

Methadone maintenance treatment in New South Wales and Victoria

Takeaways, diversion and other key issues

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Background

Methadone maintenance treatment is widely recognised as the most effective treatment for heroin dependence (Bell & Zador, 2000; Gibson et al., 1999; Ward et al., 1998; World Health Organization & United Nations Office on Drugs and Crime, 2004). It is finding increasing support internationally, especially in the Asia–Pacific region (Humeniuk & Ali, 2005; Irawati et al., 2006; U.S. Department of State, 2006). This study was designed with this success and expansion in mind, and its aim was to improve understanding of some of the challenges this valuable program faces for the purposes of policy development and service delivery.

Methadone is a full agonist synthetic opioid developed mainly for the treatment of pain. It forms the basis for methadone maintenance treatment (MMT), a central element in Australia's harm minimisation drug policy, instituted in 1985 (National Drug Strategy, 1998). MMT involves daily consumption of a prescribed dose of methadone, usually under the supervision of a pharmacist or nurse. To minimise the inconvenience associated with daily dosing, many clients

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are prescribed one or more 'takeaway' doses of methadone per week (these are doses consumed away from clinic or pharmacy premises). Some treatment clients (exact numbers are not available) are prescribed buprenorphine rather than methadone. This is a relatively new medication with slightly different properties from those of methadone (in particular, it is a partial agonist rather than a full agonist and is longer acting in the body). Even newer is the combination buprenorphine/naloxone medication which combines a partial agonist and an antagonist. It has been introduced to help minimise the injection of buprenorphine (discussed below). Together these three medications make up pharmacotherapy treatment in Australia.



A main health and enforcement concern around pharmacotherapy treatment focuses on the phenomenon of 'diversion'. This is where medication is either sold on the black market by clients or shared with friends and family. Also of concern is the injection of medication. In New South Wales methadone is dispensed neat, but in Victoria it is diluted with water or cordial to discourage injection. These two concerns—the illicit mobility of medication and its illicit consumption via injection—help shape the way treatment is delivered in both states.

This study focused mainly on methadone maintenance treatment, but also elicited some information on buprenorphine and buprenorphine/naloxone treatments. It was based on in-depth, semi-structured interviews with 87 individuals in two Australian states, New South Wales and Victoria. Participants comprised clients ($n = 50$), service providers ($n = 29$) and policy makers ($n = 8$). The interviews covered a range of issues, such as the meaning of takeaways in treatment, the circumstances under which diversion to street sale takes place, the impact of location on how easy it is to obtain treatment, and prospects for employment and social participation for clients.

The report on which this summary draws covers all these matters and many others of significance. Our aim in producing this document is to provide quick and easy access to the key findings and recommendations made in the report. We hope that it will reach a wide audience and, given the complexity of the issues canvassed here, we strongly recommend that readers maximise their understanding of the material by reading the report in its entirety. The full report is available at <http://nchr.arts.unsw.edu.au/reports/methadone2007.pdf>

Main conclusions drawn from the study

1 Takeaways were of central importance to almost all clients interviewed in this study, be they male or female, located in urban or regional settings, new to treatment or veterans of treatment. **Takeaways were identified as contributing greatly** to:

- finding and retaining employment
- fulfilling family responsibilities
- the ability to travel for work and leisure
- self-esteem and a sense of progress in treatment
- control over contact with other clients
- confidentiality in treatment
- cessation of illicit drug use.

It is essential that present and future policy on takeaways allow adequate recognition of the differences in clients' circumstances, and adequate flexibility in prescribers' ability to prescribe takeaways.

2 **Diversion of methadone was described in a range of ways** in the interviews. These included sale to strangers, sale to friends or acquaintances, and sharing with friends or acquaintances. When seeking to understand the dynamics of diversion, it is essential to bear in mind the role of the following factors in instances of sale and sharing:

- unmet demand for treatment
- the economic disadvantage of most clients
- the operation of values of reciprocal care and responsibility.

Inasmuch as opportunities for treatment are inadequate, clients are economically disadvantaged and dosing interferes with clients' ability to obtain and retain paid employment, diversion needs to be understood as a product of social and political factors as much as of individual factors. Policy makers, drug treatment service providers and other government agencies should all be seen as having a role in supporting drug users such that those both inside and outside the program can become less reliant upon diversion to meet their needs.

- 3 More broadly, there is a **need for greater coordination among agencies** so that a collaborative approach to the care of clients can be adopted. Drug dependence is not the only issue most clients face; indeed, drug dependence may be as much an outcome of other issues as it is a source of them. In this respect, there is a pressing need for agencies to work together to support clients, and for the recognition that alcohol and other drug services cannot alone provide all the necessary support if clients are to make genuine progress in treatment.
- 4 Comparisons between data from New South Wales and Victoria generally support the view that diluting methadone takeaways in Victoria helps minimise the diversion of methadone in that state. However, the data also suggest that this minimisation could simultaneously contribute to Victoria's higher levels of buprenorphine diversion and injection. There is no doubt that many factors contribute to these higher rates, but if the dilution of methadone is one of them, there is a **need to evaluate the benefits of dilution against the negative health effects of buprenorphine injection**. The hypothesis that methadone dilution relates to buprenorphine injection requires further research before any conclusions can be drawn.
- 5 Participants across all categories identified **parenting responsibilities** as an important issue in clients' ability to access and remain in treatment. For some clients, time commitments associated with child care represented a significant obstacle to dosing, especially daily dosing where takeaways were not provided. The financial burdens associated with child rearing were also identified as important in that clients sometimes experienced difficulty affording the cost of pharmacy dosing while meeting the material needs of their children. In light of this set of issues, and of increasing concern around rare instances of child mortality related to methadone (which must be viewed in the context of the many benefits to families and children of parental access to MMT), there is a pressing **need for further qualitative social research into the interplay between treatment and families**.



- 6 Our data demonstrate the heterogeneity of clients as well as the similarities between clients and service providers and policy makers. It is essential that an **awareness of diversity among clients** be actively integrated in policy development and service delivery. Clients frequently express frustration at ‘one size fits all’ approaches to treatment, which some feel involve greater restrictions than always necessary. Given that retention in treatment is recognised as central to the success of the program, it is important that clients feel their treatment is managed on an individual basis, and that policies possess enough flexibility to allow genuinely responsive care.
- 7 Clients and service providers identified a significant **unmet demand for treatment** in both New South Wales and Victoria, and suggested that this affected quality of care. Where clients have difficulty accessing the program and have limited choice of service provider, they are especially poorly placed to negotiate treatment on an equal footing. Some expressed the view that this unmet demand and competition for treatment meant service providers did not have adequate incentive to maintain high standards of care, and that clients did not feel free to pursue complaints. This serious issue points to an immediate **need for increased funding for treatment** in both states.
- 8 Indeed, much of the data collected demonstrates the central role that **quality of treatment** plays in the progress of clients. Where quality of treatment is poor, the difficulties clients already face and the disadvantage they often experience can actually be exacerbated by treatment. Factors indicating poor quality of treatment include:
 - overcrowded or run-down treatment facilities
 - overworked service providers
 - inadequate training of service providers
 - systems and procedures that do not sufficiently recognise the individuality and humanity of clients.It is essential that policy makers and service providers reflect regularly on the ways in which funding limitations and residual negative attitudes towards clients among staff might adversely affect quality of care, and consider ways in which these adverse outcomes can be ameliorated or avoided by changes in policy and program delivery.
- 9 Related to this, there was widespread recognition among clients that the conventions of treatment in MMT do not reflect those in other areas of medicine. Despite the identification of addiction as a health issue, aspects of treatment more closely resemble conditions in the criminal justice system. The impact of this disjunction, and of related **shortfalls in the areas of equity and**

Note on the 2006 changes to state policy

Policy changes have been introduced in both New South Wales and Victoria since the period of data collection. These include new recommendations for maximum numbers of takeaways to be prescribed at different time-points in treatment, to be implemented using checklists designed to aid prescribers in assessing clients. As access to takeaways was found to be critical to the experience of treatment for many clients, these changes are likely to affect clients directly or indirectly. However, as our study found, service providers in both New South Wales and Victoria interpret and make use of the guidelines in different ways (indeed, in Victoria, in that the new guidelines incorporate the abolition of the existing permit system, this discretion has increased in some respects). In relation to this, it is important to bear in mind that changes to the guidelines alone are unlikely to make access to takeaways more consistent. In that the particular circumstances of treatment delivery, including the provision of takeaways, remain largely at the discretion of service providers, the study’s findings on takeaways also remain highly relevant.

natural justice, on retention in treatment requires urgent attention. Again, more qualitative social research is needed in this area.

- 10 Our research into rural and regional service delivery highlighted both the **benefits and challenges of treatment provision in potentially isolated areas**. An important consideration in relation to this isolation is the fragility of services, their vulnerability to staff retirement and burn-out, and to difficulties in sourcing suitably qualified professionals. Programs in such areas require extra support in ensuring staff retention and continuity. Rural and regional isolation can also impact on clients, especially as a result of poor public transport. It is essential that clients living in these areas are able to access adequately flexible dosing arrangements, including sufficient takeaways, to ensure retention in treatment.
- 11 Our findings suggest that, with respect to the new clinical guidelines introduced in 2006 in both New South Wales and Victoria (see box above), **additional resources**

are urgently needed if service providers are to receive adequate support, and quality of service provision is to improve. These resources include:

- further education, training and mentoring of service providers (clinic staff, doctors and community pharmacists) in the assessment of clients and meeting client needs
- further training and support for service providers in reading and using the clinical guidelines. This includes 'refresher' courses through the life of existing policies
- a framework to monitor quality of treatment standards
- a robust and independent feedback and complaints-management process. Victoria's drug user representative organisation VIVAIDS currently runs a valuable complaints service, the Pharmacotherapy Advocacy, Mediation and Support Service (PAMS). Such mechanisms for handling complaints need significant expansion if clients are to receive adequate support in pursuing complaints to a satisfactory conclusion. This expansion should include increased resourcing for advocacy for clients navigating their state's health care complaints process (the Office of the Health Services Commissioner in Victoria and the NSW Health Care Complaints Commission) and, as noted above, consideration of the impact of competition for treatment places on clients' scope to pursue complaints.

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