Interim Prescribing

Refer to MOH Guidelines, Appendix 18: Interim Prescribing.

Opioid Substitution Treatment Service Policy regarding reporting to New Zealand Transport Authority (NZTA)

Policy Statement

1. The Service's aim is to provide comprehensive alcohol and drug assessment and treatment or referral to an appropriate treatment provider. The recent research findings have demonstrated health complications from the long term use of cannabis.

2. Section 18 of the Land Transport Act 1998 requires Medical Practitioners to advise the Director of Land Transport New Zealand (NZTA) of cases where the mental or physical condition of the Licence holder is such that, in the interests of public safety, the individual should not be permitted to drive subject to limitations and conditions – and it is considered that the individual is likely to drive or operate heavy machinery against medical advice.

Rational / Guiding Principles / Key Aims

The Canterbury District Health Board (CDHB) opioid substitution treatment Service is committed to ensuring the safety of individuals, the public, clients, and staff in relation to safe driving and the operation of heavy machinery.

The organisation in its determination to provide comprehensive assessments of all substance misuse needs to address cannabis use as a clinical issue.

Rationale

Urinary drug screens are routinely obtained and considered as part of treatment for clients undergoing opioid substitution treatment. They are therefore a relatively small subset of people about whose substance use we know, unlike the substance use of the rest of the population. Urinary drug screens indicating a Carboxy THC level greater than >500ug/L indicates heavy and daily use of cannabis. Urinary drug screens are not a perfect indicator for cannabis misuse as they are subject to the following variables:

- kidney function
- amount of fluid ingested
- PH of urine
- body

metabolism
- fat ratio (Body Mass Index)
- huge variability between different types of cannabis ingested

Despite these difficulties, a level of greater than Carboxy THC >500 ug/L indicates significant and concerning drug use which is very likely to impair that person's ability to drive a motor vehicle.

- If the client provides a urinary drug screen that is positive for Carboxy THC greater than >500ug/L, benzodiazepines, or other non-prescribed substances the results are to be reviewed with the multi-disciplinary team (MDT) and documented in the client's clinical notes.

- The clients will be advised not to drive and this is to be documented.

A treatment plan is to be developed with the client within one month of the MDT decision to address their use. In relation to cannabis use, a reduction in the Carboxy-THC:Creatinine ratio should be observed in clients who are reducing their cannabis use over time.

Should the client decline the treatment plan, deviate from the plan, and/or continue to drive or operate heavy machinery, they should be reviewed by the MDT as soon as practicable. In addition, the NZTA is to be informed in writing by a Registered Medical Practitioner where this is the MDT decision.

- If the client reveals cannabis use and complains of drowsiness or demonstrates signs of intoxication, then the same obligations apply as per Section 1 of the Driving Policy.

If individual appears to be intoxicated

Substances of concern include alcohol, hallucinogens,, inhalants, opioids, sedatives, cannabis and stimulants such as herbal highs or other substances. This list is not meant to be exhaustive, but provides a guide for the clinician; it includes prescribed as well as non-prescribed substances.

Individuals who drive or operate heavy machinery while intoxicated pose a potential risk to themselves, the organisation, and the public.

Indicators of Intoxication

The individual is obviously intoxicated or drug affected.
The individual reports, or is observed, or is reliably reported to be using alcohol and/or other drugs within a timeframe that indicates to the staff member that the individual

is likely to be unfit to drive or operate a heavy machinery.
The individual is not obviously intoxicated or drug affected, but staff observe one or more of the following:

- Unsteady gait
- Agitation and belligerence
- Suspiciousness or withdrawn behaviour
- Smell of alcohol or other volatile substances
- Uncharacteristic slurring of speech or confusion
- 'nodding', sleepiness or drowsiness
- Demonstrates emotional lability.

Staff are to advise the individual not to drive or operate heavy machinery. If the individual attempts/continues to drive or operate heavy machinery, the Case Manager or staff who witness this incident is to gather as much information as possible without putting themselves at risk.

- Express concerns to the individual and request that they do NOT drive or operate heavy machinery.
- Suggest to the individual that they leave their keys at reception for safe keeping and collect the vehicle some time later.
- Help the individual to arrange an alternative mode of transport.

Do NOT move the individual's vehicle. The police are to be informed if the vehicle has been left where it poses a hazard to others.

If the individual refuses to leave the keys with a staff member:

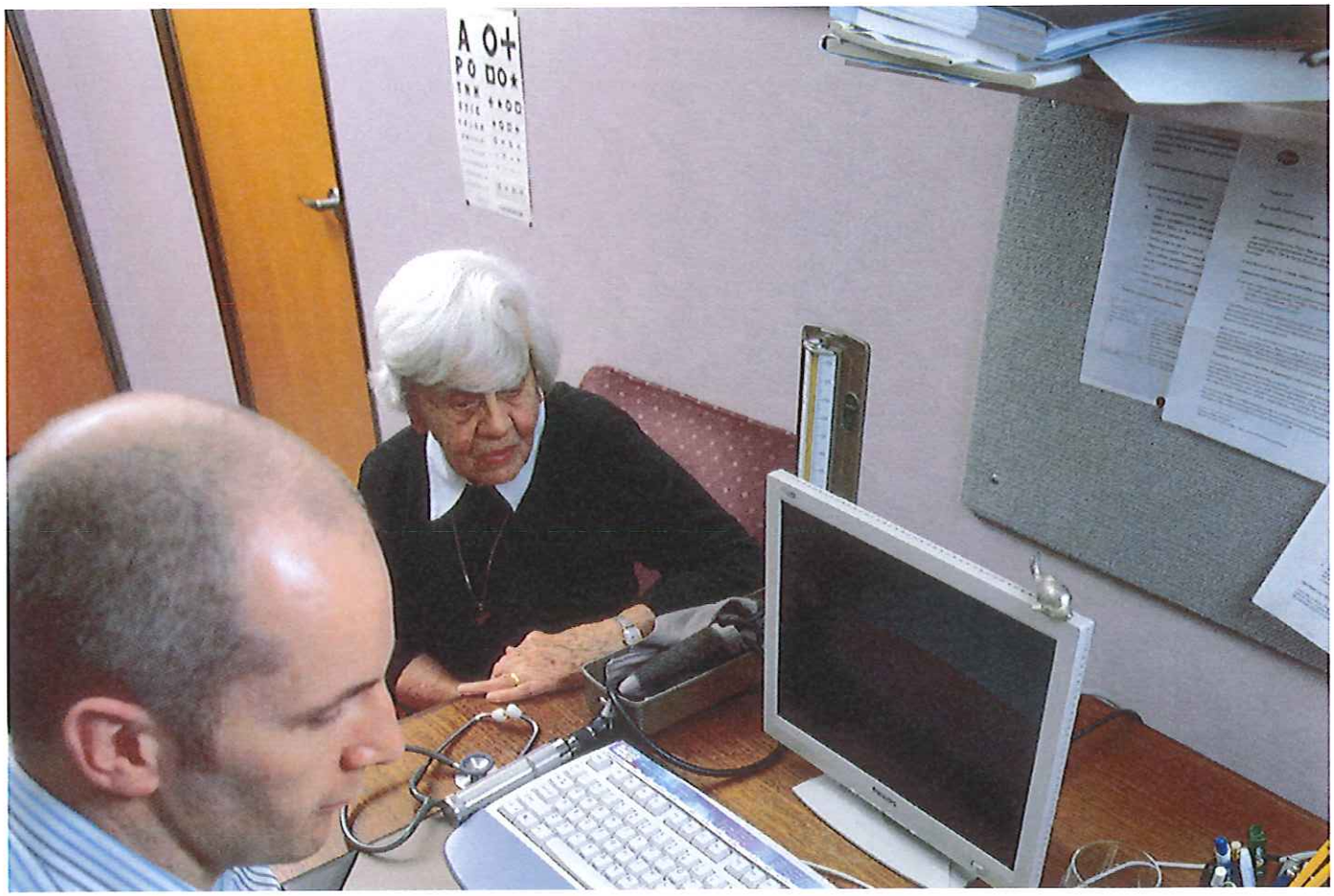
- Reiterate concerns for the individual's well-being as well as other persons.
- Advise individual that we are required by law to inform the police if they attempt to drive their vehicle or operate heavy machinery.

If the individual ignores the advice/suggestions and drives away from the unit:

- Record the vehicle information if practicable.
- Notify Clinical Manager and inform responsible clinician.
- Report your concerns to the Police (*555 on cellphone gains the quickest response, or 1-111 if cellphone not available).
- Complete Quality Improvement Event Reporting Form.
- Document clearly in clinical notes.
- Review at the next MDT meeting

Medical aspects of fitness to drive

A guide for health practitioners



NZ TRANSPORT AGENCY
WAKA KOTAHI

Safer Journeys

New Zealand Government

1.4 Reporting an individual's unfitness to drive

A health practitioner must report that an individual is unfit to drive or should only drive with certain licence conditions if:

- the health practitioner provides a medical certificate for driver licensing renewal or application purposes
- the individual is likely to continue to drive contrary to medical advice (section 18 of the Land Transport Act 1998).

Section 18 of the Land Transport Act 1998 requires health practitioners to advise the Transport Agency in cases where the mental or physical condition of the licence holder is such that, in the interests of public safety, the person should not be permitted to drive or only permitted to drive subject to limitations and conditions – and it is considered that the person is likely to drive against medical advice. The full wording of this section is set out in appendix 1.

There are also reporting requirements under section 19 of the Land Transport Act 1998 (outlined in section 8 of this guide) that relate to individuals subject to a Compulsory Inpatient Treatment Order, or special patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Procedures for notifying the Transport Agency of an individual under section 18 of the Land Transport Act 1998

The general steps are:

- inform the individual that they are unfit to drive and the reasons for this
- if the individual accepts they are unfit to drive and advises that they will not drive, take no further action
- if the individual does not accept the advice and is likely to continue to drive, advise the Transport Agency (section 18 of the Land Transport Act 1998) – an example section 18 notification letter is outlined in appendix 4.

Other advice

Health practitioners may wish to advise patients in writing, as well as verbally, that they are unfit to drive and when they can expect the situation to be reviewed. Some individuals may need to be advised that they are unfit to drive in the presence of a third party, such as a supportive family member.

11.2 Alcohol and/or drug addiction and dependency

Medical standards for all licence classes and/or endorsement types

Individuals with symptoms or effects of alcohol and/or drug dependency or abuse that may impair their ability to drive safely should be advised not to drive until effective treatment has been established, eg where the effects of the individual's dependency impair their motor skills, perceptions, cognitive abilities or other factors necessary for safe driving.

Take care where an individual has another medical condition, such as epilepsy, that can be exacerbated by the effects of alcohol and/or drugs.

11.3 Methadone

Medical standards for all licence classes and/or endorsement types

When driving can resume or may occur

An individual on an oral methadone treatment programme may continue to drive if the individual is stable on the programme and their methadone treatment is unlikely to affect their ability to drive safely.

Health practitioners should be aware of the effects of oral methadone and a combination of any illegal drugs on driving, and where appropriate advise patients that they should not drive when taking oral methadone and illegal drugs.

New Zealand Practice Guidelines for Opioid Substitution Treatment

2014

A service provider who becomes aware of or suspects opioid intoxication in a child should refer him or her to an accident and emergency department without delay, as respiratory depression may be observed for as long as 48 hours after ingestion. Providers should also consider naloxone administration. Treatment must include establishing an airway, maintaining adequate respiratory ventilation, maintaining fluid and electrolyte balance, emptying upper and lower gastrointestinal tracts and preventing aspiration of gastric contents.

4.2 Substance-impaired driving

Considerable risks arise if a client uses other substances, including alcohol, in combination with his or her OST medication and drives a motor vehicle. All services must have procedures in place to inform clients of the risks and to take action if they become aware of clients driving while impaired.

The Land Transport Amendment Act 2009 introduced new driving laws creating an offence of driving while impaired with evidence in the bloodstream of a controlled drug or prescription medicine (section 11A).

The New Zealand Transport Agency (NZTA) *Medical Aspects of Fitness to Drive: A guide for medical practitioners* (2009) advises that drugs such as sedatives, analgesics, anti-allergy drugs, antipsychotic drugs and antidepressants, anti-motion–sickness drugs, hypertensive medications, relaxants, ophthalmic agents and drugs of abuse – benzodiazepines, opioids, methadone, amphetamines, THC, hallucinogenic agents and cocaine – may impair a person's ability to drive. The NZTA provides the following checklist when considering a person's ability to drive safely:

- the impact of changing prescriptions and levels of medication
- the cumulative effects of medications
- the type of licence and type of driving undertaken
- the presence of multiple medical conditions
- other factors that exacerbate risk (eg, a history of illicit drug use and medication)
- the use of illicit or prescription drugs and medications that may cause sedation, euphoria, impaired motor coordination, blurred vision, hypotension or dizziness and exacerbation of other medical-related risks.

Current evidence concerning the effect of various drugs on driving – and in particular, the effect that drugs may have when used in combination with methadone or buprenorphine – highlights the following points:

a. Methadone and buprenorphine may affect the capacity of clients to drive or operate machinery, particularly:
    - during the induction and stabilisation phases of treatment
    - following dose increases or during rapid reductions
    - when the client is taking other drugs (illicit or prescribed) or drinking alcohol
    - when the client has a medical or psychological condition that is likely to contribute to impairment
    - when doses of ≥120 mg of methadone or 32 mg buprenorphine are being administered.

b. The addition of any psychoactive substance to methadone or buprenorphine may result in impaired driving. There is an increased risk of accidents with certain substances, especially CNS depressants including alcohol:

> Medical practitioners should be aware of the effects of oral methadone and a combination of any illegal drugs on driving and where appropriate advise patients that they should not drive when taking oral methadone and illegal drugs.
>
> NZTA 2009

c. Many factors related to opioid use influence driver safety. As well as combined use of other substances, these include route of administration, dose, time of day, tolerance and individual reaction to the substance.

d. Methadone should not cause significant psychomotor or cognitive impairment in people who abstain from other substance use:

> An individual on an oral methadone treatment programme may continue to drive if the individual is stable on the programme and their methadone treatment is unlikely to affect their ability to drive safely.
>
> NZTA 2009

e. Buprenorphine has less effect on psychomotor performance than methadone; it may therefore be a preferable medication for people who need to drive or operate machinery regularly.

Opioid substitution treatment providers and practitioners must be knowledgeable about the risks associated with the use of opioid drugs, and in particular with the risks associated with methadone when used concurrently with other substances.

Specialist service clinicians and prescribing doctors have a responsibility to advise clients of possible effects and the degree of associated risk prior to admission, when their dose is increased and when they are known to be using, or have been prescribed, other medications that could contribute to impairment or alter the metabolism of the opioid medication. (Services could provide a standard written reminder of risk of overdose to clients at these times.) Service providers must record discussion and advice about driving on individual clients' clinical records.

If a client is considered medically unfit to drive, the prescribing doctor must advise him or her of this both verbally and in writing. If the risk is likely to be ongoing and the client's other substance use or psychological function indicates that they may not follow the advice, the prescribing doctor (ideally after consulting the multidisciplinary team (MDT)) must notify the NZTA. An example letter of notification under sections 18 and 19 of the Land Transport Act 1998 as well as an example letter advising an individual that they are unfit to drive can be found in the appendices of *Medical aspects of fitness to drive: A guide for medical practitioners* (NZTA 2009).

The letter advising the client that they have been declared medically unfit to drive should outline when and how they can expect their situation to be reviewed and the process for meeting requirements to resolve the situation. When it is resolved, the prescribing doctor needs to advise the NZTA.

4.2.1 Benzodiazepines and driving

There is substantial evidence that the use of benzodiazepines (prescribed or illicit) leads to increased risk of motor vehicle accidents. All use of benzodiazepines in combination with opioid substitution medication should be considered a safety risk.

The risk of driver impairment has been shown to increase significantly with increasing benzodiazepine blood-drug concentrations and with benzodiazepines with a long half-life (eg, diazepam, clonazepam and nitrazepam), particularly with doses greater than 20 mg diazepam equivalent (refer to Appendix 7: Dose equivalence of opioid and benzodiazepine drugs). Clients taking shorter acting benzodiazepines may also be unsafe to drive if the benzodiazepine is still exerting its effects.

As Zoplicone has been implicated in more fatal road accidents than would be expected from its half-life, it is not recommended as being safer than a benzodiazepine.

Alcohol and benzodiazepines have additive effects that significantly increase the risk of accident.

4.3 Methadone and cardiac safety

QT interval prolongation[8] is evident in 10–15 percent of people on methadone. Methadone can prolong the QT interval and in rare cases induce torsade de pointes, which can be fatal. The risk of QTc prolongation in clients who are using, or being prescribed, methadone is unpredictable and does not appear to be dose dependent. Clients with a history of unexplained loss of consciousness or with family history of sudden cardiac death may be at higher risk for torsade de pointes. (Familial elongated QT affects approximately 1 in 2000 adults.) It is important therefore that service providers screen clients with this history for this risk at entry to and during OST, especially when the methadone dose is increased and when other potential QTc-prolonging medications are prescribed.

In the event of QTc prolongation greater than 500 milliseconds, service providers should seek advice from a cardiologist. Transfer to buprenorphine may be appropriate, as QTc interval prolongation is less likely with buprenorphine.

Risk factors for problematic QTc prolongation include:

- clinical or family history of QTc prolongation
- concurrent use of other QTc prolongation medications (eg, erythromycin or amitriptyline)
- female gender, especially after menopause
- older age
- hypokalaemia (low blood potassium).

Service providers might consider closer monitoring or consultation with specialists for clients with unexplained fainting or seizure episodes. Providers need to educate clients at risk of arrhythmia on symptoms to be aware of and cardiac referral arranged.

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8 'Long QT syndrome [is] a condition in which a specific type of ventricular tachycardia occurs that is associated with certain ECG abnormalities (a prolonged QT interval). Patients with long QT syndrome usually have no identifiable underlying cardiac disease, but appear to be born with the propensity to develop a particular variety of ventricular tachycardia under certain circumstances. (These circumstances can include exercise, or the administration of certain drugs.).' (http://heartdisease.about.com/cs/arrhythmias/a/cardarrhy_3.htm)