assist hospital staff in determining whether it is safe to use OST whilst a patient is in hospital and details of how to initiate and manage supervised OST dosing. The primary aim of these recommendations is to facilitate continuation of treatment, effective management of opioid withdrawal and initiation of maintenance treatment while avoiding adverse effects such as overdose.

This Guideline is intended to be read in conjunction with the WA Clinical policies and procedures for the use of methadone and buprenorphine in the treatment of opioid dependence, and the Clinical guidelines for use of depot buprenorphine (CPOP Clinical Policies and Procedures). This Guideline is not intended to be used as a substitute for compliance with legislation, Policy Frameworks or the policies and procedures of Health Service Providers (HSPs).

This guideline supports the application of MP 129/20 Medicines Handling Policy.

2 Background

OST is made available to drug dependent individuals in Western Australia (WA) through the Community Program for Opioid Pharmacotherapy (CPOP) via authorised pharmacotherapy prescribers and approved pharmacies.

When a patient receiving opioid pharmacotherapy is admitted to hospital, methadone or buprenorphine treatment should continue to be provided if it is safe and clinically appropriate to do so. The Medicines and Poisons Regulations 2016 include clauses to allow continuation of previously authorised OST for inpatients without the hospital-based prescriber requiring any additional approval from the Department of Health (DoH).

Initiation of OST in a hospital setting must be by an authorised CPOP prescriber, who has completed the CPOP prescriber training provided by the Community Pharmacotherapy Program (CPP) and been authorised by the DoH to treat each individual patient.

Hospital pharmacists who are dispensing CPOP treatment are strongly recommended to be appropriately trained in providing this service. CPP provide the CPOP Pharmacist Online Training course which is recommended to be completed by hospital pharmacists who are participating in the CPOP.

Current OST products used in WA include methadone syrup/solution, buprenorphine sublingual tablets as Subutex®, buprenorphine with naloxone sublingual films as Suboxone® and depot buprenorphine injections as Buvidal® and Sublocade®.

Methadone is associated with a higher risk of overdose in comparison to buprenorphine. Deaths due to overdose have occurred when methadone is used for OST, including the death of patients in hospital. The complex properties of methadone mean its use is considered 'high-risk' in all settings and for all indications. Hospital inpatients can only be initiated on methadone, for the treatment of opioid dependence, by an Addiction Medicine Specialist.

The CPP provide clinical support, advice, training and resources for clients and service providers across the program. For all matters relating to CPOP, CPP may be contacted by contacting the CPP office on (08) 9219 1913 or (08) 9219 1907.

The CPOP Advice and Support (CAS) can be contacted for advice on the clinical management of CPOP patients. CAS is a 24 hours-a-day, 7 days-a-week telephone service available to support health practitioners involved in methadone and buprenorphine treatment across metropolitan and regional WA. CAS can be contacted on telephone (08) 9442 5042.

3 Continuation of OST in hospitals

3.1 Liaison on presentation and admission

If the hospital employs a specialist alcohol and other drugs (AOD) liaison team, they should be notified when a patient receiving OST is admitted or commenced on OST whilst an inpatient.

The relevant hospital pharmacist should be advised when a CPOP patient has been admitted.

3.2 Dose confirmation and documentation

OST must not be prescribed for any patient until their participation in the CPOP is confirmed.

ScriptCheckWA may be accessed for patient information relating to prescribing, dispensing, alerts and authorisation history, including CPOP authorisations, at ScriptCheckWA.

Dosing information must be established prior to administering the first dose of OST in hospital to avoid inappropriate 'double dosing' and the risk of overdose. This is done by contacting the dispensing community CPOP pharmacy.

Regardless of when the patient presents to the hospital, continuation of OST dosing within the hospital cannot commence until:

- it has been conclusively determined the patient is 'in treatment'
- the patient has a current prescription in the community

- the details of the most recent OST dose, including whether any ‘takeaway’ doses have been provided, has been independently verified
- details of recent missed doses are obtained. Missed doses may require dose adjustment (reduction).

CPP and CAS can provide advice in circumstances where the patient’s usual CPOP prescriber and/or dosing pharmacy are not available.

Where a patient is admitted to hospital from interstate or overseas and has been receiving OST but is not authorised in the WA CPOP, hospital staff must notify CPP of their admission at the earliest opportunity. A temporary WA CPOP authorisation may then be arranged urgently to enable continuation of treatment whilst in hospital. Where a WA CPOP authorisation cannot be arranged for patients from interstate or overseas, the patient’s history of treatment and last dose must be verified by the hospital team. CAS should be contacted for further advice.

3.3 Determining whether the patient is ‘in treatment’

Where a patient has a current OST prescription, it must be determined whether they have been taking their doses before they can be confirmed to be “in treatment”.

A patient who is currently prescribed OST is at higher risk of overdose if they:

- are in the induction phase of treatment and have missed a single OST dose
- are in the maintenance phase of treatment and have not received an oral OST dose for four or more days
- have not received their depot buprenorphine injection within the recommended treatment interval.

A significant break in CPOP treatment with depot buprenorphine injections includes more than 14 days between weekly depot buprenorphine depot doses or more than 8 weeks between monthly depot buprenorphine injection doses.

If the patient has missed doses, OST is not to be prescribed until the hospital-based prescriber has consulted with the patient’s CPOP prescriber or has contacted CAS, if the usual CPOP prescriber is unavailable (such as after hours or on weekends). Where doses have been missed, dose adjustment may be necessary or, depending on the individual patient circumstances, advice may be to suspend treatment.

Where there has been a significant break in CPOP treatment, re-induction into treatment rather than continuation of treatment is likely to be required.

3.4 Special considerations for depot buprenorphine injection

Where OST is being administered by depot injection, there is some flexibility around when the next dose needs to be administered once the patient is stable. For example, Buvidal® Monthly depot injection can be administered up to 7 days after the due dose. This means dosing may be able to be delayed until the patient is discharged from hospital. The patient’s CPOP prescriber or CAS should be contacted for advice.

Conversely, for some patients being treated with Buvidal® depot buprenorphine, a supplemental or ‘top up’ depot buprenorphine dose may be clinically indicated such as if the patient is experiencing opioid withdrawal, cravings or persistent unsanctioned opioid use. This is more likely during the early period of treatment with depot formulations. Again, the advice of the patient’s CPOP prescriber or CAS should be sought.

Administering health professionals must familiarise themselves with the depot buprenorphine formulations prescribed and precautions to be noted.

3.5 Verifying the most recent dose

Regardless of whether a patient claims they are currently dosing, the details of their last dose must be independently verified with their dosing pharmacy.

Any details of the dosing pharmacy provided by the patient should be independently checked, such as by using an online search. This is to confirm the telephone number belongs to the pharmacy, not a friend or associate of the patient. When contacting the pharmacy, ask to speak to the pharmacist.

Some patients are authorised to have opioid pharmacotherapy dispensed at more than one pharmacy (for example, if the usual pharmacy is closed on Sundays and public holidays) or are allowed a 'takeaway' dose(s) under certain conditions. Verification of the most recent dose (including takeaway doses) may need to be obtained from more than one pharmacy.

Patients treated with depot buprenorphine injections may have their doses administered at the clinic at which their CPOP prescriber is located or at a CPOP participating pharmacy. Verification of the last administration will require contact with the CPOP prescriber or the administering pharmacy. CAS can be contacted for information when necessary. The date of administration, the dose administered, and the specific site of administration should be verified.

If the patient's usual dosing pharmacy indicates the patient's prescription has recently expired, OST should not be prescribed until the patient's usual CPOP prescriber (or CAS where the usual CPOP prescriber is unavailable) has been contacted to enquire whether they wish to continue treatment.

If takeaway doses have been supplied, they must be accounted for before further doses are prescribed or administered.

3.6 Takeaway doses

There are strict rules regarding takeaway doses due to the risk of double dosing and diversion.

Staff should be aware of the following:

- takeaway doses brought into hospital by the patient are not to be administered or otherwise used within hospitals
- patient's own takeaway doses are not to be returned to the patient, including at discharge
- takeaway doses are not to be supplied by the hospital on discharge (or if the patient is on day/weekend leave)
- dosing should not commence in the community until all takeaway doses previously issued have been accounted for.

There are strict requirements around the eligibility for oral takeaway doses in the WA Clinical policies and procedures for the use of methadone and buprenorphine in the treatment of opioid dependence. Depending on the reason for presentation or admission,

the patient may no longer be eligible for takeaway doses upon their return to the community.

3.7 Documentation in the patient's medical record

A copy of the patient's current prescription and their dosing record should be requested from their dosing pharmacy.

The following information about the confirmed dose should be documented in the patient's medical record:

- OST product being used and dose (see table below)
- date, time and location of last supervised dose
- number of takeaway doses, if any, that have been dispensed
- details of other dosing locations, where applicable
- name of pharmacy, name of pharmacist and telephone number.

3.8 Opioid substitution treatment products

Drug	Brands	Strengths available	Notes
Methadone oral liquid[1]	Aspen Methadone® Syrup[1]	5 mg per mL	
	Biodone Forte®	5 mg per mL	May not be available within public health service facilities.
Buprenorphine sublingual tablets[2]	Subutex®	0.4 mg 2mg 8mg	Not routinely used, may be in use where documented allergy to other products or where low dose treatment is prescribed.
Buprenorphine with naloxone sublingual film	Suboxone®	2 mg/0.5 mg 8 mg/2 mg	Buprenorphine:naloxone in 4:1 ratio. Naloxone added to reduce abuse potential. Films should not be cut.
Depot buprenorphine injection	Buvidal®	Multiple doses ranging from 8 mg as weekly dose to 160 mg as a monthly dose	Weekly or monthly injection
	Sublocade®	100 mg 300 mg	Monthly injection

[1] Included on the Statewide Formulary.

[2] Buprenorphine 200 microgram tablets (Temgesic®) and buprenorphine transdermal patches are indicated for pain management and must not be used for OST.

4 Use of Suboxone™ for opioid detoxification treatment within a hospital setting for patients not currently receiving OST

Patients who are hospitalised may develop signs and symptoms of acute opioid withdrawal during their inpatient admission, whereby use of Suboxone® as the preferred formulation for the treatment of opioid withdrawal may be warranted. The patient must be assessed as currently dependent on opioids, should ideally register a Clinical Opiate Withdrawal score (COWS) of 12 or more before any dose of Suboxone® is administered and should be expected to remain hospitalised to complete a 5-day scheduled protocol.

Treatment must be initiated by a detoxification prescriber or under the direction of a detoxification prescriber. Registered medical practitioners who are Next Step specialist prescribers or hold specialist registration on the AHPRA register of practitioners in one of the following Specialities are eligible to be authorised as detoxification therapy prescribers:

- Addiction Medicine
- Psychiatry.

Treatment may be initiated by consultants or registrars who are not authorised detoxification prescribers, provided they seek advice from, and are under the direction of, a detoxification prescriber for each patient before commencing detoxification therapy.

Where use of Suboxone® is supported, a Notification of the use of Suboxone® for opioid detoxification treatment within approved sites form must be completed and forwarded to the Department of Health and to CPP prior to the approved Suboxone® for opioid withdrawal protocol being commenced. Any alteration from the approved Suboxone® protocol requires endorsement from an Addiction Medicine Specialist or CAS doctor on phone (08) 9442 5042 and noted on the form.

The patient's name will thereafter be included on the Drugs of Addiction Record.

The Notification of the use of Suboxone® for opioid detoxification treatment within approved sites form can be obtained from the Addiction Medicine Specialist, the Next Step CAS doctor contacted, or from the Medicines and Poisons Regulation Branch at the Department of Health.

5 Initiation of OST for opioid dependence within a hospital setting

An inpatient who is not currently receiving treatment in the CPOP, may be considered suitable for initiation onto OST whilst an inpatient. The suitability of initiation or re-induction of OST during hospital admission requires careful consideration, on a 'case by case' basis. The first few weeks of OST treatment is the time when the patient is most at risk.

For initiation of OST within a hospital, patients should be carefully assessed for opioid dependence, have their situation suitably considered, and be appropriately counselled and have consented prior to initiation. OST should be commenced during business hours. Procedures should follow the respective policies and procedures as determined by each hospital facility and in accordance with the Monitored Medicines Prescribing Code.

Where a patient is considered suitable for commencement on OST within a hospital setting, it should be expected that the patient will remain an inpatient for the duration of the

induction period under the care of the authorised hospital prescriber, who will remain responsible for the patient and consult with CAS or CPP when needed.

Patients considered suitable for initiation or re-induction to OST must be assessed and inducted under the care of an authorised CPOP prescriber, who is employed within the hospital.

Hospital inpatients can only be initiated on methadone by an Addiction Medicine Specialist employed within the hospital, who is also an authorised CPOP prescriber. Buprenorphine treatment may be initiated by an authorised CPOP prescriber within the hospital.

Commencement of OST cannot occur unless an authorised CPOP prescriber is available to manage the patient within the health service facility.

Patients most suitable for initiation or re-induction whilst an inpatient include those:

- with established recent history of opioid substitution treatment
- with history of opiate overdose
- with history of injection-related complications such as bacteraemia/septicaemia, abscesses or infective endocarditis
- developing moderate/severe opioid withdrawal symptoms.

Where a patient is commenced on OST whilst in hospital, a CPOP Application to prescribe opioid substitution treatment, is to be submitted to CPP. Upon receipt of the Application to prescribe, CPP will forward a CPOP Hospital Discharge Notification form to the hospital prescriber. The CPP team will review the proposed treatment plan before forwarding to the Department of Health. Once approved by the Department of Health, the authorisation number will be provided to the hospital prescriber by CPP, whereafter treatment can be commenced.

The authorisation period will generally be six months, or at the discretion of the CEO.

All correspondence relating to the initiation of OST, including the CPOP Hospital Discharge Notification form, should be kept with the patient hospital record. Prior to discharge the completed CPOP Hospital Discharge Notification form is to be forwarded to CPP who will make the discharge arrangements to enable continuation of dosing in the community.

CPP will source a suitable community prescriber and pharmacy to continue the patient's treatment upon discharge, which will be advised to the prescribing doctor and the patient before discharge. Continuation of dosing and attendance by patients at organised appointments post-discharge will be monitored by CPP until transfer of authorisation to a new CPOP prescriber is completed.

CPP will provide a prescription for the patient to enable continuation of dosing in the community upon discharge. This will be produced upon last dose confirmation with receipt of the medication chart and discharge summary.

CPP must be advised of any changes which may impact a patient's ability to access treatment at a community pharmacy post-discharge. This includes changes to:

- discharge date/plan
- post-discharge address/change of destination location
- patient contact details

- mobility issues.

Where a patient is to be transferred to an external facility, CPP should be advised well before the transfer date in order to ensure that special arrangements are in place for the patient's continued dosing.

6 Administration of opioid pharmacotherapy

6.1 Oral administration of opioid pharmacotherapy

Oral formulations of OST are usually administered at community pharmacies during the morning and as a single dose. Buprenorphine sublingual preparations may sometimes be administered every second or third day, rather than every day.

Methadone oral liquid formulations are the only form of methadone that can be used in OST.

Methadone presents a higher risk in all settings and in all situations and must be prescribed under the guidance of an appropriately authorised specialist. Methadone liquid should be charted using both the mg dose and the amount in millilitres, to minimise the potential for errors (and possible five-fold overdose). For example, methadone syrup 5mg/mL: 22.5 mg = 4.5 mL each morning.

The risk of overdose with methadone is considerably higher when:

- The patient on oral maintenance OST has not received their usual oral dose for 4 or more days
- A patient is in the induction phase of treatment (i.e. the first 2 weeks) and has missed a single dose.

Management of withdrawal from OST is safer than risking overdose.

Oral Buprenorphine formulations are intended for sublingual dosing and will be inactive if swallowed.

6.1.1 Supervision of dosing

Due to the risk of diversion, all opioid pharmacotherapy dosing must be supervised appropriately to ensure the patient has taken their dose correctly.

Doses of OST must never be left with a patient for self-administration.

Supervision requirements in community pharmacies are detailed in the WA Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence. These requirements are also applicable to inpatient OST dosing. Continuing CPOP patients should already be familiar with the requirements for in-pharmacy dosing.

Requirements for dosing:

- The dose must be consumed in direct view of the administering staff with no turning of the patient's head. The patient's hands and mouth must be visible to administering staff at all times.
- Any dosing equipment such as disposable cups must be handed back to the administering staff immediately after the dose has been consumed.

- For methadone, the administering staff must watch the patient swallow the dose. Administering staff should engage the patient in a short conversation after dosing to reduce the risk of the dose being retained in the mouth for later injection or diversion.
- Buprenorphine tablets and buprenorphine/naloxone films are administered sublingually.
- Buprenorphine tablets (Subutex®) must be crushed using a commercial tablet crusher to the consistency of coarse coffee ground prior to administration. Health service policy should determine whether crushing is undertaken within the Pharmacy Department or in the patient care area.
- Crushing buprenorphine tablets reduces the supervision time and risk of diversion. It is also the way in which the doses are presented to the patient in community pharmacies. The patient should pour the prescribed dose of crushed Subutex® under their tongue and be supervised for at least three minutes.
- For buprenorphine film (Suboxone®), the patient should be watched placing the prescribed dose under their tongue and supervised for at least one minute. If multiple films are required, they must be placed so they do not overlap. Usually, two films at a time can be placed on opposite sides under the tongue or via buccal placement.

6.2 Administration of depot buprenorphine formulations

Administration of depot buprenorphine products should only be necessary where a patient has a prolonged admission and discharge is unlikely to occur until after the window for their next dose, as detailed in the Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence for WA CPOP prescribers and pharmacists.

If, and only after discussion with the patient's usual CPOP prescriber or the CAS service, a decision is made to administer a dose of depot buprenorphine injection to an admitted patient, it is important that the same depot product brand is used as previously. There are no clinical studies, and very limited anecdotal reports, about transferring between brands of depot buprenorphine products.

Depot buprenorphine injections can only be administered by appropriately trained health professionals.

The relevant Product Information should be reviewed before administering Buvidal® Weekly, Buvidal® Monthly or Sublocade® injections. Buvidal® and Sublocade® injections are each packaged differently, and each brand has specialised and unique administration instructions.

Australian Product Information is available from the Therapeutic Goods Administration website at: https://www.tga.gov.au/product-information.

Buvidal® Weekly, Buvidal® Monthly and Sublocade® injections are intended for subcutaneous use only. There should be sufficient subcutaneous tissue to allow for the injection. The area should be free of scarring, nodules or other lesions and not be inflamed, infected or bruised. A slow steady push should be used as slower injections are generally better tolerated.

The dose must not be administered intravascularly or intradermally.

Buvidal® should be administered in the upper arm, thigh, abdomen, or buttocks. Sublocade® should be administered in the abdomen.

Injection sites should be rotated between injections.

6.3 Patient monitoring

All opioid medicines, including those used for OST, are considered to be high risk medicines and clinical monitoring must therefore be consistent with the potential harmful effects of these medicines.

Even though methadone and buprenorphine are being administered for opioid pharmacotherapy rather than for pain management, the patient remains at risk of developing adverse effects. This includes respiratory depression and reduced level of consciousness, overdose and death.

Close monitoring for treatment effect and side effects is essential whilst the patient is in hospital.

7 Inter-hospital transfer and discharge

7.1 Inter-hospital transfer

CPP should be advised when hospital patients who are receiving OST are transferred between hospitals.

A copy of the medication chart detailing CPOP treatment administered should accompany the patient when transferring between hospitals. OST can then be prescribed to continue in hospital on the new medication chart without the need for a community prescription.

7.2 Discharge

CPOP patients must not be given a discharge prescription for OST or supplied with takeaway doses upon transfer or at discharge.

When an inpatient who was continuing OST is to be discharged and OST treatment is to be continued, the patient's usual CPOP prescriber and dosing pharmacy must be advised. It is particularly important the community dosing pharmacy knows the current dose, along with the date and time the last dose in hospital was administered.

As per section 5, Initiation of OST for opioid dependence within a hospital setting, CPP must be notified where a patient who recently commenced OST as an inpatient, is to be discharged, using the CPOP Hospital Discharge Notification form, in order to ensure that continuation arrangements are in place for the patient's ongoing dosing in the community.

If the patient's prescription at their dosing pharmacy has expired or the current dose is inconsistent with the prescription, the patient will require a new prescription to continue dosing. The patient's usual CPOP prescriber must be contacted to issue a new prescription where needed. If the usual prescriber is not available, CPP or CAS will provide an interim prescription which will be provided directly to the pharmacy in readiness for the patient's presentation for dosing and the patient's usual prescriber informed. A last dose confirmation must be provided by the hospital before a prescription will be provided.

Patients proceeding to discharge who are receiving OST or who are at risk for overdose should be counselled regarding risk and should be provided ready access to naloxone, including via supply of take-home naloxone if appropriate.

8 Acute pain management

Patients on methadone or buprenorphine who need acute pain management in the hospital setting should be managed as for patients who are not opioid dependent, although doses of opioid analgesic drugs may need to be higher.

Buprenorphine exerts a degree of blockade to the effects of full agonist opioids, which may complicate the prescribing of additional opioids for pain management. Liaison with an Acute Pain Service or CAS is recommended.

If pain management requirements mean alterations to a patient's OST are considered necessary, advice should be sought from the patient's usual prescriber or with CAS if unavailable.

9 Patients in the CPOP requiring S8 discharge medication

As per the usual requirements, the treating doctor must complete an Application for authorisation Opioids, Benzodiazepines and other Schedule 8 medicines form where a patient who is receiving OST requires discharge with S8 medicines. Applications should be forwarded to the Medicines and Poisons Regulation Branch (MPRB@health.wa.gov.au or fax 9222 2463) and marked as "urgent" to be considered on the same or the following business day.

Along with the usual requirements, applications for S8 medicines upon discharge for a patient in the CPOP will also be reviewed, along with any supporting documentation, by the CPOP Clinical Review Committee (CPOP-CRC) who will provide recommendations to the Department.

S8 medicines should not be supplied to the CPOP patient at discharge in the absence of Department of Health approval.

10 CPOP patients attending the emergency department seeking opioid pharmacotherapy medication

Patients may present to healthcare facilities with complaints that they have missed their methadone or sublingual buprenorphine dose, lost, or had their takeaway doses stolen, or have vomited soon after taking their dose. Such patients may state they are in withdrawal and request a replacement or additional dose. Patients may present at a time when the pharmacy at which they usually dose is not open.

Missed doses are not a medical emergency and it is not appropriate for patients to seek or be prescribed methadone or buprenorphine from the emergency department of a hospital.

The long half-lives of methadone and buprenorphine mean missing one dose is unlikely to cause significant physical discomfort, especially in a patient who is in maintenance phase opioid pharmacotherapy.

Treating staff can seek advice about the patient's status from the patient's prescriber, from CPP, or can access clinical advice about further treatment from CAS.

11 Definitions

Term	Definition
Community Pharmacotherapy Program (CPP)	Provides support, information and advice to clients, pharmacists and medical practitioners involved in methadone and buprenorphine treatment across metropolitan and regional Western Australia.
Community Program for Opioid Pharmacotherapy (CPOP)	Framework developed to regulate the prescribing of opioid pharmacotherapy medicines for the treatment of opioid dependence in Western Australia. Regulatory controls are via the Medicines and Poisons Regulations 2016.
Community Program for Opioid Pharmacotherapy Clinical Review Committee (CPOP CRC)	The CPOP Clinical Review Committee meets to review and endorse applications for OST that fall outside the WA Policies and Procedures, to review the management of clients with special dosing approval, and to respond to clinical management issues which may impact upon service providers and clients of the Program.
CPOP Clinical Policies and Procedures	WA Clinical policies and procedures for the use of methadone and buprenorphine in the treatment of opioid dependence, and Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence for Western Australian CPOP prescribers and pharmacists.
CPOP Support and Advice (CAS)	24 hours-a-day, 7 days a week telephone service available to support health practitioners involved in methadone and buprenorphine treatment across metropolitan and regional Western Australia.
Induction phase	The first 2 to 3 weeks of commencement on opioid pharmacotherapy treatment.
Opioid detoxification treatment	The use of Schedule 8 pharmacotherapy during medically supervised withdrawal from opioids.
Opioid substitution treatment (OST)	Treatment with specific long-acting opioids (methadone and buprenorphine) as a replacement for heroin and other opioids. The goal of OST is to stabilise the lives of people experiencing drug dependence, reduce their drug use and reduce the harm associated with drug use. Also referred to as opioid dependence treatment (ODT).
ScriptCheckWA	ScriptCheckWA is Western Australia's real-time prescription monitoring system. All medicines classified as controlled drugs (also known as Schedule 8 medicines) and higher risk Schedule 4 medicines are monitored through ScriptCheckWA. Doctors, pharmacists and other prescribers of monitored medicines, such as nurse practitioners, may view records about their patients in ScriptCheckWA.

Term	Definition
Takeaway doses	Community treatment of opioid dependence with methadone or sublingual buprenorphine is based on daily, supervised dosing at a pharmacy. However, in the community, some well stabilised patients with particular needs may be prescribed some of their doses as 'takeaway' doses. Takeaway doses are dispensed to the patient by their dosing pharmacy, using a standardised procedure. Public hospitals are not authorised to supply 'takeaway' doses to patients or to return previously supplied patient's own 'takeaway' doses at discharge.
WA health system	The WA health system is comprised of: (i) the Department; (ii) Health Service Providers (North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, East Metropolitan Health Service, PathWest Laboratory Medicine WA, Quadriplegic Centre and Health Support Services); and (iii) contracted health entities, to the extent they provide health services to the State.

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