

## Use of long-acting injectable buprenorphine for opioid substitution therapy

Report on consensus statement voting: Round 3

### Overview

Following Round 2, only two statements required further consideration.

For Round 3 members of the working group (n=31) were sent a voting form to record and return their level of agreement with two revised draft statements. Voting took place between 17 and 21 February 2022. Twenty one of the 31 group members provided responses.

This report summarises the distribution of voting responses (for further details and full comments, please see the accompanying Round 3 voting response document) and provides an overview of the group's comments and revisions made to address these. While individuals will be aware of their own views, the purpose of this report is to share further perspectives on the statements and to allow participants to reconsider their initial judgments about the statements in the context of the additional feedback from a multidisciplinary group of clinical and non-clinical stakeholders.

Formal consensus was reached for both statements. A small number of minor issues were raised but no respondents disagreed strongly with either statement. Minor revisions have been made to each statement to address the remaining issues and these will be added to the position statement.

## **Statement 1**

In round 3, group members were asked to indicate agreement with the following statement:

*Treatment with depot buprenorphine potentially confers the opportunity to change the way in which opioid substitution services are structured and delivered. The less frequent dosing with depot buprenorphine formulations may reduce the opportunity for daily contact between service user and care provider. This may offer advantages for some individuals as it gives them the opportunity to have time to attend recovery activities and other priorities. For others who need more support, careful scheduling of clinical reviews for example in the setting where the depot can be delivered and flexible approaches to care planning should be considered.*

21 of 31 participants responded to this statement:

- 52.4% strongly agreed with this statement
- 23.8% agreed
- 14.3% neither agreed nor disagreed
- 9.5% disagreed
- 0% strongly disagreed.

Sixteen out of 21 (76.2%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached. A minor revision has been made to address the remaining concerns.

All versions of this statement have reached consensus (>70% agreement) with the values changing from 76% in round 1, through 81.8% in round 2 and 76.2% in round 3.

Most respondents noted that the revised statement was clear and concise and did not need further changes. In general, respondents were reassured that the statement successfully emphasised the flexibility of service provision models which adapted to suit the needs of the individual.

Two respondents who disagreed with the statement noted that:

- “This statement should read ‘frequent’ in place of ‘daily’ as most people in maintenance treatment do not attend pharmacy daily. The phrase ‘care provider’, as in previous comments, is usually associated with the treatment service not the pharmacy.
- “Pick up of MAT is not the same as addictions support which should still happen and be patient led. Term ‘care provider’ in sentence two is wrong. Dispenser is not a care provider as per daily MAT whereby with depot it would be the nursing team (care provider) giving the depot although this is likely to be in a depot clinic setting and not therapeutic.”

One respondent (who agreed with the statement) suggested revisions to the statement which changed “care provider” to “a care provider” and broadened the suggestion for scheduling of clinical reviews and flexible care planning to all service users, rather than just those who may need additional support.

The research team appreciates that group members have raised concerns about the possibility of the statement misattributing the change from daily dosing to weekly or monthly dosing to imply that clinical reviews for service users may follow the same pattern, whereas it is clear that frequency of contact between service user and care provider is always based on clinical need. Supporting text will be added to the final position statement to clarify this point. The team also notes the comments that dispensers are not care providers, however this is a deliberately broad term which needs to include community pharmacists, prison pharmacists, community substance use clinics and any secondary

care services. The small change to “a care provider” emphasises that it refers to interactions between individuals using services and any provider of a relevant service.

A revised consensus statement has been drafted for inclusion in the position statement.

*Treatment with depot buprenorphine potentially confers the opportunity to change the way in which opioid substitution services are structured and delivered. The less frequent dosing with depot buprenorphine formulations may reduce the opportunity for daily contact between service user and a care provider. This may offer advantages for some individuals as it gives them the opportunity to have time to attend recovery activities and other priorities. For all service users, careful scheduling of clinical reviews for example in the setting where the depot can be delivered and flexible approaches to care planning should be considered and based on the individual's needs.*

## **Statement 2**

In round 3, group members were asked to indicate agreement with the following statement:

*General principles of chronic pain management should be followed and include patient education and engagement in the treatment process, physical interventions (eg exercise or physiotherapy), psychosocial interventions (eg Cognitive Behavioural Therapy) and the appropriate use of medications (eg paracetamol, NSAIDS, gabapentinoids, antidepressants).*

*Depot buprenorphine is used for opioid substitution therapy, and not pain management.*

21 of 31 participants responded to this statement:

- 47.6% strongly agreed with this statement
- 28.6% agreed
- 9.5% neither agreed or disagreed
- 14.3% disagreed
- 0% strongly disagreed.

Sixteen out of 21 (76.2%) respondents agreed or strongly agreed with this statement, so consensus has been reached.

All versions of this statement have reached consensus (>70% agreement) with the values changing from 76% in round 1, through 72.7% in round 2 and 76.2% in round 3.

Most respondents commented that this revision is an improvement over the original statement and favour no further changes. There were conflicting views about the second paragraph which was added as a revision after Round 2 of consensus voting.

A respondent who disagreed with the statement expressed concern with the second paragraph.

- “[I] would still disagree with the second paragraph about only for OST and not in pain management. Both for all reasons I’ve previously given. But also reading others comments I was not aware that manufacturer is now seeking to extend licence to chronic pain and has data in support of this. Especially in light of this removing this line completely may be sensible as may become out of date and not in keeping with licence if the application is approved.

In contrast, a respondent who agreed with the statement supported this paragraph:

- “I feel this is a sensible statement. I am particularly encouraged by the clarification that depot buprenorphine is for OST and not pain management.”

A respondent who neither agreed nor disagreed with the statement expressed ambivalence about the second paragraph:

- “I am not clear that the statement ‘Depot buprenorphine is used for opioid substitution therapy, and not pain management.’ is required as this position statement is about OST.”

Two respondents who disagreed with the statement suggested removal of the brackets listing possible coadministered medications.

The research team believes that the second paragraph is helpful as it reflects the current indication for use of the drug specified in the SmPC and by SMC. While an application has been made to the European Medicines Agency for an extension of indication to include treatment of moderate to severe chronic pain in patients with opioid dependence, this has yet to pass through the regulatory system. If the marketing extension was granted, the manufacturer would then need to submit an application to SMC for consideration for this specific use in Scotland. Therefore, the research team believes that the current statement is accurate at present and for the forthcoming future but could be revised if the licensing circumstances change in the future.

A revised consensus statement has been drafted for inclusion in the position statement.

*General principles of chronic pain management should be followed and include patient education and engagement in the treatment process, physical interventions (eg exercise or physiotherapy), psychosocial interventions (eg Cognitive Behavioural Therapy) and the appropriate use of other medications.*

*Depot buprenorphine is used for opioid substitution therapy, and not pain management.*