Use of long-acting injectable buprenorphine for opioid substitution therapy

Report on consensus statement voting: Round 1

Overview

Members of the working group who had submitted declarations of interests by the deadline (n=31) were sent a voting form to record and return their level of agreement with 12 draft statements on the use of long-acting buprenorphine for opioid replacement. Voting took place between 21 and 28 January 2022. Twenty five 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 1 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.

Although formal consensus was achieved across many of the Statements in Round 1, the research team noted areas where some individuals still strongly disagreed with the original statements, based on the comments you have shared. We have aimed to retain the elements that most members agreed on which underpinned the consensus, while making specific revisions to address the areas of concern. Therefore, in Round 2, we will be asking you to vote again on several statements which have been changed to try to match these even more closely to the preferences of the group, despite achieving statistical consensus. A small number of statements achieved consensus with no significant concerns raised, and these have been removed for Round 2. For each Statement, the report summarises the range of comments received and explains how the Statement has been revised to align as best as possible with these. In two cases where consensus was not achieved, the polarity of the comments has not allowed a clearly improved statement to be developed, and we have returned the original (or very slightly revised) statement for further voting after consideration of comments from other members.

Statement 1

Treatment with depot buprenorphine potentially challenges the way in which opioid substitution services are structured and delivered. The less frequent dosing with depot buprenorphine formulations may require a different approach to structuring clinical reviews, psychosocial interventions and care planning.

25 of 31 participants answered this question:

- 32% Strongly agreed with this statement
- 44% Agreed
- 8% Neither agreed nor disagreed
- 12% Disagreed
- 4% Strongly disagreed

Nineteen out of 25 (76%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached. However, based on some of the comments received – the research team felt that there would be value in allowing the group to consider and reflect on the comments.

Many respondents commented that the daily pharmacy attendance that is required for supervised dosing with some OST formulations also allows for regular assessment of the service user's safety and wellbeing and provides an opportunity for direct engagement when individuals are struggling or presenting as more chaotic. Removal of this daily contact may require other services to increase contact with these individuals to provide the same level of support. However, some respondents noted that this alteration may have practical advantages for the service user and may reduce stigma.

Several respondents agreed with the statement based on their personal experience of service delivery changes which moved away from one involving a routine of collection, prescription, supervision, attrition or retention to a more person-centred, trauma-informed service which is even more closely focused on the individual needs of the service user. One respondent noted that when depot buprenorphine is delivered in a clinic setting, care providers should ensure that appointments are focused on the holistic needs of the service user, rather than the detail of delivering the depot. They noted that longer appointment times may be required to achieve this.

One respondent who disagreed with the statement noted that there was not necessarily a relationship between the service user's level of psychosocial need and the dose or formulation of medication. A respondent who strongly disagreed with the statement did not report any changes needed in the approach to service delivery, clinical review or care planning.

Two respondents (one of whom agreed and one of whom disagreed with the statement) commented that the use of the word "challenges" could be perceived to have negative connotations. Several alternatives were offered: "enhance", "allows for the redesign of" and "confers the opportunity to change …" One respondent agreed that there are "potential challenges which may need a different approach".

A respondent suggested using the term "buprenorphine injection" instead of depot buprenorphine. The research team do not favour this revision due to potential risks of confusion with the illegal and unsafe injection of crushed tablet formulations.

A revised statement has been drafted for the group to consider.

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 reduces the regularity of contact between service user and care provider and, while this may offer advantages for some individuals, it may require careful scheduling of clinical reviews and flexible approaches to care planning, for example in the setting where the depot can be delivered.

Statement 2

There are currently no formal prescribing or administration training requirements for depot buprenorphine. However, organisations may wish to develop local training packages as this is a relatively new product. Additional administration training is recommended for services where registered healthcare professionals are not already trained to administer subcutaneous injections. There is no formal national training package available for subcutaneous injections. Organisations may wish to link in with the manufacturer for training support. Substance misuse service providers are advised to ensure sufficient staff (including locums) are trained for service resilience. If the administration is delivered by a third party (e.g. community pharmacy or residential rehab service), service providers are advised to have evidence of training to ensure competence and that training is up to date.

25 of 31 participants answered this question:

- 52% Strongly agreed with this statement
- 24% Agreed
- 8% Neither agreed nor disagreed
- 12% Disagreed
- 4% Strongly disagreed

Nineteen out of 25 (76%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached. However, based on some of the comments received – the research team felt that there would be value in allowing the group to consider and reflect on the comments.

Respondents agreed that, via clinical governance, NHS boards have a responsibility to ensure that care providers and contractors are competent in the delivery of any intervention. Several respondents provided feedback on the level of training that might be required. One respondent suggested that as the drug was simple to administer, only basic training would be needed. Other respondents pointed out that the administration of long-acting buprenorphine has differences from other subcutaneous injections and specialised training was required. One respondent who strongly agreed with the Statement suggested that a healthcare professional administering long-acting buprenorphine should be competent not only in the delivery mechanism but also in the recognition and management of adverse effects or hazards, which would require more specialised training than could be derived from generic injection courses.

A respondent who disagreed with the Statement expressed concern that the requirement for training could be a barrier to offering long-acting buprenorphine if training infrastructure was not well implemented in boards. They noted that some areas “will take several months or years to put a training package together” and suggested that training packages should be available to run alongside the provision of depot buprenorphine.

Several respondents (who strongly agreed and strongly disagreed with the Statement) suggested that training courses should be provided at national level:

- “national guidance and standards and training”
- “Once for Scotland training to standardise care, efficiency and quality assurance”

- "TURAS and LearnPro could support this and be accessible for employers and clinicians alike."
- "there could be key trainers who ensure staff are trained and have regular updates to ensure competence.

A further respondent who also strongly agreed with the statement did not feel that training courses should be provided at national level:

"The training of staff will be different depending on the service set-up for this and I think that the statement covers this."

These consensus statements are targeted at clinicians and will include actions that individuals can build into their standard practice, but cannot determine the work of national agencies. A supporting statement will be added to encourage the development of training pathways at national levels (see below).

Different views were expressed on the role of the manufacturer in training. Respondents who strongly agreed with the Statement favoured accessing support from the manufacturer on the development of training materials:

- "Manufacturer has provided training which has been useful"
- "If there is expert knowledge to be given by manufacturer, they could be persuaded to provide seminars"
- "Maintaining good links with manufacturer is key, as [they] are able to assist with training needs and information for both clinical staff and patients."

A respondent who disagreed with the Statement, suggested that NHS organisations should remain independent of the manufacturer for training purposes.

A revised statement has been drafted for the group to consider.

NHS organisations and contracted services must ensure staff are trained and competent to deliver care. This includes the administration of medicines such as subcutaneous injections. There are no established formal prescribing or administration training standards for depot buprenorphine. Additional training is required to deliver depot buprenorphine which is currently available only in dosed prefilled safety syringe formulations. Standard operating procedures should be developed with staff.

Substance misuse service providers are advised to ensure sufficient staff (including locums) are trained for service resilience. If the administration is delivered by a third party (e.g. community pharmacy or residential rehab service), service providers are advised to have evidence of training to ensure competence and that training is up to date.

<u>Additional supporting statements</u> (for the body of the document - not consensus statements)

Further advice on administration of depot buprenorphine is available from the manufacturer.

The development and delivery of training at national level on the pharmacodynamics and administration technique of depot buprenorphine will promote consistency, skills maintenance and

quality assurance in the appropriate use of this product. A combination of delivery mechanisms, such as LearnPro, TURAS|Learn and key trainers may offer focus on the range of different skills and knowledge required.

Statement 3

Service users who present intoxicated at the time of dose administration should be assessed to identify any safety concerns regarding dosing. Peak plasma and clinical effects occur approximately 12-24 hours after weekly depot buprenorphine injections and 6-10 hours after monthly depot buprenorphine injection, and hence there is usually little clinical indication to withhold a depot injection due to a service user presenting intoxicated, in contrast to intoxicated presentations for sublingual buprenorphine or methadone dosing, where peak medication effects are likely to occur whilst the service user is still intoxicated.

Service users should be assessed as having capacity to provide informed consent to their usual dose, and to understand warnings regarding risks of sedation and overdose from polysubstance use. If there are concerns that the service user is very intoxicated and unable to understand or follow instructions, the administration of the dose may be deferred and rescheduled.

25 of 31 participants answered this question:

- 40% Strongly agreed with this statement
- 28% Agreed
- 8% Neither agreed nor disagreed
- 20% Disagreed
- 4% Strongly disagreed

Seventeen out of 25 (68%) respondents agreed or strongly agreed with this statement, so consensus has not been reached.

In general, respondents noted their concern about administering depot buprenorphine to intoxicated individuals, and agreement that ability to record consent was vital but there were different views about whether any level of intoxication may be a barrier to delivery.

Respondents who disagreed or strongly disagreed with the statement noted:

- "I do not feel it is appropriate to administer Buprenorphine to an individual who is sedated and giving consent. If they are under the influence are they considered to have capacity to give consent when the consequences are life threatening? I feel their appointment should be rescheduled and this should be out lined in an agreement with them prior to them commencing treatment…"
- "If a service user presents as intoxicated then the staff member cannot be sufficiently satisfied that the patient is able to provide informed consent. The service user may also be unable to take onboard advice given regarding risk of sedation and overdose or be in a position to take action should they become sedated/overdose. The dose should be rescheduled and the patient reassessed the following day"
- "Clinically there will always be a concern about administering this type of medication to an intoxicated person. I would have concerns that inhibitions continued to be lowered and after administration, further drugs were taken. I would reschedule the appointment for the following day, asking the patient not to be intoxicated."

Some respondents who agreed or strongly agreed with the statement made similar comments:

- “Traditionally, HCPs are very wary of giving any drug to an intoxicated person, especially if there is a risk of sedation, or criticism. Capacity is key in this situation, as is consent and relationship. Deferring due to inability to understand or consent would be beyond reproach
- “I feel that service users should be in a position to provide consent for a depot injection”
- “rearrange appointment for following day.”

In contrast, some respondents who voted “strongly agree” supported the existing statement:

- “Absolutely no reason to withhold administration”
- “This matches both our existing local policy and clinical experience. We have not had any adverse events from giving LAB to patients who have been intoxicated, in line with the guidance above”
- “No suggested changes. Agree with ethos of explaining unlikely to require to withhold dose”
- “Clearly explains how to make a decision when a person is intoxicated and the difference between depot and other OST. The information about peak plasma will help in better understanding and will increase confidence in making the decision.”

In line with the last comment, other respondents supported the importance of the sentence describing the pharmacokinetics of depot buprenorphine but also noting that the overall Statement was long and difficult to understand:

- “As time to peak levels is delayed the patient needs to be compliant with no further substance use (if they receive the LAIB) to minimise any further intoxication”
- “I agree with what this statement is trying to say, however, I feel that the sentence starting 'Peak plasma and clinical...' is too long, making it harder to understand.”

One respondent noted potential practical difficulties of rescheduling injections in rural settings:

- “This would be difficult to implement in rural areas due to the amount of time that it takes the client to travel to a particular area to receive their injection. Patient may not return to have their injection - keep the lines of communication open and offer alternatives/dates/times if possible.”

One respondent questioned the use of the term “service user”:

- “The use of the term "service user" places the importance on the service rather than the person. Is there any evidence as to what people accessing services would like to be referred to as? Not all services providing care for people will be health services and so the term patient may not be appropriate. Would "people" be an option?”

Formal consensus has not been achieved for this statement but due to the polarity in comments received, the research team has not been able to improve the text to a single Statement and align it with all views expressed. As consensus does not equate to universal agreement, but rather to quantified consent, an important part of the process is to reflect on views that may not initially match your own and reconsider the issues in the light of a wider collaborative perspective.

Among the views received were that the statement was too long and that the second paragraph was more widely supported. For this reason, we have separated the two paragraphs into separate statements, and are presenting these for further voting in Round 2. This allows participants to support either, both or neither statement, which may help to focus areas of common agreement.

Statement 4

In round 1, group members were asked to indicate agreement with the following statement:

In community settings, it is recommended to have "did not attend" and "unsuitable for administration" procedures in place for situations where service users fail to attend their scheduled appointments or the dose is not administered due to clinical reason (e.g. the service user is too intoxicated to provide consent). The procedures should contain the following:

- *communication system (i.e. who to inform - key worker, clinician)*
- *documentation*
- *actions to be taken to contact and recall the service user if applicable. It should detail who is responsible for carrying out these actions.*

Key workers should prepare an individualised "Did Not Attend" plan for each person prescribed depot buprenorphine. This will inform staff unfamiliar with the service user of the actions to be taken when they do not attend appointments.

25 of 31 participants answered this question:

- 52% strongly agreed
- 28% Agreed
- 12% Neither agreed nor disagreed
- 8% Disagreed
- 0% Strongly disagreed

Twenty out of 25 (80%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached.

Based on some of the comments received, some respondents considered that the language should be modified in order to comply with the Medication Assisted Treatment (MAT) Standards. It was also suggested that a Standard Operating Procedure should be in place to ensure follow up of all service users who fail to attend or were unsuitable for treatment at that particular time. Good communication and clear, specific documentation were also considered to be important.

A revised statement has been drafted for the group to consider.

In community settings, it is recommended to have "did not attend" and "unsuitable for administration" procedures in place for situations where service users do not attend their scheduled appointments or the dose is not administered due to clinical reason (e.g. the service user is too intoxicated to provide consent). The procedures should contain the following:

- *communication system (i.e. who to inform - key worker, clinician)*
- *documentation of actions to be taken to contact and recall the service user if applicable. It should detail who is responsible for carrying out these actions.*

Key workers should prepare an individualised "Did Not Attend" plan for each person prescribed depot buprenorphine. This will inform staff unfamiliar with the service user of the actions to be taken when they do not attend appointments.

Statement 5

In round 1, group members were asked to indicate agreement with the following statement:

In populations at risk of poor engagement with opioid substitution therapy due to:

- *comorbid health conditions (eg, cognitive impairment, severe psychiatric conditions or poor mobility),*
- *socioeconomic circumstances (eg child protection concerns, domestic violence, homelessness, poor literacy or social isolation) or*
- *demographic backgrounds (eg individuals from culturally diverse backgrounds, women, LGBTI people, prisoners or older people).*

Particular attention to informed consent to treatment with depot formulations is required, and advocacy services should be available. Service providers and users should collaboratively implement strategies that aim to enhance attendance for dosing and clinical reviews, and consider active follow-up strategies for service users who do not attend for scheduled appointments.

25 of 31 participants answered this question:

- 48% strongly agreed
- 28% Agreed
- 8% Neither agreed nor disagreed
- 16% Disagreed
- 0% Strongly disagreed

Nineteen out of 25 (76%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached.

Based on the comments received, some respondents considered that this statement is aligned with the principles of the MAT Standards. It was suggested that some reference should be made to the latter. No further voting is required on this statement.

Statement 6

In round 1, group members were asked to indicate agreement with the following statement:

The service user's care may be transferred to another provider (acute/ community/ mental health/ health and justice) and vice versa. There should be clear documentation and communication between healthcare professionals at both settings to minimise disruption to the service user's treatment and ensure continuity of care.

25 of 31 participants answered this question:

- 72% strongly agreed
- 16% Agreed
- 8% Neither agreed nor disagreed
- 4% Disagreed
- 0% Strongly disagreed

Twenty two out of 25 (88%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached.

Based on the comments received, some respondents considered that it is essential to have good communication between service providers. Documentation should be electronic with interlinking databases to ease the sharing of information.

A revised statement has been drafted for the group to consider.

A service user's care may be transferred (temporarily or permanently) to another provider (acute/ community/ mental health/ health and justice) and vice versa. There should be clear documentation and communication between professionals at both settings to minimise disruption to the service user's treatment and ensure continuity of care.

Statement 7

In round 1, group members were asked to indicate agreement with the following statement:

As a minimum, the following needs to be communicated to the receiving provider upon transfer:

- *the formulation of depot buprenorphine that was administered: (weekly or monthly)*
- *the date and dose of last dose administered*
- *the date and dose of the next dose due*
- *the current dosing regimen (and equivalent dose of sublingual or supralingual buprenorphine should the depot formulation need to be converted back)*
- *the preferred site of administration, including last site of administration*
- *the dose titration regimen if the service user is not on a stable regimen*
- *if applicable, where the service user normally receives treatment (eg directly from substance misuse service provider, community pharmacy)*
- *any monitoring required*
- *any adverse events, risks or concerns regarding depot buprenorphine treatment that is relevant to other healthcare providers*
- *contact details of the transferring team, if further information is required*

25 out of 31 participants responded.

Participants voted for each bullet point statement individually. All of these achieved well above the formal consensus limit (>70% 'Strongly agreed' or 'agreed') with the exception of the highlighted point above which scored as follows:

Of 25 respondents:

- 52% strongly agreed
- 8% agreed
- 12% neither agreed nor disagreed
- 28% disagreed
- 0% Strongly disagreed

Fifteen out of 25 (60%) respondents agreed or strongly agreed with the statement so consensus was not reached.

Respondents frequently noted that it was unnecessary to provide information on oral dose equivalence and that this could cause confusion and delays. One respondent suggested that the points in the statement are adequately covered by the first three bullets on formulation, previous dose and next dose. This part of the statement has been removed and consensus reached on all other bullet points, with no significant disagreement, therefore no further voting is required on this statement.

Statement 8

In round 1, group members were asked to indicate agreement with the following statement:

Doses should generally be reduced under the following conditions:

- *the service user reports buprenorphine dose-related adverse events (eg sedation or lethargy, persistent headaches, nausea, elevated liver function tests)*
- *the service user is seeking to reduce their dose in an attempt to ultimately withdraw from opioid agonist treatment*
- *the service user is reporting the dose is 'too high' and/or is seeking a dose reduction, and there are no significant concerns regarding deterioration in clinical condition (eg substance use, physical or mental health symptoms) that may arise with a dose reduction.*

25 of 31 participants answered this question:

- 44% strongly agreed
- 28% agreed
- 16% neither agreed nor disagreed
- 12% disagreed
- 0% Strongly disagreed

Eighteen out of 25 (72%) respondents agreed or strongly agreed with this statement – therefore consensus has technically been reached. However, based on some of the comments received, the research team felt statements could be improved by removing 'liver function tests' from the bracket with symptoms in bullet one and rewording the second bullet point to be more supportive of the service user and remove the term 'opioid agonist'.

One respondent suggested additional bullet point on the situation where a patient is regularly delaying their return appointment longer than the scheduled interval (weekly or monthly) but reporting they do not need the medication administered at either one or four weeks as the medication is still holding them sufficiently, this is indicative that the formulation strength can be reduced. Consensus voting on this addition point will be undertaken in round 2.

One respondent suggested the addition of bullet points on the circumstance of the pregnancy or planned pregnancy of a service user using depot buprenorphine and around potential medication interactions. These were felt by the research team to risk overlap or contradiction with dose titration information from the summary of product characteristics which will be cited in the position statement.

Two respondents noted that dose reduction is not an essential aspect of withdrawal from depot buprenorphine due to the pharmacokinetics of the drug formulation. The phrase 'reduce their dose' was removed from the second bullet point to reflect this point.

A revised statement has been drafted for the group to consider:

Doses should generally be reduced under the following conditions:

- *the service user reports buprenorphine dose-related adverse events (eg sedation or lethargy, persistent headaches, nausea) or has elevated liver function tests*
- *the service user wishes to be supported to work towards withdrawal of opioid substitution therapy*
- *the service user is reporting the dose is 'too high' and/or is seeking a dose reduction and there are no significant concerns regarding deterioration in clinical condition (eg substance use, physical or mental health symptoms) that may arise with a dose reduction.*

An additional bullet point has been drafted for consideration (this is included in round 2 voting)

Doses should generally be reduced under the following conditions:

- *the service user is regularly delaying their return appointment longer than the scheduled interval as the medication is still holding them sufficiently*

Statement 9

In round 1, group members were asked to indicate agreement with the following statement:

Doses should generally be increased under the following conditions:

- *the service user is not achieving desired treatment goals (e.g. persistent unsanctioned opioid use, opioid withdrawal symptoms or cravings)*
- *the service user does not report dose-related adverse events related to buprenorphine (e.g. sedation or lethargy, persistent headaches, constipation, nausea, elevated liver function tests)*
- *the service user reports their dose is too low and they would like a dose increase, and there are no significant clinical safety concerns*

25 out of 31 participants responded.

- 28% strongly agreed
- 28% agreed
- 16% neither agreed or disagreed
- 24% disagreed
- 4% strongly disagreed

Fourtenn out of 25 (56%) respondents agreed or strongly agreed with this statement therefore consensus has NOT been reached.
Several respondents commented that a lack of adverse events was not in itself a reason to increase dose. A suggestion for improved wording of the first bullet point around unsanctioned opioid use was also made. 'Elevated liver function tests' have been moved out of the brackets describing symptomatic adverse events to be consistent with other statements.

A revised statement has been drafted for the group to consider:

Doses should generally be increased under the following conditions:

- *the current dose is not meeting the needs of the service user (eg they are experiencing withdrawal symptoms or cravings)*
- *the service user reports their dose is too low and they would like a dose increase, there are no significant clinical safety concerns AND the services user is not experiencing adverse events related to buprenorphine (e.g. sedation or lethargy, persistent headaches, constipation, nausea) or elevated liver function tests.*

Statement 10

In round 1, group members were asked to indicate agreement with the following statement:

In general, doses should be maintained if:

- *the service user is achieving key treatment outcomes, such as no unsanctioned use of opioids, no clinically significant opioid withdrawal or cravings*
- *there are no clinically significant dose-related adverse events related to buprenorphine (eg sedation or lethargy, persistent headaches, nausea)*
- *the service user is satisfied with their current dose, and requesting the dose be maintained*

25 out of 31 respondents answered this question

- 56% strongly agreed
- 24% agreed
- 8% Neither agreed nor disagreed
- 8% disagreed
- 4% strongly disagree

Twenty out of 25 (80%) respondents agreed or strongly agreed with this statement – therefore consensus has been reached. However, based on some of the comments received – the research team felt that there would be value in the guideline group considering and reflecting on the comments received.

Three people (one strongly disagreed with the statement, one disagreed, and one neither agreed nor disagreed) suggested that it needed to be clearer whose treatment outcomes were being referred to – the service user or the service. Some others who agreed/strongly agreed noted that treatment should be patient-led. Another person (who disagreed) felt that 'and' should be added to the end of each statement.

Other points were raised by people who agreed or strongly agreed with the statement:

- ongoing support even although stable to ensure future compliance
- there are agreed review dates to monitor
- service user has reached maximum dose
- add a statement saying " The service user has not required any additional top up doses since administration of their last depot".

A revised statement has been drafted for the group to consider.

In general, doses should be maintained if the service user:

- *is comfortable and not experiencing opioid withdrawals or cravings; and*
- *is achieving their own treatment goals and wishes; and*
- *is not experiencing clinically significant dose-related adverse events related to buprenorphine (eg sedation or lethargy, persistent headaches, nausea); and*
- *Is satisfied with their current dose, and requesting the dose be maintained.*

Two additional bullet points have been drafted for consideration (these are included in round 2 voting)

In general, doses should be maintained if the service user:

- *has reached maximum dose (strongly agree etc)*
- *has not required any additional top up doses since administration of their last depot (strongly agree etc)*

Statement 11

In round 1, 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, appropriate use of opioid and non-opioid medications (eg antidepressants, NSAIDs, paracetamol or gabapentanoids), physical (eg exercise or physiotherapy) and psychosocial (eg Cognitive Behavioural Therapy) interventions.

25 out of 31 respondents answered this question

- 44% strongly agreed
- 32% agreed
- 4% neither agreed nor disagreed
- 16% disagreed
- 4% strongly disagreed

Nineteen out of 25 (76%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached. However, based on the comments received, the research team felt there would be value in the guideline group considering and reflecting on the comments received.

The main issue raised for this statement was the inclusion of 'opioid' medications (raised by four respondents). Some suggestions were also made to improve the readability of the statement.

A revised statement has been drafted for the group to consider.

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 opioid and non-opioid medications (eg paracetamol, NSAIDS, gabapentinoids, antidepressants).

In Round 2 voting, the group will be asked to consider if 'opioids' should be removed from the statement and to explain their answer.

In Round 2 voting the group will be asked to consider if the following sentence should be added to the statement and to explain their answer:

Depot buprenorphine is used for OST, and not pain management.

Statement 12

In round 1, group members were asked to indicate agreement with the following statement:

Buprenorphine should not be used in conjunction with other opioid analgesics (eg morphine, fentanyl, codeine) in chronic pain management, given the 'blockade' effects of depot buprenorphine.

25 out of 31 respondents answered this question

- 36% strongly agreed
- 16% agreed
- 32% neither agreed or disagreed
- 16% disagreed
- 0% strongly disagreed

Thirteen out of 25 (52%) respondents agreed or strongly agreed with this statement, so consensus has NOT been reached.

Given the disparity of responses, it is unclear how this statement could be reworded in order to achieve consensus. Three respondents noted that it should be clearer that this is about depot buprenorphine. This has been the only revision made to the statement.

Depot buprenorphine should not be used in conjunction with other opioid analgesics (eg morphine, fentanyl, codeine) in chronic pain management given its 'blockade' effect.