International Journal of
Mental Health Nursing

International Journal of Mental Health Nursing (2014) 23, 451–459 doi: 10.1111/inm.12076

FEATURE ARTICLE

How clinicians manage access to opioid replacement therapy

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ABSTRACT: *In Australia, people wait to access opioid replacement therapy (ORT). The aim of this study was to examine how clinicians (n = 35) prioritize consumers for opioid replacement therapy (ORT). The study used a methodology informed by a constructivist approach to grounded theory. Based on a scenario related to two consumers seeking admission to opioid replacement therapy (ORT), participants were asked to prioritize one for preferential admission and questioned about their decision-making. Clinicians were neither confident nor unanimous in their decision-making. Team involvement and work experience influenced their judgment. Differences between clinicians in regard to understanding risks and protective factors were identified. To support uniformity in managing treatment requests, clearer policy direction to gui clinician practice, and further exploration of how models of care and team involvement influence consumer outcomes, are recommended.*

KEY WORDS: *access, management, opioid replacement therapy.*

INTRODUCTION

Recommended treatment for people with opioid dependency is opioid replacement therapy (ORT). The pharmacotherapies used for ORT are methadone and buprenorphine. Methadone is a synthetic opioid agonist with a relatively long plasma half-life. Buprenorphine is available as subutex (buprenorphine only) or suboxone (buprenorphine plus naloxone) (Drugs of Dependence Unit 2012). As of June 2012 (the most recent published findings), 46 697 people were registered in Australian ORT programmes with treatment provided by general practitioners (65.3%), publicly-funded clinics (27.6%), correctional services (6.6%), and through a dual private/public arrangement (0.6%) (Australian Institute of Health and Welfare 2013). Despite this large number engaged in ORT, people are still waiting to receive treatment. In Queensland and New South Wales (NSW) in Australia, waiting is acknowledged as part of the treatment process (Drugs of Dependence Unit 2012; Harlow *et al*. 2013; Winstock *et al*. 2008), although nationally, there is no reporting of the number of people waiting for ORT (Australian Institute of Health and Welfare 2012). The extent of the wait list is unknown. Clinicians working in these settings face requests for treatment, outnumbering the treatment places available. How clinicians manage this situation has not been investigated.

Public health policies provide some guidance by identifying certain people for priority treatment. These prioritized groups include pregnant women, people with HIV and carriers of hepatitis B, and the partners of these people who also have opioid dependency, people on a drug-diversion programme, people with significant medical or mental health concerns, and people recently released from prison, particularly within the past month. In the ACT, Australia, people identified as Aboriginal or Torres Strait Islander, people aged under 18 years, and parents with children under the age of 2 years are also

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Accepted March 2014.

given priority. For other people, clinicians are directed to use their clinical judgment (ACT Health 2010; Drug and Alcohol Office 2007; Drug and Alcohol Services South Australia *et al.* 2008; Drugs of Dependence Unit 2012; Intergovernmental Committee on Drugs 2007; Mental Health and Drug & Alcohol Office 2006). What this direction means and how it is applied has not been defined. We do not know how decisions are made or what influences clinicians' decision-making (Harlow *et al.* 2011).

Clinical decision-making, clinical judgment, and clinical reasoning have been used interchangeably in the literature to describe the clinician's response to processing information in clinical practice (Fossum *et al.* 2011). Gallacher (2007) described decision-making and clinical judgment as interrelated processes, with the decision not made until a judgment has occurred. Tanner (2006) suggested that clinical judgments are reliant on the clinician's expertise and their relationship with the consumer, the context of the situation, the clinician's pattern reasoning, and the clinician's reflection on prior events to make a decision. Clinical judgment and decision-making are acknowledged as part of the clinical reasoning process: clinical judgment being the identification of the problem, and decision-making being the response to this problem (Levett-Jones *et al.* 2010).

Clinical reasoning has been defined as 'a complex process that uses cognition, meta cognition, and discipline-specific knowledge to gather and analyse patient information, evaluate its significance, and weigh alternative actions' (Simmons 2010, p. 1151). It involves a dual-action process, with the brain responding to information through an automated approach – a reflex action following the path of one's intuition – and by controlled thinking – a rational response that follows analytic processes (Croskerry 2013). Inexperienced clinicians have been recognized to use analytic procedures more frequently to make their decisions through assessment of the pros and cons of an event. In contrast, experienced clinicians use their intuition more often to respond to problems (Pretz & Folse 2011). The ability to clinically reason is a core practice requirement for every clinician (Higgs *et al.* 2008).

The environment plays a significant part in decisions. Clinical reasoning is influenced by the context in which the decision occurs and is discovered in action within that particular context (Durning *et al.* 2011). This can result in clinicians from the same setting having different interpretations of a consumer presentation (Durning *et al.* 2010). To facilitate decision-making within a community setting, Polkinghorne (2004) suggested that clinicians apply 'engaged reasoning'; that is, the consumer is consulted in the process of making a decision. This approach is supported by Elliott's (2010) understanding of clinician decision-making in the community, with a grounded theory of 'mutual intacting', presented to describe how clinicians engage consumers to achieve an acceptable outcome for the consumer.

Literature focusing on general and mental health care suggests appropriate clinical decisions are applied when clinicians are competent in their field of practice, and have an understanding of consumer needs, knowledge of the boundaries of their service, and an awareness of guiding policy in making their decisions (Andersson *et al.* 2006; Kam & Midgley 2006; Purc-Stephenson & Thrasher 2010). With people waiting for ORT treatment and a limited knowledge on how clinicians manage this situation, it is important to investigate this issue. The aim of this study was to examine how clinicians prioritize consumers for ORT and to explore how they are influenced in their decision-making to develop an understanding of their clinical reasoning process.

MATERIALS AND METHODS

Design

The present study forms part of a larger study aimed at developing a substantive theory to explain how clinicians apply clinical judgment in managing access to ORT programmes. A modified grounded theory is used based on the constructivist approach of Charmaz (2006). In constructivist grounded theory, the researcher interprets the participants' meanings in a situation, with the data and analysis considered social actions occurring between the researcher and participants to obtain a constructed interpretation of the phenomenon (Charmaz 2006; Silverman 2010). This approach was undertaken as the primary researcher was an experienced clinician in ORT and did not have a detached position. Grounded theory is useful when there is limited research on a phenomenon and there is a need for a deep understanding (Charmaz 2006).

This paper presents the early findings through the descriptive analysis of the coded participant data (Andrew & Halcomb 2009; Holloway & Wheeler 2010). Generated focused codes were examined to develop an understanding of the influences on clinician decision-making. The researcher undertook the descriptive analysis at this stage of the project to support the construction of a grounded theory on the phenomenon. The researcher considered this the half-way point in the study, and the findings would be used to guide the remaining research, with further refinement of focused coding, memo writing, diagramming of interactions, raising of categories, and the interpreting of the journey to allow generation of theory to occur (Charmaz 2006). The findings from this analysis will be of interest to clinicians practicing within this setting, with clinical decision-making previously unexplored in this context. Clinicians with an interest in clinical decision-making will also gain insight into the factors influencing the process within this situation, adding to the body of knowledge on decision-making in health care.

Participants

Health-care professionals registered to practice in publicly-funded ORT clinics within the Australian states of NSW and Queensland were the participants in this study. They were located through the Alcohol and Other Drugs Treatment Services National Directory (www.adin.com.au/) (Commonwealth of Australia 2008). The focus of this research was on clinicians working in NSW and Queensland public ORT clinics, as waiting periods for treatment have been identified in these services (Drugs of Dependence Unit 2012; Winstock *et al.* 2008). Managers of potential ORT providers were contacted in writing to inform them of this study, and were invited to participate as a research site. Once site-specific approvals were obtained, clinicians at these locations were further informed in writing of the study and invited to participate. A total of 35 health-care professionals from 10 sites participated in the study between March and August 2012. They included nurses (n = 27), medical officers (n = 6), and psychologists (n = 2); 20 females and 15 males. Nurse participants included six first-level registered nurses, 11 second-level clinical nurses (CN), one third-level CN consultant, eight third-level nurse unit managers (NUM), and one fourth-level program manager.

Procedure

Data were collected from participants through semistructured interviews by a mental health nurse experienced in this qualitative research technique. The following case scenario was employed:

> John and Jane present for access to ORT. John is a 24 year old with a history of a 6-month heroin habit, homelessness, and symptoms of depression. Jane is a 27-year-old single mother of a 5-year-old child, with a 9-year on-and-off habit of heroin use and a previous history on ORT treatment.

Participants were then asked a number of closed- and open-ended questions, including: (i) who should receive treatment first?; (ii) why make that decision?; and (iii) what factors, experiences, or information have been influential in making the decision? Could your decision-making be assisted with additional resources? If yes, please explain.

By presenting a scenario of two people requesting ORT treatment, and the task of choosing the person to receive treatment first, clinicians were stimulated to use their clinical judgment, allowing exploration of how this was applied. The scenario was designed to exclude the priority groups defined in national and state ORT policy, limiting clinician guidance from these resources. Data collection ceased when no new data were presented in the interviews or generated from the analyses; this is a strategy recommended by Charmaz (2006). The participant interviews were audio-recorded, and then transcribed verbatim.

Data analysis

Initial data analysis incorporated word-by-word and then line-by-line coding to allow conceptualization of ideas to summarize and define the data. Constant comparative analysis was undertaken: comparing, coding, and analysing data concurrently to gain an awareness of what was occurring in the study to guide further data collection. Memo writing was used to question the initial codes and the data they represented to support the analysis process. By sorting and combining the most frequent and significant initial codes, focused codes were developed. This approach is recommended by Charmaz (2006), as it helps to make sense of the data and provides an early understanding on the phenomenon. The reliability of the focused codes was obtained by member checking. In member checking, the focused codes are presented to participants to ensure they are a valid representation of their data (Charmaz 2006; Holloway & Wheeler 2010).

A strategy suggested by Charmaz (2006) to support researcher awareness of their placement within a project is to apply a reflexive stance to explore the cause and effect of researcher ideas on data and analysis. This included, within the study, the use of constant comparative analyses, memo writing, field-note recording, journaling ideas for discussions with supervisors, and mapping the path travelled to check that the researchers' experiences were aiding towards the creation of theory, and not imposing with undue bias on the research (Charmaz 2006).

Ethics considerations

Ethical approval was granted by both NSW and Queensland public health services. Ten site-specific approvals for the NSW (n = 3) and Queensland (n = 7) locations were obtained to undertake the study.

RESULTS

Prioritizing consumers for ORT

Clinicians decided whether Jane should receive treatment before John (nurses, medical officers, and psychologists, *n* = 25), John should receive treatment before Jane (nurses, *n* = 5), or if they were undecided (nurses and medical officers, *n* = 5). Five of the 10 ORT clinics had clinicians with a difference of opinion on which person should receive treatment first: John, Jane, or undecided. For example, at one clinic, the NUM was undecided, three CN chose Jane, and one CN chose John. At the remaining five clinics, all of the clinicians chose Jane.

Clinicians influenced in their decision-making for Jane

Clinicians deciding on Jane (nurses, medical officers, and psychologists) all identified the child in her care:

> The clincher for me is around the child and the child's safety. There's likely to be limited external resources for the child while she is drug effected . . . the risks are higher for Jane, as it's not just her we are thinking of for treatment; it will also have a flow on effect to a person who clearly can't look after themselves.

Another main factor in their choice was prior treatment history (nurses, medical officers and psychologists):

> She's had treatment before, it's been a long-standing habit, so we would certainly like her in treatment because of the length of time.

Interestingly, John's homelessness was an issue and a reason to choose Jane (nurses):

> It becomes difficult with someone homeless . . . we accidentally overdose them . . . we can't send an ambulance off to treat them as we don't know where they live.

These clinicians identified their drug-treatment experience (nurses, medical officers, and psychologists) as 'the longer you work in the service, you realize it's not black and white'. The ORT guidelines and the child-safety requirements/training influenced the decision (nurses, medical officers, and psychologists). They described team involvement (nurses, medical officers, and psychologists):

> We make all our decisions as a team here when it comes to putting people on. So if we did an intake today, then tomorrow morning it would go to the intake meeting, and as a team we would discuss the actual pros and cons of who is going to come first.

They also cited a broad range of experiences to impact on their decision-making process (nurses and medical officers): 'working in general health', 'having a common-sense approach to the situation', 'knowledge and experience from working in mental health', gaining an awareness 'through having children and me understanding motherhood', 'working in corrections', 'I had 2 weeks of D & A (drug and alcohol) training', 'evidence from clients and learning from them', and 'not being insular (investigating what other services do)'.

These clinicians were 'confident' (nurses, medical officers, and psychologists), 'fairly confident' (nurses and medical officers), and 'not very confident at all' (nurses, medical officers, and psychologists). One CN deciding on Jane questioned their decision and remained unsure at the end of the interview if they had made the right decision.

Clinicians influenced in their decision-making for John

The clinicians who chose John (nurses) referenced a large number of of reasons for their decision: 'he is at risk of mental health' and 'he's also homeless, so his activities of daily living are compromised'. They also stated: 'he's got more of an acute thing', 'he has recently commenced', and 'he hasn't got any risk protectors. (For Jane) a protective factor would be her child', and with Jane: 'she can build on the skills she has used when she hasn't been using'.

They referenced team involvement – 'all cases go through a team discussion' – their experience – 'the longer you are in a certain field, the more you get a sense of what the field is', 'I've got a child protection liaison role', and 'my background is emergency' – as factors influencing their decision. They also advised: 'we've got the ORT guidelines', understanding 'the triaging of people and what moves a higher risk person up into treatment', and 'you are influenced by what other clinicians bring to the table, it could be experience, it could be history . . . there are times when I'm influenced by that', as knowledge helping critique their judgments. They stated: 'I am very confident', 'yes, I feel confident', and that they were 'reasonably confident' with their decision.

Clinicians undecided

The clinicians undecided (nurses and medical officers) advised: 'you can't make a decision without getting collateral information', 'the person who first contacted me would come first . . . it is the only fair way . . . these cases aren't priorities', or were undecided as they provide treatment to both consumers: 'we don't have a wait list'. These clinicians identified that their experience influenced their decision (nurses and medical officers): 'if you are naïve, it's easy to be punitive to say it's your fault, you got yourself here, but as you work in a service for a long time, it's not black and white', 'I have been a doctor for over 30 years . . . as a GP (general practitioner) . . . in mental health . . . in the prisons. You can call that education and experience'.

Team involvement, the ORT guidelines, the impact of their local workplace guidelines (nurses and medical officers) were factors in their practice: 'you gain insight to what the company line is to the scenario', as well as child safety: 'being a drug user does not mean the child's safe' and their model of service delivery (nurses and medical officers): 'we put high priority in having access and the whole team based case management system we designed is to allow this'. These clinicians stated they were 'very confident' (nurses and medical officers), 'I have become confident through experience' (medical officer)' 'I'm fairly confident in who to prioritize for treatment' (medical officer), and 'no, I wouldn't (be confident), of course not' (nurse).

Resources to assist with decision-making

Broader assessment of consumers' risks, needs, and protective factors was a resource identified by clinicians (nurses, medical officers, and psychologists) to assist their decision-making. One participant (nurse) described their initial consumer contacts are recorded on:

> A standard community health intake form, so it's a lot of demographic detail, and on the back it's pretty much a blank page. So it is up to clinician(s) to know what to prompt. It's not standardized . . . and sometimes you get one or two liners with minimal information.

They requested more treating clinicians (nurses and psychologist): 'our bottle neck is the lack of consistent access to a doctor' and 'in reality, the greatest resource we could have would be more clinicians, so that people did not have to sit around waiting. So if I think we had more people on the floor. More clinicians trained up and ready to do it. That would be wonderful'. Another clinician (medical officer) described the need for revised ORT guidelines to include a triage assessment process:

> The clinics I have worked in have been fairly concrete and only prioritize a small number of things, namely HIV, pregnant, or just out of prison. We need a universally-agreed prioritizing tool. It would not make the decision for us, but it potentially could be useful.

The resources identified to assist clinicians include: (i) broader assessment of the consumer risks, needs, and protective factors; (ii) more treating clinicians; (iii) increased accessibility to consumer information; (iv) triage assessment process; (v) no further resources; (vi) counselling and welfare services; (vii) define case management; (viii) more treatment space to assess consumers; (ix) clinical director; (x) parenting programmes; (xi) homeless person resources; (xii) more treatment places; (xiii) onsite mental health services; (xiv) consumer case conference; (xv) increase ORT access points; (xvi) increased general practitioner management of stable clients; (xvii) reduce repetition with ORT commencing; (xviii) access to ORT treatment in 24–48 hours; (xix) increase the number of take home doses allowed; (xx) increase the number of dispensing services; (xxi) better consumer data-management system; (xxii) training for new clinicians; and (xxiii) research on the subgroups that are more of a priority for treatment.

DISCUSSION

The findings suggest there are differences in the way clinicians make decisions in managing consumer access to ORT. There was inconsistency in practice, and this was evident with the clinicians not making a clear choice between John and Jane. With clinicians working in teams and team involvement identified to influence clinician decision-making, one might expect some similarity in the choice of consumer. The sharing of expertise through discussion to deliver agreed outcomes is an attribute of clinicians working in teams (Mitchell *et al*. 2008). Also, health-care professionals rely on their work experiences to guide their practice (Andersson *et al*. 2006; Kam & Midgley 2006; Purc-Stephenson & Thrasher 2010), and it is not surprising that the participants suggested that this informs their practice. The relationship between team involvement and work experience is the likely reason that there was a difference between clinicians in the choice of consumer to prioritize. Participants were located within different teams with their practice, guided by their experiences in these settings. Interestingly, with some participants from the same ORT provider, the preference of consumer varied (e.g. NUM, undecided; CN, Jane; CN, John), and this difference of opinion was observed to be linked to how clinicians understand risks and protective factors.

Clinicians viewed John's homelessness as a greater risk compared to the child's safety. For other clinicians, the child's safety was considered the more immediate and important risk. Several clinicians understood the child to be a protective factor, and a few noted John's homelessness was a risk with ORT. This disparity in how clinicians responded to the procedure is concerning, given consumers expect consistent quality and equity in their health care (La Rosa-Salas & Tricas-Sauras 2008). Which clinicians are right and which are wrong? Does Jane come first or John? How do we decide? There is a no direction in ORT policy to help answer these questions. Clinicians can determine consumer risks and protective factors when a person has parenting responsibilities (Frye *et al.* 2008), homelessness (Martins 2008), a mental illness (Bizzarri *et al.* 2005), or wants to reengage in treatment (Bell *et al.* 2006), although this evidence is not concisely located or cited within ORT policy. It requires sourcing through a broad range of literature (Harlow *et al.* 2011). ORT guidelines need to include a description of consumer risks, with suggestions on how these can be managed to minimize harm to the individual and others under their care.

Other health-care settings have systematic procedures for managing treatment requests, and these approaches could be used to assist ORT clinicians to respond in their environment (Andersson *et al.* 2006; Broadbent *et al.* 2010). For example, in emergency departments, clinicians are directed to identify the person with the highest risk and least protective factors to determine who will receive treatment next. Consumers are allocated a priority category: one (highest) to five, based on the urgency for treatment, with the expected wait time conveyed to the person (Australian Government 2007). In mental health services, the process is similar, with consumers allocated a priority rating: A (highest) to G, reflecting their need for intervention, with clinicians provided direction on how to respond and the timeframe to complete for each allocation (Department of Health 2010). With the high rate of comorbidities associated with people with mental health and substance use concerns (National Mental Health Commission 2013), this approach is likely to be successful in managing access to drug-intervention services, with people already familiar with the access-management system. For instance, a variation to the process was applied in one ORT clinic, which trialled a three-tiered triage categorization system. Clinicians used criteria to sort and prioritize people into groups. The results demonstrated that consumers were granted access to ORT in timeframes reflecting their allocated priority category (Harlow *et al.* 2013).

For some clinicians who were undecided in the choice of consumer, they reported managing access to ORT by a first-come-first-serve approach. Equity in health care involves providing fair and safe access to treatment, considering individual needs (La Rosa-Salas & Tricas-Sauras 2008). Triage systems exist in general and mental health services to address this issue, to allow the people in most need of help to receive help (Andersson *et al.* 2006; Broadbent *et al.* 2010; Grigg *et al.* 2002; La Rosa-Salas & Tricas-Sauras 2008). The remaining clinicians who were undecided believed that, by practicing under their model of care (i.e. team-based case management), the choice is irrelevant, as they could provide treatment to both consumers at contact. This suggests alternative approaches to delivering ORT can decrease the wait time for treatment. Team-based case management has been reported to open up additional treatment places which are previously closed under an individual case-management model (Day *et al.* 2012). With requests for more treating clinicians to increase treatment capacity, further investigation is required to explore the clinical implications of team-based case management, as it presents as an appealing option towards reducing consumer wait times for ORT.

The findings from this study support Gallacher's (2007) description of clinical judgment and decision-making. The clinical judgments applied on John and Jane's treatment requests were informed by the influencing factors presented in this study, which assisted the clinician to make a decision and determine an outcome for the consumer. Tanner's (2006) understanding of clinical judgment was also demonstrated with the clinician expertise, the context of the situation, and the clinician's ability to relate to the consumer, all impacting on the decisions made. The experience of clinicians might also impact on their cognitive processing of treatment requests. For instance, there was variation between clinicians who worked in teams that encompassed base grade and senior positions. However, the approach to the study does not allow us to ascertain whether thinking was dominated by automated or analytic processes (Croskerry 2013).

Some clinicians working in programmes with a wait time for treatment were unable to choose the person for preferential treatment, as their programme had a wait time. For ORT programme with no wait for treatment, they cited that they did not need to make a selection, as they could treat both consumers. Clinicians from both contrasting environments made a decision of 'undecided'. These findings suggest that the context of the health-care system in this situation influenced the clinical judgment and decision-making of clinicians, which informed their clinical reasoning to the task (Durning *et al.* 2011). Additionally, clinicians raised the need for further assessment, with the consumer to guide their decision-making, although this was not consistent across the participant group. Some clinicians made a decision without engaging with the consumer. This is in contrast to Polkinghorne's (2004) and Elliott's (2010) suggestion that consumer engagement is part of the decision-making process in the community. Further participant recruitment, data gathering, and analysis are recommended to explore this discrepancy to identify the extent of consumer involvement that occurs with ORT treatment requests.

Over one-third of clinicians were fairly confident or not confident in their decision, with one CN questioning their decision. This was an interesting response, as many of these clinicians hold senior positions requiring expertise in decision-making (Australian Nursing & Midwifery Council 2006). Their actions influence their peers, including the junior clinicians (Victorian Government Department of Human Services 2005). The suggestion for a 'universally-agreed prioritizing tool', triage, as applied in broader health care, can reduce discrepancy that occurs with individual decision-making (Australian Government 2007; Department of Health 2010) and build clinician confidence.

For some participants, the quantity of consumer detail in the scenario was similar to their reality of practice. It is probable that the participant's claim of 'one or two liners' would not contain an interim management plan reflecting the consumer risks and protective factors. National and state ORT policies have no requirement for the initial assessment, only that a comprehensive assessment should be undertaken at some stage (Intergovernmental Committee on Drugs 2007). To gain an understanding of the consumers' situations at the point of contact, risk screening has been recommended (Department of Health 2012).

Limitations

With only 35 participants in this study, the generalizability of findings is limited. The clinicians did come from 10 separate services, which added depth to the study by investigating for variance and consistency between clinicians in their responses. This sample size is appropriate for this study, with the focus on the quality and richness of the data aimed at the development of an early understanding of how clinicians make decisions in providing access to ORT.

CONCLUSION

The present study explored how clinicians make decisions in managing access to ORT, identifying team involvement, work experience, and consumer risks and protective factors as the influences in their decision-making process. People are waiting to access ORT, and with no national requirement for reporting the numbers, there is little incentive to address the problem of managing wait lists for ORT. A revision of national ORT policy to include a definition of consumer risks and protective factors, and linking these into a triage system to support clinicians to uniformly respond to treatment requests, is needed. This policy needs to be informed by research. This research could include broader examination of the ORT models of care to improve treatment productivity. Without these undertakings, the inconsistency in how clinicians understand and then manage access to ORT is likely to remain an unresolved issue.

ACKNOWLEDGEMENTS

We would like to thank the Queensland and NSW clinicians who participated in this study, and Gold Coast Health Alcohol and Other Drug Service for releasing the researcher to undertake the investigation. The project was supported through the Central Queensland University Student Research Higher Degree scheme.

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