Healthcare Improvement Scotland | Evidence
Advice, guidance and intelligence

Use of long-acting injectable buprenorphine for opioid substitution therapy

Report on consensus statement voting: Round 2

Overview

After Round 1 of consensus voting, some of the original statements were revised to take account of comments received. Elements of the statements which were most strongly supported were retained and areas for improvement were added. A small number of statements which had achieved formal consensus and for which there was little or no negative feedback were considered finalised.

For Round 2 members of the working group (n=31) were sent a voting form to record and return their level of agreement with 11 revised draft statements. Voting took place between 3 and 10 February 2022. Twenty two 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 2 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.

As with Round 1, formal consensus was achieved for most statements. In all cases where consensus was previously achieved (except one – statement 10) the level of agreement increased from Round 1. In a small number of cases, the research team noted areas where some individuals still strongly disagreed with the original statements, based on the comments shared. Where we believe that there is an opportunity to further improve the statements based on addressing specific issues raised by members, the research team has revised the statements again and is presenting these for a final round of voting. Therefore, in Round 3, members are asked to vote again on two statements which have been changed to try to match these even more closely to the preferences of the group, despite achieving formal (>70%) consensus.

Statement	Consensus?	Agreement	Action
1	Y	81.8%	Revised for Round 3 vote
2	Y	86.4%	No further voting – finalise in Position Statement
3	Y	81.8%	No further voting – finalise in Position Statement
4	N	40.9%	No further voting – remove
5	Y	90.9%	No further voting – finalise in Position Statement
6	Y	100%	No further voting – finalise in Position Statement
7	Y	90.9%	No further voting – finalise in Position Statement
7a	N	45.4%	No further voting – remove
8	Y	86.3%	No further voting – finalise in Position Statement
9	Y	90.9%	No further voting – finalise in Position Statement
9a	N	40.9%	No further voting – remove
9b	N	63.6%	No further voting – remove
10	Y	72.7%	Revised for Round 3 vote
11	N	40.9%	No further voting – remove

A number of statements achieved consensus with no significant concerns raised, and these will be added to the final Position Statement. A number of statements achieved consensus with some concerns raised, however in the views of the research team, these would not be resolved by further voting and, in the context of consensus, no further voting is indicated. In two cases, after two rounds of voting consensus was not achieved and in the views of the research team, further voting would not alter the views expressed by members sufficiently to obtain consensus.

In Round 2 members voted on suggested additions to existing statements which had previously reached consensus (statements 7 and 9). None of these amendments reached consensus. These suggested amendments and statements which did not reach consensus will be listed in an annex of the final position statement. For each statement, the report summarises the range of comments received and explains how the statement has been revised to incorporate these.

Statement 1

In round 2, group members were asked to indicate agreement with the following statement:

Treatment with depot buprenorphine potentially confers the opportunity to change the way in which opioid substitution services are structured and delivered. The less frequent dosing with depot buprenorphine formulations 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.

22 of 31 participants responded to this statement:

- 54.5% strongly agreed with this statement
- 27.3% agreed
- 4.5% neither agreed nor disagreed
- 9.1% disagreed
- 4.5% strongly disagreed.

Eighteen out of 22 (81.8%) 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.

The original statement achieved a formal level of consensus (76%) but revisions were made to attempt to address specific feedback from respondents. The revised statement has achieved a higher level of agreement and most respondents now strongly agree with this version.

Respondents noted that the revised statement was “much better” and “improved clarity of meaning”. In general respondents noted that it was important to have a structured care plan in place for all service users which took a flexible approach to suit the needs of the individual.

Three respondents who disagreed or strongly disagreed with the statement noted that:

- “The requirement to have regular contact with the care provider is driven by clinical need not the formulation of the treatment.”
- “It absolutely does not automatically reduce patient contact. That is and always will be determined clinically.”
- “Administration of medication is different from seeing a patient for other psychosocial treatments. Pharmacy dispensing is not "care providers" in the same sense that an addictions team is.”

Two respondents (who agreed with the statement) commented that the second sentence was long and, although accurate, could be alarming. Two alternatives were offered:

- The less frequent dosing with depot buprenorphine formulation will alter the frequency of contact between the service user and care provider and....."
- “The less frequent dosing with depot buprenorphine formulations *may* reduce the regularity of contact between service user and care provider. This may offer advantages for some individuals as it gives them the opportunity to have time to attend recovery activities and other priorities. For others who need more support, careful scheduling of clinical reviews for example in the setting where the depot can be delivered and flexible approaches to care planning should be considered.

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 may reduce the opportunity for daily contact between service user and care provider. This may offer advantages for some individuals as it gives them the opportunity to have time to attend recovery activities and other priorities. For others who need more support, careful scheduling of clinical reviews for example in the setting where the depot can be delivered and flexible approaches to care planning should be considered.

Statement 2

In round 2, group members were asked to indicate agreement with the following statement:

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 (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.

22 of 31 participants responded to this statement:

- 59.1% strongly agreed with this statement
- 27.3% agreed
- 9.1% neither agreed nor disagreed
- 4.5% disagreed
- 0% strongly disagreed

Nineteen out of 22 (86.4%) respondents agreed or strongly agreed with this statement, so consensus has been reached. No further consensus voting is required.

The original statement achieved a formal level of consensus (76%) but revisions were made to attempt to address specific feedback from respondents. The revised statement has achieved a higher level of agreement and most respondents now strongly agree with this version.

Most respondents commented that this revision is an improvement over the original statement. Several respondents noted that healthcare professionals should be provided with the sufficient training to ensure their competence in administering a new medication and should take responsibility to ensure their own competence.

A respondent who neither agreed nor disagreed with the statement expressed concern that the mechanism for training had not been described.

- I think this statement recognises that there is a training need, without dictating to local areas how to implement it. But also doesn't give guidance as to what training is acceptable. At present the manufacturer does offer reasonable training, this was in the previous statement but has been removed. I wonder if the statement now leaves it as suggesting training is needed, but gives no reference on how to access it. I wonder if a reference to being able to seek training from the manufacturer as appropriate or a suggestion of using nationally developed training were it to become available may be sensible. I fear that otherwise there may in some areas be delay in the use of LAB as they won't have training that is seen as meeting the standard.

Another respondent who strongly agreed with the statement reiterated that use of Turas Learn and LearnPro would help to support clinical governance in the delivery of training to use depot buprenorphine.

As included in the report to Round 1 consensus voting, the two additional supporting statements relevant to the role of the manufacturer and the possible value of online training will be added to the draft Position Statement. These are not consensus statements. Consensus statements are targeted at health and social care professionals and include actions that individuals can build into their standard practice, but cannot determine the work of national agencies.

One respondent suggested that "appropriate terminology would be 'Substance use service providers', not 'substance misuse service provider'."
Two UK guidelines which have been used to inform this Position Statement - *Drug Misuse and Dependence, UK Guidelines on Clinical Management (2017)*, and the Regional Medicines Optimisation Committee guideline *Buvidal (buprenorphine prolonged-release injection): Considerations for opioid substitution treatment use in community settings and secure environments in England (2021)* use the term "substance misuse service" while no other sources among the guidelines reviewed have used the term 'substance use service provider'. The team suggests no change at this time, pending further feedback at consultation.

The research team believes that this statement has reached maximum consensus, and the remaining issues are addressed by the additional supporting statements which will accompany the consensus statement. No further consensus voting is required.

<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

In round 2, group members were asked to indicate agreement with the following statement:

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.

22 of 31 participants responded to this statement:

- 68.2% strongly agreed with this statement
- 13.6% agreed
- 9.1% neither agreed nor disagreed
- 9.1% disagreed
- 0% strongly disagreed.

Eighteen out of 22 (81.8%) respondents agreed or strongly agreed with this statement, so consensus has been reached. No further consensus voting is required.

The original statement did not achieve a formal level of consensus and it was noted that the two paragraphs contained in the statement had different levels of support. Some revisions were made to attempt to address specific feedback from respondents and the original statement was divided into two new statements, of which this is the first. This subdivided statement has achieved a high level of formal consensus and most respondents now strongly agree with this version.

As with the original statement, in general, respondents noted their concern about administering depot buprenorphine to intoxicated individuals, and agreed that ability to record consent was vital but there were different views about the strength of wording used to express this. Respondents who believed that a treatment should never be delivered when the service user was unable to give informed consent voted both in agreement and disagreement with the statement.

A respondent who disagreed with the statement noted:

- "There is still ambiguity in the last sentence – '*if the service user is very intoxicated... the dose may be deferred and rescheduled*'. If the service user is intoxicated, unable to understand or follow instruction then they cannot provide informed consent. The dose must be deferred. Also consent required for any doses that are not the usual ones too!

Some respondents who agreed or strongly agreed with the statement believed that it accurately reflected the prescriber's responsibilities:

- "Informed consent to treatment is required and patients must have the capacity to provide this. This statement support safe patient centred care."
- "Capacity is important to allow informed consent. Deferring the usual dose has to be a reasonable option."

One respondent commented on the relationship between an episodic inability to give verbal consent when intoxicated at time of injection and the overall consent given to receive depot buprenorphine as part of treatment planning and the attendance at a scheduled treatment appointment.

- Whilst I agree with this statement. I think it can be expanded on to reflect this situation including to highlight risks of not giving treatment. Patients who have been started on LAB have clearly had the treatment explained and consented to it at the start of treatment. Even if intoxicated their decision to choose to present again for the next injection is significant. Capacity judgements take into account clear previous expressed wishes alongside current, in this case even if intoxicated the patient has both previously consented and is by attending expressing continued consent. This alongside the judgement that must then be taken in the room on capacity is significant. There is risk in not giving treatment, patients may not attend again and may come out of treatment. It is frustrating for patients to feel they have come as asked and then be turned away. In a rural area where travel is already a barrier to retention in treatment this becomes even more significant. There are many other examples of capacity assessment and needed treatment given to intoxicated individuals, the most obvious being an intoxicated patient in A&E with a laceration. You wouldn't send them away with an open wound and tell them to come back and have it stitched at a later date if they were clearly consenting when the treatment is in their best interests.

In the view of the research team, the views held by group members about the balance between

- potential risks of treatment administration when the individual is judged not to have capacity to give consent in the immediate context of a depot injection and
- the potential harms of refusing or delaying treatment when the individual has previously given consent to an ongoing treatment programme

are unlikely to be resolved by further voting. The current wording permits interpretations of a treatment protocol which allows treatment to be delivered or not delivered according to the individual interpretation of consent across the wider context of the shared decision making at treatment planning and initiation and during administration sessions. As this statement has achieved formal consensus (81.8%), the statement will be retained without further revision. Cross references to the General Medical Council ethical guidance on assessment of capacity and obtaining consent will be included in the position statement.

Statement 4

In round 2, 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.

22 out of 31 participants responded to this statement.

- 9.1% strongly agreed with this statement
- 31.8% agreed
- 31.8% neither agreed nor disagreed
- 22.7% disagreed
- 4.5% strongly disagreed.

Nine out of 22 (40.9%) respondents agreed or strongly agreed with this statement, so consensus has NOT been reached.

The original statement did not achieve a formal level of consensus and it was noted that the two paragraphs contained in the statement had different levels of support. Some revisions were made to attempt to address specific feedback from respondents and the original statement was divided into two new statements, of which this is the second. This subdivided statement has not reached formal consensus.

Reasons given by members for not agreeing, disagreeing or strongly disagreeing focused on consent, safety and clinical governance including:

- "There may not be a clinical indication to withhold, however there is an ethical one. The service user must have capacity to provide voluntary, informed consent every time. This needs to be clear within this statement. This information is helpful when the patient is intoxicated but still assessed as having capacity to understand, remember and use the information to communicate an informed decision. The assessment of the staff member will vary depending on prior knowledge of the patient and the clinical relationship."
- "I would not be happy to administer Buvidal to a patient that is intoxicated and not clearly able to give consent. I would ask the patient come back the next day."
- "would still be unsure …giving this to an intoxicated patients"
- "This statement does not consider intoxication from illicit substances which may not be opiate or opioid and which could present a danger eg benzodiazepines"
- "Unsure about how the management of my organisation and critical incident review panel would view the theoretical example of someone overdosing having presented intoxicated and then receiving treatment. This would need to be discussed and agreed at a local level before I would feel confident about administration."
- "How can we be sure of what the patient is intoxicated as a result of? And how long they will continue to present as intoxicated for? Therefore administering a depot remains a risk."

- “If a patient is intoxicated on presentation they may continue to use even post administration, thus increasing risk. I think deferring 24 hours if possible is a better and safer outcome.”

As most of the concerns about this statement relate to consent in the context of intoxication, the research team has taken account of the voting results for Statement 3, where there was a strong level of agreement for the principle of assessment of capacity as a key stage in determining consent. This statement reflects the consensus of the working group about consent and the circumstance of intoxication, and, along with citation of the GMC ethical guidance on capacity assessment and obtaining consent, the research team concludes that retaining Statement 4 would not add value to the Position Statement, and therefore it will not be included in Round 3 voting or the final Position Statement. As with all statements which fail to reach formal consensus, it will be listed in an annex of the final position statement.

Statement 5

In round 2, 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 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 (ie 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.

22 out of 31 participants responded.

- 63.6% strongly agreed
- 27.3% agreed
- 0.0% neither agreed nor disagreed
- 9.1% disagreed
- 0.0% strongly disagreed.

Twenty out of 22 (90.9%) respondents agreed or strongly agreed with this statement, so consensus has been reached. No further consensus voting is required.

The original statement achieved a formal level of consensus (80%) but revisions were made to attempt to address specific feedback from respondents. The revised statement has achieved a higher level of agreement and most respondents now strongly agree with this version.

The two respondents who disagreed gave the following remarks:

- "This should always be completed by the medical staff! Keyworkers are often social care staff and not really involved in the administration of a medication, so why would we expect them to fill out an individualised plan?"
- "I do agree with pretty much all of the statement. Though I still am unsure of the value of an 'individualised' DNA plan is for every patient. It is another use of staff time to create a care plan document for each individual. Are these likely to vary significantly from the service standard plans for these situations? Our experience is not. Our service has an individualised plan only in … those cases where it would be seen to add value, rather than a blanket requirement for another care plan document to be completed for all."

Statement 6

In round 2, group members were asked to indicate agreement with the following statement:

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.

22 out of 31 participants responded.

- 86.4% strongly agreed
- 13.6% agreed
- 0.0% neither agreed nor disagreed
- 0.0% disagreed
- 0.0% strongly disagreed

Twenty two out of 22 (100%) respondents agreed or strongly agreed with this statement, so consensus has been reached. No further consensus voting is required.

The original statement achieved a formal level of consensus (88%) but revisions were made to attempt to address specific feedback from respondents. The revised statement has achieved a higher level of agreement and most respondents now strongly agree with this version.

Most of the comments submitted described the need for good communication to ensure safety and continuity of care.

Statement 7

In round 2, 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 (e.g. 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 (e.g. substance use, physical or mental health symptoms) that may arise with a dose reduction.*

22 out of 31 participants responded.

- 59.1% strongly agreed
- 31.8% agreed
- 4.5% neither agreed nor disagreed
- 4.5% disagreed
- 0.0% strongly disagreed.

Twenty out of 22 (90.9%) respondents agreed or strongly agreed with this statement, so consensus has been reached. No further consensus voting is required.

The original statement achieved a formal level of consensus (72%) but revisions were made to attempt to address specific feedback from respondents. The revised statement has achieved a higher level of agreement and most respondents now strongly agree with this version.

Statement 7a

In round 2, group members were asked to indicate if the following bullet point should be added to the statement:

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.*

22 out of 31 participants responded.

- 13.6% strongly agreed
- 31.8% agreed
- 13.6% neither agreed nor disagreed
- 27.3% disagreed
- 13.6% strongly disagreed.

Ten out of 22 (45.4%) respondents agreed or strongly agreed with this statement, so consensus has NOT been reached.

Several respondents who agreed, disagreed or strongly disagreed noted reasons which may delay service users attending appointments:

- “This may not be to do with the dose being too high. There may be other reasons so whilst there may be a reason to reduce the dose it isn't a confirmed so would not feel comfortable with this statement in.”
- “Including this may worry the service users as they may feel they will be penalised due to being late.”
- “There are a number of reasons why a SU might delay their return appointment, if we add this to the statement it may then be assumed that the delay is due to the medication still holding them which might not be the case!”
- “May be number of reasons why delaying. Explore all reasons and increase psychosocial supports to ensure patient centred care plan. Change schedule of appointment rather than dose of medication.”

One respondent noted difficulties with the term ‘holding’ and another suggested the point is sufficiently covered within the third bullet of Statement 7.

- “I am not sure that the phrase 'holding them' is a widely understood term - certainly outside addiction services.”
- “I feel this can be covered in the third bullet point in the original statement - whether the dose is too high and need to be adjusted.”

The research team has taken account of the high level of consensus reached for statement 7, and the comment that the sense of this amendment is already contained within the third bullet point of that statement. Given the disagreement with this amendment and the suggestion that it may make invalid assumptions about the attendance of the service user, the team has not incorporated this amendment and it will not be included in Round 3 of consensus voting.

Statement 8

In round 2, group members were asked to indicate agreement with the following statement:

Doses should generally be increased under the following conditions:

- *the current dose is not meeting the needs of the service user (for example, 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 (for example, sedation or lethargy, persistent headaches, constipation, nausea) or elevated liver function tests.*

22 of 31 participants answered this question:

- 54.5% strongly agreed
- 31.8% agreed
- 4.5% neither agreed nor disagreed
- 9.1% disagreed
- 0% strongly disagreed.

Nineteen out of 22 (86.3%) respondents agreed or strongly agreed with this statement, so consensus has been reached. No further voting is required.

The original statement did not achieve consensus (56%) but revisions were made to attempt to address specific feedback from respondents. The revised statement has achieved a higher level of agreement and most respondents now strongly agree with this version.

In the second round of voting, two people disagreed with this statement. One respondent said that there should be clinical evidence for a dose increase (for example, withdrawals or a positive drug test). Another respondent felt that the bullet points could be combined into one statement. One person neither agreed nor disagreed because they felt that this was an area outwith their expertise.

Two respondents who strongly agreed with the statement suggested additional criteria:

- “They are not within an elderly population with impaired hepatic function or have respiratory impairments. They do not have any physical impairments which would indicate an increase may exacerbate serious health complaints.”
- “This should be reviewed and discussed on an ongoing basis between patient and health care professional, reasons and rationale explored and if the above criteria was met then this would be an appropriate decision.”

Given the strength of support for this statement, the research team felt that no further voting was required for this statement – consensus has been reached.

Statement 9

In round 2, group members were asked to indicate agreement with the following statement:

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 (for example, sedation or lethargy, persistent headaches, nausea); and*
- *is satisfied with their current dose, and requesting the dose be maintained.*

22 of 31 participants responded to this statement:

- 54.5% strongly agreed
- 36.4% agreed
- 4.5% neither agreed nor disagreed
- 4.5% disagreed
- 0% strongly disagreed.

Twenty out of 22 (90.9%) respondents agreed or strongly agreed with this statement, so consensus has been reached. No further voting is required.

The original statement achieved a formal level of consensus (80%) but revisions were made to attempt to address specific feedback from respondents. The revised statement has achieved a higher level of agreement and most respondents now strongly agree with this version.

One respondent neither agreed nor disagreed with this statement as they felt it was outwith their area of expertise. One person disagreed with this statement, they questioned:

- "Should there be some mention of frequency of review of dose and clinician opinion being important as well as service user?"

Two people who agreed with the statement also highlighted the issue of review. One said that agreed review dates set at the beginning of treatment are helpful; and the other said that ongoing conversations are needed between the service user and their worker on long-term plans to eventually withdraw from the drug.

Given the overall strength of support for statement 9, the research team felt that no further voting was required – consensus has been reached. However, in the final publication, the issue raised around review dates and ongoing conversations can be included in the discussion that will accompany this statement.

Statement 9a and b

In round 2, group members were asked to indicate if the following bullet points should be added to the statement:

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

- *has reached maximum dose.*

- *has not required any additional top up doses since administration of their last depot.*

Only 40.9% of respondents agreed or strongly agreed with adding in the first statement, and 63.6% of respondents agreed with adding in the second. Therefore, these bullet points have not been added to the final statement.

Statement 10

In round 2, group members were asked to indicate agreement with the following statement:

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

22 of 31 participants responded to this statement:

- 22.7% strongly agreed
- 50% agreed
- 0% neither agreed nor disagreed
- 18.2% disagreed
- 9.1% strongly disagreed.

Thirteen out of 25 (72.7%) respondents agreed or strongly agreed with this statement, so consensus has technically been reached. However, significant concerns have been raised with this statement, including from people who agreed or strongly agreed with it and the research team felt that there would be value in allowing the group to consider and reflect on the comments.

The original statement also achieved a formal level of consensus (76%) but revisions were made to attempt to address specific feedback from respondents.

Inclusion of 'appropriate use of opioid medications': Six respondents flagged concerns about the inclusion of opioid medications in this statement – including two people who agreed with the statement. This issue was also raised in the first round of consensus. In this round, we asked respondents whether opioid medication should be removed from the statement – 50% of people said 'yes' and 50% of people said 'no'.

Consideration of acute pain: One respondent (who agreed with the statement) noted the need for a statement on acute pain. Another respondent disagreed with the statement because they felt the difference between acute pain management and chronic pain management should be emphasised/clarified. It should be noted that a section on acute pain is included in the summary of product characteristics for Buvidal and reproduced in the Position Statement in development.

Inclusion of gabapentinoids: Two people (who disagreed or strongly disagreed with the statement) felt that gabapentinoids should not be included because of concerns that these particular drugs are often abused and easily diverted.

Inclusion of a statement around depot buprenorphine not being for pain management: Respondents were asked to vote on the inclusion of the following to statement 10: 'Depot buprenorphine is used for OST, and not pain management'. 72.7% of respondents agreed it should be added to the statement, and 27.3% disagreed with adding it. Therefore, consensus was technically reached, though a significant minority disagreed.

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 medications (eg, paracetamol, NSAIDS, antidepressants).

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

Statement 11

In round 2, group members were asked to indicate agreement with the following statement:

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

22 of 31 participants responded to this statement:

- 18.2% strongly agreed
- 22.7% agreed
- 36.4% neither agreed nor disagreed
- 22.7% disagreed
- 0% strongly disagreed.

Nine out of 22 (40.9%) respondents agreed or strongly agreed with this statement, so consensus has NOT been reached.

This statement did not achieve consensus in Round 1 (52%), and it was not clear how it could be changed to achieve consensus. In the second round, the group were given the opportunity to read through everyone's comments, reflect on their own opinion, and re-vote. Consensus has still not been achieved. The disparity of views makes it unlikely that consensus will be achievable for this statement and it will not be included in the final position statement.