Healthcare Improvement Scotland | Evidence
Advice, guidance and intelligence

Use of long-acting injectable buprenorphine for opioid substitution therapy

ROUND 1: RESPONSES

Statement 1

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

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.

Of 25 respondents:

8 strongly agreed with this statement;

11 agreed;

2 neither agreed nor disagreed;

3 disagreed;

1 strongly disagreed.

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

Respondents' comments are detailed in table 1:

Table 1: responses to consensus statement 1

Respondent	Response and comments
1	AGREE Treatment delivered via a depot, should give staff more time to provide support to the patient and in turn the patient not being required to attend a pharmacy daily will give them more time to receive support and move forward with their planned outcomes.
2	STRONGLY AGREE: Some clients may not have as much contact with Healthcare professionals (HCP) as previous which may or may not benefit the client. For many clients who make contact with treatment services, it is also important to look broadly at the opportunity to address their psychological problems and the impact of past traumas, and to provide support to gain meaningful employment, stable housing, alongside family and other social support. Staff may have to find different ways of working re follow up visits.
3	STRONGLY AGREE: I agree with this statement as the experience I have had with this medication has made me change the way that I work and I have had to structure my days differently to incorporate it. However, I feel it should not be referred to as depot buprenorphine, maybe the buprenorphine injection instead as this is clearer.

4	AGREE There are several potential advantages for patients in no longer having the requirement to attend pharmacies on a daily basis to receive their opioid substitution medication. May reduce stigma.
5	AGREE I agree with this statement as, from my experience, the mind set and focus of patients can change when they are transferred over to the depot and therefore their care plan and input requires to change to reflect this
6	AGREE I do not think that the word challenging is useful. It has a negative connotation associated with it. Could this be changed to "...enhance..." or "...allows for redesign of..." be used instead? I think the work may in the second sentence should be replaced with "...will allow for...".
7	NEITHER AGREE NOR DISAGREE Because the treatment has changed it does not necessarily mean the way we address care delivery is required to change. Clients' needs are assessed on an individual basis, as everyone's needs are different so is the care planning and delivery. Psychosocial interventions would remain unchanged.
8	STRONGLY AGREE I feel that psychosocial interventions are a key component of OST treatment and therefore, this should be structured around Buvidal administration.
9	STRONGLY AGREE I believe that focussing on the whole person with person centred and trauma informed care where there is a depot LAB containing the prescribing side of living experience of addiction allows clinicians to support recovery, focus on e.g. lung and heart health rather than a constant grind of daily pick up, prescribing, attrition, retention- this is a potential game changer and takes away some of the public humiliation and ability for dealers to target people in the communities. Services will have to change from an 'industrial' model to one in which each patient is at the centre
10	AGREE Depot buprenorphine is suitable for a range of patients, from those who are stable to those who frequently miss doses of OST and/or use other substances on top of their prescribed treatment. Patients who are not stable in treatment may require services to review how they deliver clinical reviews and care planning. The daily collection and/or supervision of OST at community pharmacy provides a safety mechanism where services would be alerted if there are any concerns for the patient's wellbeing and safety. Removal of this daily contact may require other services to increase contact with these individuals. When depot buprenorphine is delivered in a clinic setting, care providers need to ensure that appointments are focussed on the holistic needs of the patient and do not become focussed on the task of administering the depot. Longer appointments times may be required to achieve this which will impact on service delivery. Consideration also needs to be given to provide care in a more flexible way, for example providing depot buprenorphine in community settings such as community pharmacy and GP surgeries rather than in central specialist clinics.
11	DISAGREE I disagree with the use of the word 'challenges' as could be read with either of its alternative meanings in that statement. Suggest 'Treatment with depot buprenorphine confers the opportunity to modify the way in which....'.

12	AGREE The use of LAIB is a different process, not from the medication used (buprenorphine - as we have used this for many years) but the actual preparation lasting 4 weeks (or in case of the implants 6 months). This makes the consultation more involved as this is the sole point of contact generally for a 4 week period (although interventions and support can still be delivered in the interim)
13	AGREE Current daily or regular pharmacy pick up allows some level of regular assessment which will be lost with monthly dosing
14	STRONGLY AGREE I agree that it may be difficult to access patients if they are potentially not having to attend for treatment
15	DISAGREE I disagree with this statement as it is currently written and I believe more detailed information is required to support a suggestion that treatment with depot buprenorphine will alter service structure and delivery. The services need to be patient centred, not treatment modality centred. Requirements for clinical reviews, psychosocial interventions and care planning may change over time, but I do not think we can say that yet.
16	STRONGLY DISAGREE From my personal experience and the service I work in, I have not seen any major adjustments needed on our approach. I do not understand why there is a need to change the structure of clinical reviews, it will be fundamentally same with an added option with the existing ones like Methadone and Tablet buprenorphine. It also doesn't change how I do the mental health assessments. The psychosocial interventions may change slightly. Usually there are more contacts by keyworkers in the start of opiate replacement therapy to adjust doses and also to provide supports to reduce chaos and achieve stability. Later in the treatment stages, more focussed interventions are delivered and I don't think the monthly or weekly depot will have any impact on that. Similarly, I don't think it will have any effect on care planning. There is a possibility that services which work differently may find it more challenging, I would like to hear opposing views if there is any.
17	DISAGREE This patient dependant and clinical intervention does not always determine level of psychosocial need, for example it is equally feasible that a person on depot buprenorphine may need little support as stable or intense support as unstable - dose frequency would not have a bearing on this. This statement makes the assumption that patients are stable.
18	STRONGLY AGREE This new medication has been described as a "game changer". We need to revisit service delivery because of it.
19	AGREE i agree that there are potential challenges and this may need a different approach to all of the above mentioned.
20	STRONGLY AGREE May be a good option for patients to participate in group psychosocial interventions-offered weekly, but not mandatory. Monthly r/v's however would be part of their ongoing care plan If a person does de-stabilise could change to weekly depot until stable
21	NEITHER AGREE NOR DISAGREE This reflects the experience of our service. We have made changes to the structures of clinics and contacts. I wonder if anything is needed (assuming not in another statement I have not got to yet) to reflect that sometimes we have needed to consider our staff in fact having more contact with patients, as we do not with LAB have

	the feedback from pharmacy as to when patients are struggling or presenting as more chaotic.
22	STRONGLY AGREE Agree with content and the "clinical reviews, psychosocial interventions and care planning" covers all aspects.
23	AGREE the clinical reviews may reduce but PSI's and care planning should stay the same.
24	AGREE Dispensing of oral medication at the community pharmacy occurs daily in many cases, and consideration should be given to increasing opportunities for other structured clinical reviews for people prescribed depot buprenorphine
25	AGREE I agree because the statement says "may require" had this not been included I would have disagreed. Many clinics and reviews would potentially remain the same however this does provide the opportunity to change the way services are delivered and the way people access their care/ treatment.

Statement 2

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

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.

Of 25 respondents:

13 strongly agreed

6 agreed

2 neither agreed nor disagreed

3 disagreed

1 strongly disagreed.

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

Respondents' comments are detailed in table 2:

Table 2: Responses to consensus statement 2

Respondent	Response and comments
1	DISAGREE I don't agree with this statement! As when you begin to suggest that training is a requirement for staff, this becomes a barrier and prevents this being offered to patients as a choice. Some areas will take several months or years to put a training package together. I agree that training is important but only if it is run alongside the provision of depot buprenorphine.
2	STRONGLY AGREE As well as training all staff in the administration of depot buprenorphine, there could also be "key trainers" who ensure staff are trained and have regular updates to ensure competence. Could the training be on TURAS (which happens with the COVID vaccine) to ensure that the theoretical components are covered). (Which is Mandatory prior to giving vaccines).
3	STRONGLY AGREE I strongly agree with this statement as I think it is very important for staff to be trained in this for consistency and safety of patients. It is important for everyone to follow the same protocols and pathways to ensure this.
4	STRONGLY AGREE It is appropriate to have standard training in place

5	STRONGLY AGREE I strongly agree that there are benefits from having a training package in place given it is a new product and staff have not worked with the product previously. This will ensure all staff administering the medication are competent to do so and have all the appropriate information required to safely administer the medication
6	STRONGLY AGREE The training of staff will be different depending on the service set-up for this and I think that the statement covers this.
7	STRONGLY AGREE Manufacturer has provided training which has been useful.
8	AGREE I feel that an official training package being developed, in terms of recording when training was undertaken and is due for renewal, is essential going forward. Particularly for administration training.
9	STRONGLY AGREE Governance is key. HCPs who administer depot buprenorphine (DB) would have to be competent in giving SC injections, but also what hazards or side effects there may be. This is especially germane given the scrutiny this may be under publicly. As DB will be given by registered clinicians, they will want to be protected and assured by governance and health and safety from their organisation. If there is expert knowledge to be given by manufacturer, they could be persuaded to provide seminars? TURAS and LearnPro could support this and be accessible for employers and clinicians alike
10	NEITHER AGREE NOR DISAGREE This is not specific to substance use services. NHS organisations and contractors must ensure that staff are trained and competent to deliver care. Suggest revision to state "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. Standard operating procedures should be developed with staff."
11	STRONGLY DISAGREE Should we not be recommending training on a once for Scotland basis? This will deliver best standardisation of care, efficiency and quality assurance. (Especially as we are moving to pan-Scotland standardisation through the MAT standards).
12	STRONGLY AGREE There should be national guidance and standards for a training pack to accompany. This would formalise and record training to ensure staff are competent (and to the same standard across Scotland). A nationally developed training pack should cover all options and products of Long Acting Injectable Buprenorphine
13	DISAGREE It would be preferably for organisations to be independent of the manufacturer for training. Otherwise fine
14	STRONGLY AGREE Due to this being a new product which is administered in a different way, training should be undertaken prior to the product being used
15	AGREE I think this statement accurately summarises the current position and makes realistic proposals for governance and assurance requirements for service providers.
16	AGREE I was not aware that there was no formal requirement for training. I agree with the rest which highlights the need for training development.

17	STRONGLY AGREE All staff involved in the administration of this drug must have an understanding of how it is administered, need for test dosing, and local systems of work to ensure that the patient continues to receive dose as the right time.
18	AGREE It is simple to administer, so only basic training would be required.
19	STRONGLY AGREE as there is no formal training in place I agree with all the advice in the above statement.
20	STRONGLY AGREE Maintaining good links with manufacturer is key, as are able to assist with training needs and information for both clinical staff and patients. Regular updates/meetings would be advised for pharmacies Would be mandatory for services to engage in training-may be possible for an e learning module to be developed
21	AGREE This reflects our experience of introducing LAB. We have needed to consider training needs for staff and resilience around being able to practically deliver SC injections within our service
22	DISAGREE Wording not specific enough to explain that there is training requirement for both the prescribing and the administration. Additional training is required for all as there are differences in administration from "ordinary" subcutaneous injections. Suggested wording below. 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 which requires understanding of both pharmacodynamics and administration technique. 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 (eg 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
23	AGREE agree training and evidence of training is essential
24	STRONGLY AGREE I fully agree assurances regarding competence to administer the depot is essential, and ensuring sufficient staff are trained to assure continuity of service provision needs to be considered.
25	NEITHER AGREE NOR DISAGREE "There are currently no formal prescribing or administration training requirements for depot buprenorphine." The word additional should be in this sentence. "However, organisations may wish to develop local training packages as this is a relatively new product." Agree but I don't think you need to have "relatively new product" as this will age the guideline significantly. "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." I would remove this as it is not relevant - Buvidal is administered differently to other subcutaneous injections as far as I am aware. "Organisations may wish to link in with the manufacturer for training support." Agreed "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 (eg 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." Agreed

Statement 3

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

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.

Of 25 respondents:

10 strongly agreed

7 agreed

2 neither agreed nor disagreed

5 disagreed

1 strongly disagreed.

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

Respondents' comments are detailed in table 3

Table 3: Responses to consensus statement 3

Respondent	Response and comments
1	DISAGREE This statement is too long and seems to be covering different points assessment of risk, consent. However it does not state what the threshold to withholding a dose would be? This cannot be left to the individual prescriber as this would become too subjective based on that individuals experience of dealing with risk. If a statement like this is forming part of a wider statement it needs to be more concise and clear on what steps to take and when.
2	AGREE 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.
3	AGREE 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. Does the word 'depot' need to be in there? Is there a way of breaking it up a bit? I completely agree with the last paragraph.
4	AGREE This appears to be sensible advice
5	STRONGLY AGREE I feel this should always be the process followed with administration of medication, where applicable and patient safety is not compromised, in these circumstances
6	STRONGLY AGREE This promotes a person-centred risk-assessment to be undertaken.
7	DISAGREE 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 there appointment should be rescheduled and this should be out lined in an agreement with them prior to them commencing treatment. It could be included in their care plan.
8	AGREE I feel that service users should be in a position to provide consent for a depot injection.
9	STRONGLY AGREE If there is little to suggest withholding is safer than administering, then there would have to be safeguards around that. 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. This does underpin the reason why clinicians would need to be confident in vicarious support and in the clinical facts of DB
10	STRONGLY DISAGREE 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. 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?
11	NEITHER AGREE NOR DISAGREE Out with my clinical expertise
12	AGREE This should be in the standardised training / guidance package. As time to peak levels is delayed the patient need to be compliant with no further substance use (if they receive the LAIB) to minimise any further intoxication
13	NEITHER AGREE NOR DISAGREE This sounds sensible but is outside my clinical experience
14	DISAGREE Should service users who are obviously intoxicated be able to continue on this product if they are obviously not stable
15	STRONGLY AGREE Clinicians / service providers would need to identify the source if intoxication in the presenting patient. This is unlikely to be be due to opiates/opioids if the patient is currently receiving depot buprenorphine treatment. Other sources of intoxication e,g

	bezodiazepines, NPS etc may pose a clinical risk to the patient that will need to be mitigated.
16	STRONGLY AGREE 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.
17	DISAGREE 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.
18	STRONGLY AGREE Absolutely no reason to withhold administration
19	STRONGLY AGREE agree that there should be a system in place to access a person who appears to be intoxicated at time of dose.
20	STRONGLY AGREE rearrange appointment for following day
21	STRONGLY AGREE 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.
22	STRONGLY AGREE No suggested changes. Agree with ethos of explaining unlikely to require to withhold dose.
23	AGREE the person needs to be cognitively able to make a decision.
24	DISAGREE Capacity can't be assumed if someone is intoxicated, as people can change their decisions.
25	AGREE No additional comments, this seems sensible and reasonable.

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.

Of 25 respondents

13 strongly agreed

7 agreed

3 neither agreed nor disagreed

2 disagreed

0 strongly disagreed.

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

Respondents' comments are detailed in table 4

Table 4: Responses to consensus statement 4

Respondent	Response and comments
1	DISAGREE I agree with the bulk of this statement, however it is weighted towards the service user? I would like there to be a section completed by the nurse/pharmacist giving details of why people are deemed unsuitable. I wouldn't just want there to be a box which said intoxicated?
2	AGREE Multidisciplinary working each client should have a key worker/primary nurse to ensure good outcomes clear, concise action plan for patients who don't attend Could there be a Standard Operation Procedure ?? Flow chart??
3	STRONGLY AGREEI strongly agree with this statement as I feel it is very important to know what to do if a patient does not attend, for both keyworkers and other staff. It's important to discuss this with the patient prior to commencing on Buvidal so that they know what to expect.
4	STRONGLY AGREE Good communication is key
5	STRONGLY AGREE This ensure continuity of care and eliminates the wasting of staff time looking for this information

6	STRONGLY AGREE This is a very person-centred approach and I think promotes good communication for the individual and between services. The idea of a "Did Not Attend" plan is used locally within Mental Health services and agreed at the start of treatment which has worked well when used.
7	STRONGLY AGREE If the client does not make contact with the service or is unable to be contacted within a 72 hour period and no one can account for them a welfare check should be carried out. There should be a plan as to a period of time in which the client falls outside of when treatment would need to be reviewed before the dose was given.
8	AGREE I feel it is important to record when a patient does not attend for a prescribed dose of Buvidal. I feel that the recording of this would give an indication as to whether a patient's treatment is stable.
9	STRONGLY AGREE There is a legacy of 'Did not attend' and this is infused with the notion that the patient does not value the clinical process or treatment when in fact, this may not be the case at all. If the language could be modified and a clear retention plan triggered, this would be in the spirit of the Medication Assisted Treatment Standards (MAT) and hopefully that approach would have been agreed with the patient at the outset of engagement. There must be a care plan in place with instructions for staff so they feel empowered that this type of follow up can be lifesaving so thus clinically imperative.
10	AGREE There should be a standard operating procedure to ensure that all patients, regardless of OST preparation, who do not attend appointments are followed up. When patients do not attend for buprenorphine depot there is a short time window to administer the dose and so there should be procedures to book patients into clinic to ensure they receive this within the timescale and are not lost to follow up. Patients prescribed depot buprenorphine are especially vulnerable to this as they do not have frequent contact with community pharmacy who would flag any concerns regarding wellbeing.
11	DISAGREE Need to specify what is meant by 'documentation'. For 3rd point suggest 'Actions to be taken to contact and recall the service user if applicable. These should detail who is responsible for carrying out these actions and confirmation that the person responsible has been notified'
12	STRONGLY AGREE Individual plans for patients are required (standard template but advice needs to vary to that patient). Needs to be robust and sensible plans and communication and patients should be made aware previous to agree. Arrangements need to be in place to "pick up" at treat patients who miss their appointment as soon as mutually agreeable. This falls into local agreements and service level agreements
13	NEITHER AGREE NOR DISAGREE Again, seems sensible but is not within my clinical knowledge
14	AGREE It is important to have a process in place so that service users who fail to attend do not get lost to follow up
15	STRONGLY AGREE I believe this proposal would be a requisite element of an appropriate, patient centred model of care.
16	STRONGLY AGREE I feel this is clear and well written as explains the roles of everyone involved.

17	STRONGLY AGREE In this situation, communication is key and allows for clearly documented rationale to be in place for the clinical decision made. This can also be shared with the keyworker who can then speak to their patient about the lapse and make amendments to the care plan as needed.
18	AGREE There is "wriggle room" in administration, so it doesn't need to be an "emergency" situation.
19	STRONGLY AGREE agree with this recommendation of having procedures in place to communicate, document and follow up on any person who did not attend or was unsuitable for administration, also having a system to follow in this instance where someone attempts to reengage the Peron.
20	AGREE There may be multiple reasons that the patient is unable to attend, so would be good for all staff to be aware
21	NEITHER AGREE NOR DISAGREE I am unclear on what an “individualised” DNA plan would look like. We have a standard policy on recall and recontacting patients who DNA.
22	NEITHER AGREE NOR DISAGREE Minor wording changes suggested below. (I can't highlight or bold the text) 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 a 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 with 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.
23	AGREE this is good key working practice
24	STRONGLY AGREE I agree care planning, documentation and communication are important
25	STRONGLY AGREE This recommendation would be welcomed.

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.**

Of 25 respondents

12 strongly agreed

7 agreed

2 neither agreed nor disagreed

4 disagreed

0 strongly disagreed.

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

Respondents' comments are detailed in table 5

Table 5: Responses to consensus statement 5

Respondent	Response and comments
1	DISAGREE This should always be done at assessment and no-one should begin the depot buprenorphine until the above mentioned strategies are in place and agreed with the service user.
2	AGREE Staff should try and ensure engagement with services, telephone calls/ near me/home visits. Could depot buprenorphine be offered in areas closer to where people reside. Written information in different languages, use of translators when appropriate. Depending on area there may not be any advocacy services.
3	STRONGLY AGREE I strongly agree with this statement as I currently work in a homeless GP practice so this one is very relevant to my patient group. It is paramount that service users have a good understanding of this medication prior to starting it and that they can make an informed decision along with their service provider.

4	STRONGLY AGREE It is important that active steps are taken to help individuals who have difficulty engaging with services/treatments, no matter the specific reason
5	STRONGLY AGREE Assertive outreach is currently utilised in these circumstances which, without looking at specifics, appears to be effective in getting patients engaged with their medication regime. Patient suitability for a medication should be reviewed on an ongoing basis
6	DISAGREE I think that this should be the case for all individuals. We would want advocacy for everyone not just those at risk of poor engagement.
7	STRONGLY AGREE This population has been identified as difficult to engage with services therefore it may be beneficial to provide increased flexibility which may not always be possible to achieve due to limited staff numbers in rural areas.
8	AGREE I feel that active follow up strategies for any patient group at risk of poor engagement with OST is essential.
9	STRONGLY AGREE I would imagine ALL b people in my clinical setting (Justice) will be marginalised and have some key fears about attending on occasion- women for fear of personal protection/violence and if that triggers safeguarding issues at home, especially they may feel unfairly judged. It is almost to be expected that a person who has living experience of addiction will have had their self esteem and worth compromised at some point, and likely also for people with severe and enduring MH problems. Making services person centred allows relationships to flourish and understanding of the issues and barriers to be addressed as part of the clinical team with the person at the centre of it.
10	STRONGLY AGREE Depot buprenorphine should be provided when it is agreed by patient and prescriber to be the optimal choice for the patient. Some patients may require additional support to be fully involved and informed in decision making. The decision to use depot buprenorphine should not be made for convenience for the service due to frequent DNA appointments.
11	DISAGREE 'and advocacy services should be available'. Would suggest this should be part of standardised national training.
12	STRONGLY AGREE There needs to be an assertive outreach service to complement this standard service for these patient groups
13	AGREE Strong need to ensure consent is informed and valid in these groups. Active follow up will benefit these groups in particular
14	AGREE A process to help reduce the risk of poor engagement is very important
15	STRONGLY AGREE I agree with this statement as it is aligned with the principles of the MAT standards. I think the statement would be strengthened by linking it to the relevant MAT standards.
16	AGREE The collaborative planning to reduce DNAs is a good suggestion. Advocacy when taking consent for people who is at risk of poor engagement is a good advice. I think the examples above is too broad and runs the risk of significantly increasing the number of people needing advocacy, increasing pressure on services and possibly diluting the

	process. I would leave it to services to identify who are at greater risk of poor engagement and focus advocacy and other services accordingly.
17	STRONGLY AGREE Important to always ensure that all patient have full understanding of what they are taking including these groups who may need extra support to come to the same understanding as others.
18	STRONGLY AGREE We should do everything in our power to promote concordance.
19	STRONGLY AGREE agree with this to make it inclusive to all no matter their background.
20	STRONGLY AGREE may require home visits text reminders of appointments should be able to have the option where to administer (whether in clinic or at pharmacy)
21	NEITHER AGREE NOR DISAGREE I am unclear what the significant differences are in seeking consent relating to LAB compared to oral treatments. I would agree that both access to advocacy and strategies to seek to enhance attendance for those at poor risk of engagement are needed and we have assertive outreach services that aim to do this.
22	DISAGREE I'm uncomfortable with the idea of "poor engagement" - it is usually due to service issues rather than individual characteristics. I don't think this part is necessary. Suggested wording below. As with all opioid substitution therapies, attention to informed consent to treatment is required, and advocacy services should be available. Service users and providers 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.
23	AGREE good practice
24	NEITHER AGREE NOR DISAGREE Don't agree with assumptions regarding for the need for advocacy related to demographics
25	AGREE Seems sensible.

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.

Of 25 respondents:

18 strongly agreed

4 agreed

2 neither agreed nor disagreed

1 disagreed

0 strongly disagreed.

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

Respondents' comments are detailed in table 6

Table 6: Responses to consensus statement 6

Respondent	Response and comments
1	DISAGREE Given the reduced number of consultation that service users of depot buprenorphine will have with their prescriber. Each service user should have a running log of depot injections which include comments/observations and any risks etc.
2	STRONGLY AGREE there would have to be clear communication between providers with the client being at the centre of any decisions made.
3	STRONGLY AGREE I strongly agree with this statement, this is key to ensuring continuity of care. There should be a clear pathway to transferring patients between services.
4	STRONGLY AGREE It is important that patient treatment and clinical records (electronic) interlink and are accessible in different healthcare settings
5	STRONGLY AGREE I strongly agree that this should always be the case to ensure continuity of care. Patient's care and treatment should not be negatively impacted by these types of situations.
6	STRONGLY AGREE This will be the only way that we can ensure that patients are safely managed cross-boundaries.
7	STRONGLY AGREE Highland already has standardised notes throughout the substance use recovery service and is in the process of moving to digital notes which makes documentation more accessible to all. Access to social work databases and documentation would be useful.

8	AGREE I feel this is vitally important as service users' Buvidal treatment may not show up on certain sources used for medicines reconciliation (ie ECS), if it is prescribed by a specialist service. This is a common issue with other medications prescribed by other specialist services. To reduce the likelihood of a medication error, clear documentation and communication should be a hallmark of treatment.
9	STRONGLY AGREE THIS is where the system falls down, 'my data is more important than your data' or where systems do not speak to one another, or services do not have access, to information, particularly in receiving essential medicines or leaving prison/police custody for example. Essentially this info should be electronic and follow the patient wherever they go. 20 % of people who succumbed to a DRD in Scotland last year had been in Police Custody in the months before they died. Data sharing - with ease- is essential.
10	STRONGLY AGREE There should be a smooth transition of care between providers with all working for the benefit of the patient. Patients are often required to have multiple services involved with their care and require to build trusting relationships to gain maximum benefit. Undoubtedly, repeating past history and trauma to multiple service is not beneficial for patients. Clear documentation and communication is key to provide smooth transitions through this journey.
11	STRONGLY AGREE Agree. No suggestions for change
12	STRONGLY AGREE Documentation needs to be clear to allow for the information to be passed over and clearly understood when patients pass between providers. This needs to be timeous and without any ambiguity to ensure the transfer is seamless.
13	AGREE Supplier may well change from time to time, or more regularly. Ensuring continuity of care is important
14	AGREE Continuity of care is extremely important
15	STRONGLY AGREE We know that harm happens at interfaces and it is therefore critical that documentation and communication follow the patient to support safe continuity of care. Better sharing of, and access to, the relevant information will assist.
16	STRONGLY AGREE This should be standard practice with any transfer and should apply to depot as well.
17	STRONGLY AGREE This should be a baseline practice which involves the patient at the initial suggestion of transfer through to the completion of transfer so that they feel consulted with and part of the treatment plan.
18	STRONGLY AGREE As with any other form of OAT
19	STRONGLY AGREE agree so as the person can access the service no matter what setting and in conjunction with other service providers
20	STRONGLY AGREE Date of administration, site of administration should be documented Dose and expiry should also be documented If administered whilst inpatient would always document on electronic records, and also inform community team Will need to consider when community pharmacies administering
21	STRONGLY AGREE This would appear to represent good practice.

22	NEITHER AGREE NOR DISAGREE Minor amendment suggested below. Healthcare removed as 50% some integrated teams are social care, third sector etc. 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.
23	AGREE good practice
24	STRONGLY AGREE This is similar to all transfers of care for any treatment
25	NEITHER AGREE NOR DISAGREE This is integral to recovery. The word "timely" may add weight to this recommendation.

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**

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

Of 25 respondents:

13 strongly agreed

2 agreed

3 neither agreed nor disagreed

7 disagreed

0 strongly disagreed.

Fifteen out of 25 (60%) respondents agreed or strongly agreed with this statement, so consensus has NOT been reached on the statement section highlighted above. See Appendix 1 for further information on voting for this statement.

Respondents' comments are detailed in table 7

Table 7: Responses to consensus statement 7

Respondent	Response and comments
1	NEITHER AGREE NOR DISAGREE All of the above is clinical data and will be recorded anyway! I would include what I wrote for Q13
2	STRONGLY AGREE All of these are extremely pertinent Who prescribes the injection.
3	DISAGREE I do not think the current dosing regimen needs to be transferred as services should all be providing similar services and should have the information on how to convert back already. I agree that the last

	site of administration should be passed on, however, sites should be alternated.
4	STRONGLY AGREE Agree with all of the above
5	STRONGLY AGREE I strongly agree that all of the above information should be available as standard to ensure continuity of care
6	DISAGREE The only one that I do not think should be included is information about equivalence. I think that this would give rise to confusion, potentially alarm the patient and should be a clinical discussion between the teams if this was needed.
7	STRONGLY AGREE Update regarding concordance with treatment. Is there a need for two workers-risk of violence?
8	NEITHER AGREE NOR DISAGREE While I feel that clear documentation and communication should be a priority when a patient is transferred to another provider, I also feel that ensuring there is not an overload of information, and the key aspects of the patient's Buvidal treatment are highlighted (ie current dose, date last administered, date due), should be given precedence.
9	AGREE This info would be so incredibly helpful. I believe that not being able to transfer this really diminishes HCP confidence as they may have to spend a lot of time seeking this info from source and this holds up engagement and safety. HOw we do this, I would reiterate , an agile electronic prescribing module
10	STRONGLY AGREE "the current dosing regime" is absolutely required, however I think providing an equivalent sublingual dose should the patient be transferred back may cause confusion. Should the patient require a switch back to sublingual/lyophilisate preparations then the service should contact the substance use service for a conversion which takes into account the patient’s current situation and requirements. The sublingual/lyophilisate preparations are not bioequivalent and so advice is required.
11	STRONGLY AGREE Suggest 'the planned dose titration regimen' - circumstances change and to ensure the service receiving the service user does not follow the titration regimen to the letter when it may be no longer appropriate Suggest changing 'any monitoring required' to 'current monitoring arrangements' 'other health care providers' - just health care providers or should it be more wide?
12	STRONGLY AGREE There should be a clear plan along with dates, times and locations for next appointments and information should be sent in advance with plenty of time for the appointment to be scheduled.
13	STRONGLY AGREE All essential for continuity of care. preferred site of administration may vary over time and can be reported by the individual receiving the therapy
14	STRONGLY AGREE I have no additions, deletions or revisions to make
15	DISAGREE I do not think the 4th statement is required. The receiving service clinician needs to be competent to calculate that dose, but the dose required may be different due to the presenting clinical situation and patient preference.

16	AGREE The equivalent doses of buprenorphine (sub or supralingual) would need involvement of a prescriber who may not be accessible at the time of transfer and thus would take longer to send the information. The receiving prescriber can make the decision with other available information (current dosing regimen should be provided). The information about preferred site of administration and last site of administration is valuable but depends on whether it is being clearly documented. I am not sure this guideline is providing suggestions about should be documented (may be it will be in next pages, if not maybe there should be one) 'any monitoring required' is bit vague - ideally would include more specific information about mental health or substance misuse. Also ideally should include information about attendance history and whether specific person centred adjustments were being made
17	STRONGLY AGREE Only less in agreement with the preferred site part, important to rotate sites and reiterate this to the patient but of course, still take into account their preferences.
18	STRONGLY AGREE As with any other form of OAT
19	STRONGLY AGREE none
20	STRONGLY AGREE agree with all of the above Definitely last point-contact details of transferring team Also communication with pharmacies if administering-procedures/ guidance will need to be developed/provided
21	DISAGREE I would expect a service able to prescribe LAB to be able to convert back to oral without needing a plan provided for them, especially as this may need to be tailored to individual circumstances at the time the decision is taken and services may use different preparations of oral BUP that may not be bioequivalent. I would agree with all others.
22	DISAGREE Advice can be sought from the contact details provided re transfer to other OST at the time required as there may be changed factors to consider. Monitoring and concerns/risks not required.
23	STRONGLY AGREE All good practice
24	DISAGREE I agree with the above except for the dosing transfer to oral buprenorphine which would relate to the new provider of care and their assessment.
25	DISAGREE "the current dosing regimen" - is already covered in the previous 3 points. "(and equivalent dose of sublingual or supralingual buprenorphine should the depot formulation need to be converted back)" - should not have to be expressed as should be known by the prescriber (who will take over the prescription) if they require to convert back.

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.**

Of 25 respondents:

11 strongly agreed

7 agreed

4 neither agreed nor disagreed

3 disagreed

0 strongly disagreed.

Eighteen out of 25 (72%) respondents agreed or strongly agreed with this statement, so consensus has been reached. Respondents' comments are detailed in table 8

Table 8: Responses to consensus statement 8

Respondent	Response and comments
1	DISAGREE This part of the statement below needs to be separate in my view! There are often disagreements with service users and prescribers regarding dose titration. It needs to be clear what each party can do in these circumstances >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.
2	STRONGLY AGREE May need regular liver function tests and regular monitoring (even if dose is reduced) Discuss with client common side effect also provide written information Close monitoring if reducing Support client to reduce dose safely following discussion of alternative treatment if required Ensure client is aware of the possibility of withdrawal symptoms/and what the alternatives are.
3	AGREE I agree with this statement, no other comments.
4	STRONGLY AGREE Agree with these statements

5	STONGLY AGREE The patients views and requests should be taken into consideration and unless there are any clinical concerns about their request, should be acted upon
6	STRONGLY AGREE These all seem like appropriate reasons to reduce the dose.
7	AGREE Service user is pregnant or planning pregnancy. Service user has interaction with another medication which is considered essential for physical health needs.
8	AGREE These appear to be sensible reasons to reduce the dose of Buvidal.
9	NEITHER AGREE NOR DISAGREE I agree in terms of if the does is causing iatrogenic illness or side effects that the person cannot tolerate- but equally, if it is safe to persevere and the patient requires more support and explanation, that is equally as important as the ritual of drug taking etc, has been removed and treatment can take time to get used to. The treatment benefit should be revisited at this time and this is the strength of understanding the psychology of addiction and trauma in particular. The service user will be expert in their own titration of 'old' substances and may feel exposed by the power of the 'new' one. Careful consideration to be given, and a joint decision- unless there is an immediate clinical reason not to continue.
10	NEITHER AGREE NOR DISAGREE Need to ensure consistency between use of opioid substitution treatment (OST) and opioid agonist treatment (OAT). Patients generally understand OST and it is a widely accepted term. Buprenorphine is a partial agonist and so OAT may not be the best terminology. This statement "the service user is seeking to reduce their dose in an attempt to ultimately withdraw from opioid agonist treatment" is not written in a supportive way. Suggest "The service user wishes to be supported to reduce dose working towards withdrawal of OST"
11	NEITHER AGREE NOR DISAGREE Out with my clinical expertise
12	STRONGLY AGREE These are appropriate reasons for dose reduction. A further consideration for reduced dose is if a patient is regularly delaying their return appointment longer than the scheduled interval (week or 4 weeks) but reporting they do not need the medication administered at either 1 or 4 weeks as the medication is still holding them sufficiently, this is indicative that the formulation strength can be reduced.
13	AGREE Important situations when dose may be reduced.
14	AGREE A patient centred approach should be applied in this instance
15	AGREE I agree that the above statements capture the situation where a dose reduction is indicated. It not always necessary to have a dose reduction titration regimen to withdraw from OST due to the pharmacokinetics of the drug formulation. May wish to refer to this in any guideline
16	STRONGLY AGREE Happy with this, clear guidance
17	STRONGLY AGREE Important to respond to these request as the patient is an active participant in their care. Any changes should be clearly agreed upon and documented in the care plan.

18	DISAGREE A dose reduction is not always required for a "detox". The monthly injections can take up to 3 months to wear off completely, so just stopping the injection can be just as effective.
19	STRONGLY AGREE strongly agree to promote choice of the person in line with the MAT standards.
20	AGREE again should be patient led
21	STRONGLY AGREE This all seems reasonable and is our current clinical practice.
22	DISAGREE Unnecessary to detail reasons for request to reduce dose - covered in 2 points below. Doses should generally be reduced under the following conditions: the service user reports or experiences 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, 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 and a detoxification risk assessment and care plan has been completed.
23	STONGLY AGREE good practice
24	STRONGLY AGREE Agree dose should be reduced with patient preference and dose related adverse effects
25	NEITHER AGREE NOR DISAGREE I agree except for the part stating the service user reporting elevated LFTs - I doubt the service user would be the one reporting this, possibly this should be a separate section "medical concerns" for example.

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.**

Of 25 respondents:

11 strongly agreed

7 agreed

4 neither agreed nor disagreed

3 disagreed

0 strongly disagreed.

Eighteen out of 25 (72%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached.

Respondents' comments are detailed in table 9

Table 9: Responses to consensus statement 9

Respondent	Response and comments
1	DISAGREE This is not clear who's treatment goals we are talking about? "the service user is not achieving desired treatment goals (eg persistent unsanctioned opioid use, opioid withdrawal symptoms or cravings)" This can cause issues of engagement, retention etc if it is not clear. Service users and services often have different treatment goals (services end to have more fixed goals and service users tend to have more flexible goals a statement should include both when we are talking about informed choice.
2	STROGLY AGREE Ensure flexibility for dose adjustment based on individual client's needs. Use of clinical judgement after assessment of client is at risk of using illicit substances?? No clinical risk to client Not on any other medication that would interact with depot buprenorphine.
3	AGREE The second bullet point is not relevant but I agree with the other two bullet points.
4	DISAGREE In agreement with these statements. Chronic pain is common in this population. Depot buprenorphine will have analgesic effects but is not licensed for treatment of pain. Would report of pain ever be considered in individual patient decisions?

5	STRONGLY AGREE Patients views should always be taken into consideration and acted on appropriately if clinically indicated along with working in connection with their ongoing recovery plan/goals
6	DISAGREE I do not think that not having adverse effects is a reason to increase the dose I see this as a positive thing.
7	NEITHER AGREE NOR DISAGREE service user does not report dose related adverse event related to buprenorphine" does not indicate does should be increased it indicated if increase is required it is safe to do so. This should be changed.
8	AGREE These are sensible reasons to increase the dose of Buvidal.
9	NEITHER AGREE NOR DISAGREE Again, this is part of the discussion with clinician - but increase could be indicated.
10	STRONGLY DISAGREE The statement "the service user is not achieving desired treatment goals (eg persistent unsanctioned opioid use, opioid withdrawal symptoms or cravings)" requires re-wording. "persistent unsanctioned opioid use" is judgemental and should not be used. It is the medication that is not achieving what the patient needs rather than the patient not meeting the prescriber's goals for them. The statement "the service user does not report dose-related adverse events related to buprenorphine (eg sedation or lethargy, persistent headaches, constipation, nausea, elevated liver function tests)" would not in itself prompt a dose increase. Suggest statements read -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, and there are no significant clinical safety concerns. AND the service user is not experiencing any adverse events related to buprenorphine (eg sedation or lethargy, persistent headaches, constipation, nausea, elevated liver function tests
11	NEITHER AGREE NOR DISAGREE Out with my clinical expertise
12	STRONGLY AGREE Completely appropriate reasons for dose increase. An addition would be if a patient has returned to the clinic if a "top up" dose reporting that the medication is not sufficiently holding them.
13	DISAGREE first two conditions need to be linked
14	AGREE Should a ceiling dose be added?
15	AGREE I think that these statements capture the situations where dose increase will be indicated, but would also add a statement "The service user has received top up doses of depot buprenorphine since their last appointment and this one."
16	STRONGLY AGREE Again, very clear guidance. Happy with it.
17	DISAGREE Before an increase in dose I would not just take the patients word for it that it was too low, instead would be looking for clinical indications via a clinical opiate withdrawal scale for example. I would not be looking to increase a dose in the absence of adverse events - this statement to me sounds like we are trying to induce an adverse event?
18	STRONGLY AGREE Makes absolute sense
19	STRONGLY AGREE Strongly agree to promote choice of the person in line with the MAT standards.

20	AGREE again should be patient led
21	NEITHER AGREE NOR DISAGREE Should second bullet point make clear that not reporting side effects alone is not a reason for increase? If fully stable not on top dose there is not a reason to increase.
22	DISAGREE Doses should generally be increased under the following conditions: the current dose is less than the equivalent evidence based optimal dose range for buprenorphine the service user is experiencing opioid 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 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)
23	AGREE good practice
24	STRONGLY AGREE These are generally the indications for buprenorphine dose increase
25	AGREE All seems acceptable and easy to follow.

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 (e.g. sedation or lethargy, persistent headaches, nausea)**
- **the service user is satisfied with their current dose, and requesting the dose be maintained.**

Of 25 respondents:

14 strongly agreed

6 agreed

2 neither agreed nor disagreed

2 disagreed

1 strongly disagreed.

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

Respondents' comments are detailed in table 10

Table 10: Responses to consensus statement 10

Respondent	Response and comments
1	NEITHER AGREE NOR DISAGREE Same as above to last question [This is not clear whose treatment goals we are talking about? >the service user is not achieving desired treatment goals (eg persistent unsanctioned opioid use, opioid withdrawal symptoms or cravings) This is can cause issues of engagement, retention etc if it is not clear. Service users and services often have different treatment goals (services end to have more fixed goals and service users tend to have more flexible goals a statement should include both when we are talking about informed choice].
2	STRONGLY AGREE Ongoing support even although stable to ensure future compliance.
3	STRONGLY AGREE I agree with the statement, however, don't like the word 'unsanctioned', could use illicit or unnecessary?
4	AGREE Agree with these statements
5	AGREE I agree with the above with addition that there are agreed review dates to monitor
6	AGREE All of the above seem appropriate.
7	STRONGLY AGREE Service user has reached maximum dose.

8	AGREE The key of OST treatment is to maintain the patient on a stable regime that reduces harm. I feel that all these points achieve this central aim and a dose change would be unnecessary.
9	STRONGLY AGREE The above sounds as if there is harmony in prescribing and the relationship with medication and prescriber
10	STRONGLY DISAGREE Similar to Q18/19 the statements are judgemental and read as the service user meeting the services demands. Suggest - the dose is supporting the service user to achieve their own goals and wishes - the service user is comfortable and not experiencing withdrawal symptoms or cravings - there are no 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.
11	NEITHER AGREE NOR DISAGREE Out with my clinical expertise
12	STRONGLY AGREE Completely agree with these rationales
13	DISAGREE Should be lined with AND to show that all 3 conditions are required
14	STRONGLY AGREE This statement is clear and doesn't need changing
15	AGREE The above 3 statements would demonstrate that the current regime is meeting the patient's requirements. I would add a statement saying " The service user has not required any additional top up doses since administration of their last depot"
16	STRONGLY AGREE Similar to previous two - clear and straightforward advice.
17	STRONG AGREE These situations are all reasonable to me
18	STRONGLY AGREE As with any form of OAT
19	STRONGLY AGREE strongly agree to promote choice of the person in line with the MAT standards.
20	STRONGLY AGREE patient led
21	STRONGLY AGREE This all seems reasonable and is our current clinical practice.
22	DISAGREE In general, doses should be maintained if: the service user is not experiencing opioid withdrawals or cravings the service user is achieving their individual treatment goals 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.
23	AGREE All good practice
24	STRONGLY AGREE These are generally the indications for buprenorphine dose increase
25	STRONGLY AGREE All seems acceptable and easy to follow.

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.

Of 25 respondents:

11 strongly agreed

8 agreed

1 neither agreed nor disagreed

4 disagreed

1 strongly disagreed.

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

Respondents' comments are detailed in table 11

Table 11: Responses to consensus statement 11

Respondent	Response and comments
1	NEITHER AGREE NOR DISAGREE This should also include the education of staff on pain management for opioid dependent patients.
2	STRONGLY AGREE Clients should be monitored during treatment Primary HCP to ensure continuity of care/treatment
3	AGREE I agree with this statement, however, I feel that it does not flow and could maybe worded in a different way.
4	DISAGREE Agree with the above, but in this population treatment with gabapentinoids has risk of abuse and other treatments for neuropathic pain should be considered first
5	STRONGLY AGREE A holistic care approach should always be utilised to address patient needs
6	STRONGLY AGREE This forms part of a well rounded treatment plan.
7	AGREE It is important to adopt a holistic approach to pain management and consider alternative approaches where available. Group therapy such as peer support should be an option also "Let's get on with it together".
8	DISAGREE I don't feel that patients prescribed OST for opioid addiction should be prescribed opioids for pain unless absolutely necessary. I do agree with the other points in this statement. Additionally, I feel it is important that Buvidal is not unintentionally used to treat chronic pain ie patients asking substance misuse prescribers for an increase in their

	Buvidal dose due to experiencing pain, as opposed to experiencing cravings, for example.
9	STRONGLY AGREE Clear education for clinicians should be readily available regarding medication choice for pain management and how to navigate this. Thinking in terms of smart medicine, social prescribing and engagement with other non-pharmaceutical interventions should be part of the armoury- although societally, this will be part of a gradual response to manage expectations. Using the above meds for the reason of managing pain is reasonable in a whole systems context, but with review
10	AGREE Suggest that the order is reviewed. "General principles of chronic pain management should be followed and include patient education and engagement in the treatment process, physical (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)"
11	STRONGLY AGREE Nil to add and agree
12	STRONGLY AGREE This is appropriate advice and relevant to the treatment of pain in individuals.
13	AGREE important issues in these patients
14	AGREE I would suggest that the statement is clear that this product is for opioid replacement rather than pain management. The dose should not be increased for pain control alone
15	AGREE Agree. There is evidence of benefits of educating patients that opiate/opioid based painkillers will not provide the same level of pain control when receiving depot buprenorphine.
16	STRONGLY DISAGREE As far as I understand we cannot use opioid painkillers for chronic pain management for people who are on long acting depot buprenorphine due to the partial opiate blocking effect of buprenorphine. The next statement (no 24) covers this. Suggestion - please remove 'opioid' and keep the non-opioid medication bit.
17	STRONGLY AGREE These general principles shouldn’t be different if someone is on depot buprenorphine
18	STRONGLY AGREE Everybody is entitled to adequate pain management
19	AGREE agree that all the above mentioned strategies should be available to the person.
20	STRONGLY AGREE challenging to manage pain in particular acute pain when admitted to hospital. Good to have links with pain management team Also good to have good links with inpatient pharmacy
21	STRONGLY AGREE Fully agree. This is the same as our local guidance.
22	DISAGREE opioid medications should be removed here General principles of chronic pain management should be followed and include patient education and engagement in the treatment process, appropriate use of non-opioid medications (eg antidepressants, NSAIDs, paracetamol or gabapentanoids), physical (eg exercise or physiotherapy) and psychosocial (eg Cognitive Behavioural Therapy) interventions.
23	AGREE good practice. Pain management would need care consideration

24	STRONGLY AGREE Agreed pain pathways should be followed
25	DISAGREE Appropriate use of opioid? I am unsure when this would be when on Buvidal.

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.

Of 25 respondents:

9 strongly agreed

4 agreed

8 neither agreed nor disagreed

4 disagreed

0 strongly disagreed.

Thirteen out of 25 (52%) respondents agreed or strongly agreed with this statement, so consensus has NOT been reached. However, 32% of respondents neither agreed nor disagreed.

Respondents' comments are detailed in table 12

Table 13: Responses to consensus statement 12

Respondent	Response and comments
1	AGREE Other opioid analgesics would have little effect.
2	NEITHER AGREE NOR DISAGREE May require higher doses May require titration until maximum effects are achieved.
3	DISAGREE It can be used in conjunction with other opioid analgesics but it means a higher amount of the other drug would need to be given to flood the receptors.
4	STRONGLY AGREE No pharmacological sense in prescribing other opioids
5	STRONGLY AGREE With addition that guidance is taken from the appropriate practitioners
6	DISAGREE I don't think that it is appropriate to say do not use. It should be a case by case discussion about the most pressing need at the time.
7	STRONGLY AGREE Risk of precipitated withdrawal and pain relief would be ineffective. Alternatives should be explored. Risk of over dose. Difficult to monitor.
8	AGREE I feel that the requirement to treat chronic pain with opioid analgesics may preclude Buvidal as an appropriate option in treatment of opioid addiction. Where it is necessary to prescribe opioid analgesics for this patient group, I feel that the benefit of prescribing Buvidal could be outweighed by the risk of overdose, due the higher doses of opioid analgesics that would be required to have an effect.
9	NEITHER AGREE NOR DISAGREE This is not my area of expertise- but understanding the blockade effect suggests that it would not be first choice

10	NEITHER AGREE NOR DISAGREE It is unclear if this statement relates to buprenorphine in all formulations or specifically to depot buprenorphine. Sublingual/lyophilisate buprenorphine may provide a bigger risk if given with other opioid analgesics as the dose may need to be higher for the patient to receive any benefit due to blockade effect. There is a risk if doses of buprenorphine are missed then the opioid dose may be too high and put patient at risk of overdose. In general, opioid analgesics for chronic pain should be avoided for those prescribed buprenorphine.
11	NEITHER AGREE NOR DISAGREE Out with my area of expertise
12	AGREE Not all opioid receptors may be occupied by buprenorphine thus sometimes an opioid for analgesia will still have an effect in reducing pain. Some patients (especially on lower doses) will get the benefit of the analgesic effects of the other opioids (especially if full agonists or with high affinity for receptors)
13	NEITHER AGREE NOR DISAGREE I am not aware of how these medicines can be combined.
14	STRONGLY AGREE Use of multiple opioids should always be discouraged
15	STRONGLY AGREE The evidence supports this approach.
16	STRONGLY AGREE Suggestion to add - This should be made clear to service user at the time of taking consent and the risks of precipitated withdrawal explained and documented.
17	STRONGLY AGREE Giving these drugs to a patient on depot buprenorphine would yield little therapeutic effect
18	DISAGREE Everybody is entitled to adequate pain management. No analgesia should be explicitly withheld
19	NEITHER AGREE NOR DISAGREE don't wish to comment on this as i am not a medically trained so unsure of the implications of using these in conjunction with each other.
20	DISAGREE As a drug liaison nurse see this frequently in inpatient setting Some conditions would require opioids Work closely with pain team
21	NEITHER AGREE NOR DISAGREE Fully agree. This is the same as our local guidance. But wonder if for clarity should either read Depot buprenorphine at the start, or just buprenorphine at the end, as same principle with regular oral treatment.
22	NEITHER AGREE NOR DISAGREE Minor amendment below Depot buprenorphine should not be used in conjunction with other opioid analgesics (eg morphine, fentanyl, codeine) in chronic pain management, given its ‘blockade’ effect.
23	AGREE see response 23 [good practice. Pain management would need care consideration]?
24	STRONGLY AGREE I agree generally buprenorphine should not be prescribed with other opiates
25	STRONGLY AGREE Agreed and reads well.

Appendix 1 – Results of consensus voting for Statement 7 broken down to individual substatements

Statement 7 described a minimum dataset for information transfer on clinical handover of service users on depot buprenorphine. Participants were asked to return voting on ten individual statements within this dataset. The results are shown in Table 13.

Table 13: Detailed voting breakdown for Statement 7

	VOTING (n=25)					
Statement *"As a minimum, the following needs to be communicated to the receiving provider upon transfer:"*	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**	**Formal consensus achieved?**
the formulation of depot buprenorphine that was administered: (weekly or monthly)	0	0	1	0	24	Yes (96%)
the date and dose of last dose administered	0	0	1	0	24	Yes (96%)
the date and dose of the next dose due	0	0	1	1	23	Yes (96%)
the current dosing regimen (and equivalent dose of sublingual or supralingual buprenorphine should the depot formulation need to be converted back)	0	7	3	2	13	No (60%)
the preferred site of administration, including last site of administration	0	0	2	7	16	Yes (92%)
the dose titration regimen if the service user is not on a stable regimen	0	1	2	3	19	Yes (88%)
if applicable, where the service user normally receives treatment (eg directly from substance misuse service provider, community pharmacy)	0	0	2	5	18	Yes (92%)

any monitoring required	0	2	1	5	17	Yes (88%)
any adverse events, risks or concerns regarding depot buprenorphine treatment that is relevant to other healthcare providers	0	2	1	3	19	Yes (88%)
contact details of the transferring team, if further information is required	0	0	1	2	22	Yes (96%)