REVIEW OF THE NEW SOUTH WALES OPIOID TREATMENT PROGRAM

STAKEHOLDER CONSULTATION COMPONENT

REPORT

TOWARDS REINTEGRATION

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PART ONE: INTRODUCTION

The Opioid Treatment Program run under the auspices of the NSW Ministry of Health is one of the most successful public health interventions and initiatives in this State. However the OTP lacks any significant public champion or advocate and as a result its benefits remain largely unknown and its future remains constantly under threat. It would be a signal outcome of this Review were the Minister and the Ministry to be prepared to give open and enthusiastic endorsement to such a successful public health initiative and to make clear that its continued support and further development is clearly in the public interest, as well as being in the interest of the patients and their families and carers who are its direct and immediate beneficiaries.

The Report which follows is based upon observations, submissions and research derived from the conduct of an extensive series of consultations with key stakeholders commissioned from the Consultant as part of a broad review of the OTP initiated by the NSW Minister for Health. Although the contract called primarily for a report on stakeholder consultations that is "advisory in nature", this Report goes further and expands on some of the issues and themes which emerged in the consultations. All the issues raised however, derived from and are based upon issues raised in that process.

Background and Conduct of the Review

In January 2014 the Minister for Health and Medical Research, the Hon Jillian Skinner MP, directed that there would be a "*review of all components of the NSW Opioid Treatment Program to ensure the most effective and cost effective operation of the program with consistency state-wide*."

The aim of the Review was stated to be "*to guide program change to better support clients to recovery."* Full Terms of Reference are set out in Appendix A.

As part of the comprehensive review it was decided that there should be a detailed program of consultation with all major stakeholders who had any connection with the OTP, ranging from providers of OTP services, pharmacists, medical practitioners, nurses, Local Health Districts, researchers, and above all, patients and their families, carers and support networks.

These consultations were undertaken from June to November 2014 by the Consultant with the support of the NSW Ministry of Health and in particular with the executive assistance of Ms Janet Forbes of the Ministry.

Over 60 meetings were undertaken and in addition the Consultant visited Lismore, Orange, the Hunter and Illawarra regions and Broken Hill as part of the process. Numerous visits were undertaken to individual clinics, pharmacies and general practice surgeries.

The principal professional organisations such as the RACGP and the AMA, the Pharmacy Guild and the Pharmaceutical Society were also consulted, as were the professional organisations of the nursing profession specialising in drug and alcohol services, and various Aboriginal Medical Services. The Consultant met with the NSW Mental Health Commissioner.

A round-table discussion was held with representatives of several other NSW Government departments and agencies (including the Police Service) which have some degree of involvement in the provision of services to people who might be patients of the OTP at some stage of their lives or where a patient's participation in OTP impacts (actually or potentially) upon their family or children.

Regrettably, the Consultation was unable to meet with the Ministry of Aboriginal Affairs during this process.

In addition, telephone consultations were undertaken with representatives of the West Australian, South Australian and Victorian Departments of Health and with clinicians and non-government organisation representatives in the Australian Capital Territory.

Within NSW, consultations also took place with the Agency for Clinical Innovation, the Clinical Excellence Commission and the Justice Health and Forensic Mental Health Network.

The Consultant also made a visit to the Maudsley Hospital in London and met with leading practitioners in the field, following this up with a further international teleconference. Full details of the consultations are provided at Appendix B.

Given that this program has been the subject of innumerable reviews over many years[1] and that its future has always appeared problematic, it is not surprising that among the initial reactions to the approach of the Review team to various stakeholders there was a degree of suspicion and cynicism and a concern that this exercise was merely window-dressing or a covert attempt to provide grounds for the program to be curtailed or indeed abolished.[2]

The most serious concern expressed was that the Terms of Reference appeared 'loaded' in favour of a policy of 'recovery' and that this objective was to be imposed on the program regardless of the evidence which might or might not support such an approach.

Over the course of the review process there is reason to believe that these concerns were addressed and the bona fides of the process was established and accepted. Indeed, there

was a high degree of willingness to participate in the review process and the consultations themselves were most valuable and informative.

The Review also benefitted from a great deal of material supplied to it by various participants both at the meetings and subsequently.

By way of further background it was noted that new *National Guidelines for Medication-Assisted Treatment of Opioid Dependence* had been promulgated and endorsed by the Australian Health Ministers' Advisory Council in November 2013. The current NSW Guidelines [*NSW Opioid Treatment Program – Clinical Guidelines for methadone and buprenorphine treatment of opioid dependence*] were issued in 2006 and are currently subject to revision in light of the new national guidelines and in light of advances in pharmacology and treatment practices. Consultation partners expressed a keen desire for revised State guidelines to be published as quickly as possible, accepting that they may well be influenced by the outcome of this Review and so needed to wait upon its conclusion and any decisions made by government as a result.

It was also noted that Siggins Miller Consultants were currently undertaking a review of the national OST strategy for the National Reference Group (via work with the Tasmanian Department of Health) and that they had issued a Background Paper on 1 September 2014. The Consultant had a useful discussion with the Siggins Miller researchers involved.

The Aims and Objectives of the Opioid Treatment Program

The current NSW *Guidelines*[3] state:

> "The aims of methadone or buprenorphine treatment are to:
>
> - Reduce or eliminate heroin and other illicit drug use by those in treatment
> - Improve the health, psychological functioning and well-being of individuals and families
> - Facilitate the social rehabilitation of those in treatment
> - Reduce the spread of bloodborne diseases associated with injecting opioid use
> - Reduce the risk of overdoses and deaths associated with opioid use
> - Reduce the level of involvement in crime associated with opioid use."

Similarly, the Ministry's paper *Review of the NSW Opioid Treatment Program* states[4]:

> "*Treatment of opioid dependence is a set of pharmacological and psychosocial supports aimed at reducing or ceasing opioid use, preventing future harms*

associated with opioid use, and improving quality of life and well-being of the opioid-dependent patient."

There is overwhelming evidence that these stated aims have been achieved by the OTP[5]. Lives have been saved.[6] There is recent evidence that OTP protects against hepatitis C virus acquisition in people who inject drugs.[7] The use and significance of the OTP as an intervention to assist in the management of bloodborne viruses in general and HCV in particular is a major positive public health intervention.

Starting with methadone alone in Australia in 1969[8], the OTP now provides access to

- Methadone (methadone syrup, Biodone Forte). Swallowed as syrup.
- Buprenorphine (Subutex)
- Buprenorphine-naloxone (Suboxone). Taken in the form of sublingual film.

Advice was provided in the course of consultations that at least one pharmaceutical manufacturer is investigating the introduction of a monthly depot injection and the first swallowable tablet form of buprenorphine. It is to be expected that in the course of time further forms of medication will be added to the OTP armamentarium.

The Consultant is not qualified to make judgements which require clinical, medical or technical expertise but is able to be well satisfied that the overwhelming weight of evidence is to the effect that OTP is successful in achieving its stated aims.

It certainly has the practical effect of keeping people more healthy than they would otherwise have been but for participation in the OTP and thus out of hospital, which is one of the stated goals of the State Government's NSW 2021 Plan to Make NSW Number One.[9]

The Current Operation of the NSW OTP

All Australian States and Territories operate some form of OTP, and as usual in our federation, none of them are exactly the same. Indeed, NSW has a number of features which distinguish it markedly from the majority of other jurisdictions. For example:

- NSW has 156 public prescribers (out of a national total of 270) whereas Victoria has none
- Despite its higher population NSW has only 636 prescribers compared with 821 in Victoria
- NSW operates a Pharmacy Incentive Scheme which is not replicated in any other State

- There is a limit (50) on the number of patients who may be treated at any community pharmacy. Victoria imposes no such restrictions

- NSW appears to take a more 'liberal' approach to the provision of take-away doses compared with most of the other States or Territories.[10]

The NSW system operates within a legislated regime outlined in the NSW *Poisons and Therapeutic Goods Act 1966* and the *Poisons and Therapeutic Goods Regulation 2008*. These are supplemented by various Guidelines and Policy Directives issued by the Ministry of Health[11].

In brief, there are three principal elements to the scheme:

- Prescribing: this is done by qualified medical personnel who have been authorised as prescribers by the Ministry of Health and work in private practice, public or private treatment clinics or primary health settings, or within the custodial system[12]. To become a prescriber: applicants must submit a formal request for approval to NSW Health indicating that they are interested in attending the Opioid Treatment Accreditation Course (OTAC) and providing relevant other details. The application will be assessed by the Ministry's Pharmacotherapy Credentialing Subcommittee.

- Dispensing: can be done in a public clinic or hospital, a community pharmacy, a private clinic or within the custodial environment. Pharmacies have to register with the Ministry of Health and meet criteria set out in the *Regulations* (see below), including being registered under section 90 of the *National Health Act* as approved to supply pharmaceutical benefits.

- Counselling: can be provided in any of the prescribing or dispensing environments or locations or within services specifically provided by non-government organisations (NGOs).

Patients enter the OTP after they have been assessed by a qualified practitioner. The NSW *Guidelines* outline the basis on which these assessments are undertaken and focus on establishing an effective therapeutic relationship with the patient and the development of a relevant treatment plan. Where a practitioner wishes to prescribe OTP they must gain authorisation from the Ministry of Health. General Practitioners without accreditation are limited to the prescribing and management of up to a maximum of five stable OTP patients who have been transferred from an accredited prescriber. Only an accredited prescriber is able to initiate a patient onto the Opioid Treatment Program. If a GP wishes to prescribe for more than five patients they must complete the Opioid Treatment Accreditation Course.

Patients may be inducted into the OTP via the program run by Justice Health for people within various forms of custodial care. People may also initially come into contact with the OTP through the Drug Courts or the MERIT (Magistrates Early Referral into Treatment) program.

NSW Health publishes a *Treatment Agreement* which outlines the conditions of methadone / buprenorphine treatment in terms of patients' rights and responsibilities.[13]

Once a patient has entered the program they are provided with access to a treatment/dispensing point which may be located in a clinic, hospital or community pharmacy. An important difference between these dispensing points is that in public clinics of hospitals, patients are not required to pay for their medication, whereas in private facilities or community pharmacies they are required to pay a dispensing fee (the medication itself is provided at no cost by the Commonwealth Government) which may vary considerably in amount.

Once patients are "stabilised" within the public clinic system they may be "transferred" to the care of a community pharmacy for the continuation of their treatment. There is a current limit of 50 patients who may be treated at any single community pharmacy.

Treatment may take place within an approved setting (clinic or pharmacy) and patients may be provided with take-away doses to cover for events such as closure of the pharmacy, public holidays, travelling away from the treatment site, where they have shown themselves to be stable and compliant with treatment requirements.

Retention in the program is dependent upon the patient's adherence to certain requirements and random urine screening is used to determine if the patient is still using illicit substances. 'Failure' of such a test does not lead to removal from the program but may result in the patient being transferred back from a community pharmacy to a public facility or the withdrawal of take-away privileges.

On a "snapshot day" in June 2012 of the 18,715 patients in the OTP (now approximately 19,870) 57.8% were prescribed in the private sector, 32.8% in public clinics and 8.0% in a correctional facility. Half of the patients (50.1%) were dispensed in a community pharmacy, with 16.9% in a public clinic and 8.4% in a correctional facility.

Financing for the OTP comes from three sources:

- The Commonwealth Government pays for the medication itself and for GP services rebated through Medicare – approximately 24% of total funding
- The State Government funds public clinics and hospitals which both prescribe and dispense – approximately 43% of the total
- Patients pay fees for GP consultations and dispensing – approximately 37% of the total.[14]

The Issue of Unmet Need

There are approximately 19,870 people on OTP throughout NSW at the present time, including up to 1,400 being managed by Justice Health. [Justice Health has set an arbitrary

limit of 1,400 on the number of OTP places which it provides in 21 of its facilities. There are 8 correctional facilities, generally with low populations or operating as work camps, in which OTP is not available.]

There is considerable dispute as to the extent of the "unmet need" for places in the OTP, itself highlighting the paucity or poor quality of data which surrounds this program.

Unmet need arises from a number of reasons, not mutually exclusive, and including:

- People who do not want treatment
- People who engage some parts of the system but not through a formal OTP route
- People who cannot afford treatment
- People who seek treatment but cannot access it for reasons of geography
- People whose personal circumstances prevent them from accessing treatment suitable to their needs (especially in relation to management of family or carer responsibilities).

The lack of access in rural and remote areas is a significant barrier, as is the fact that many services are "full" and simply cannot provide more places – this is especially an issue within the correctional environment.

Some services reported during the consultations that their services had "no" or "minimal" waiting lists. Others suggested that a waiting list of up to two months could exist, while Justice Health indicated that waiting lists could be up to 5 months from initial screening (on entry to a correctional facility) to commencing on treatment if appropriate.

To date the most definitive study of unmet need is that produced by the National Drug and Alcohol Research Centre (NDARC) in October 2012. Using a variety of modelling they have estimated that unmet need could vary between 26% and 65% of the opioid dependent population, with a middle estimate of 30% to 50% which would represent somewhere between 7,000 and 12,000 individuals.[15]

The data in the NDARC report is comprehensive but relies on a number of assumptions, including the extent to which individuals want to join the OTP as distinct from potentially being eligible to do so. Nevertheless these figures appear to be the best currently available and are produced by the acknowledged leading research organisation in this field.

In another study, Australian researchers estimated that the number of dependent opioid users in Australia in 2010 was in the order of 93,000 whereas only some 47,442 people were on OTP, leading to the conclusion that approximately 45,000 people who could benefit from OTP were not in any program. This represents an estimate at the upper range of the NDARC study cited above but is generally in line with its conclusions.[16]

Apart from the general issue of unavailability of an important public health service, there is some evidence from the international literature that rates of mortality are particularly high among opiate-dependent individuals who are on the waiting list for entry into OTP.[17]

The Current and Changing Nature of the OTP Population

As of December 2013 the age profile of the OTP population was: aged 10 to 19 years (20.5%); 20 to 29 (10.5%); 30 to 39 (34.1%); 40 to 49 (31.8%); 50 to 59 (20.5%) and over 60 (3.1%). Over the years the OTP population has aged and this in itself adds to the burden of health management as the issues of opioid dependence conflate with those of ageing. One paper suggests that there may be as many as 30,000 regular opioid users in Australia over the age of 40.[18]

Length of treatment profiling reveals that 24.7% are in OTP for less than six months and 8.6% less than one year. Thereafter, those in OTP from 1 to 3 years comprise 28.3%; 3 to 5 years 14.5%; 5 to 8 years 10.9%; 8 to 10 years 4.9% and over 10 years 8.1%.

Apart from being an ageing population there is an increasing presentation into the OTP of people whose dependence is on prescribed opioids, especially pain management medications such as oxycodone and over-the-counter codeine based formulations (eg Nurofen Plus[19]).

There has been much discussion about the rise in prescription of opioid medications and comments about an "epidemic" of chronic non-cancer pain. Between 1992 and 2012 opioid dispensing increased 15-fold with the cost to the Commonwealth budget rising from $8.5 million to $271 million. Opioid-related hospitalisations increased from 605 cases to 1464 cases (1998-2009) outnumbering hospitalisations due to heroin poisonings since 2001.[20]

The NDARC has undertaken some profiling of people entering treatment as a result of pharmaceutical opioid dependence showing that 66% initiated such use for pain management and 13% "to get high". About half of this sample reported using both heroin and non-medical pharmaceutical opioids. The mean age of such users was 40.7 years and just over half (525) were female. Again over half (52%) reported moderate to severe depression and 82% had experienced some form of trauma with 31% reporting a previous suicide attempt. Substances used in recent times included nicotine (73%); cannabis (42%); methamphetamines (26%); alcohol (61%); illicit benzodiazepines (20%) and heroin (17%). Some 58% had previously injected drugs and 68% had experience of previous drug or alcohol treatment.[21]

It is beyond the scope of this Report to make comment on steps which might be considered appropriate to address this issue, other than to note that most professional advice is against an overly regulated response to opioid prescription both because of its value in dealing with

pain management, but also because of a fear that creating an artificial shortage of such opioids would precipitate some people back into the use of illicit drugs such as heroin.

From the OTP point of view, the important thing to note is that this is resulting in the profile of the OTP demographic changing: moving away from people who are dependent on illicit drugs and hence associated with some form of criminality, to those dependent on legally prescribed medications. This is not to say that there is not an illicit trade in prescribed opioids, some of it involved with serious organised criminal behaviour. Instances were drawn to attention of cases where elderly patients who had prescribed opioids for pain management were being coerced (usually by family members) into diverting them for the use by others, or of elderly patients obtaining such medications by deception (improperly claiming to be in pain) and then selling them.

The seriousness of the misuse of oxycodone preparations was highlighted in recent discussions at the hearings of the Senate's Community Affairs Legislation Committee examining the Estimates of the Commonwealth Department of Health. The Commonwealth Chief Health Officer (Professor Chris Baggoley) reported data indicating a significant rise in the misuse of oxycodone preparations and even the injection of supposedly "tamper proof" preparations.[22]

One aspect of this changing demographic is that more people in the OTP are living their lives fully integrated into the community in terms of being in stable/regular employment, one aspect of which is that it is often very inconvenient for these employed people to attend at a pharmacy for treatment during their working hours. Many pharmacies are not open at the times that people are travelling to or from work, and finding time to manage both regular attendance at their workplaces and appointments at a pharmacy is increasingly problematic for many patients. Successful participation or reintegration in the world of work is a major (perhaps the major) indicator of the capacity and prospect of a patient to eventually exit from the OTP, and barriers such as this are major disincentives for this occurring.

There are also regular cases coming before the Pharmacy Tribunal of NSW dealing with pharmacists diverting such medications, often for their own dependence use or for illegal sales.[23]

[A Cautionary Note: recent reports suggest a significant revival of heroin use in the United States as cheap supplies become increasingly available, and linked with an enhanced appetite for prescription painkillers[24]. Warnings have been issued by US authorities to counterparts in Australia to anticipate such developments here. Similarly, recent reports of the success of manufacturing morphine, codeine, oxycodone and hydrocodone from a process based on a synthetic yeast preparation using biotechnology techniques, has the potential to allow for the creation of these products in factory settings totally divorced from their natural origins in the poppy fields.[25]]

PART TWO: OUTCOMES OF THE CONSULTATIONS

At this stage it is appropriate to report on the general outcome of the Consultations themselves and to reflect, as faithfully and accurately as possible, the concerns which were expressed to the Consultant many of which were followed up with further written submissions.

It may be useful to divide the consultation participants into a number of generic groups as there tended to be a high degree of agreement within such groupings whereas the differences that emerged were more likely to be between them.

1. Patients and their Organisations

Wherever possible, the Consultant sought to engage directly with patients in the OTP and was very grateful for the extent to which this was facilitated by a number of clinics and health services. Otherwise extensive consultations took place with community groups and organisations who represent the interests of OTP patients, either being disease specific in focus (eg HIV or HCV), or focussed on behavioural issues (SWOP, NUAA) or specific demographics (WIPAN – women in prison).

Overwhelmingly the feedback from these consultations identified the following issues:

- The impact of stigma and discrimination against patients of the OTP
- The financial burden of OTP payments related to medical and dispensing fees
- The unavailability of services outside major metropolitan centres
- Failure to provide support services for families or carers of people in the OTP
- Failure to involve 'consumers' in discussions about the development, management and operation of the OTP
- A willingness to be engaged with aspects of the OTP but only with a greater understanding of the NGO funding model proposed for introduction in 2015
- The lack of related psychosocial support arrangements for OTP patients. [In this Report the term "psychosocial support" is used in preference to the term "counselling" as it implies a far greater rage of support services and wider interventions.]

2. Health Service Providers

Included in this category are medical and other health professionals and providers, pharmacists, nurses and specialist health service providers, such as pregnancy services. Their issues were primarily:

- The over-regulation of their activities primarily by the Ministry of Health and occasional uncertainty about requirements imposed on the professional participants in the OTP. Among issues raised here were:
    - Caps on numbers of patients at pharmacies
    - OTAC requirements for prescribers
    - Limits imposed on issuing licenses for additional private clinics
- The lack of support from their own professional organisations directly related to OTP
- Lack of access to workforce and professional development opportunities
- Lack of co-ordination between services, even within small geographic areas
- Lack of integration of numerous NSW Health policies with the OTP (for example the pain management policy or anti-smoking initiatives)
- Lack of access to PBS support for some items and of an appropriate Medicare Number to cover addiction medicine services
- Difficulty in knowing how to manage some of the personal difficulties associated with their actual or potential OTP clientele and uncertainty about their ability to refer such patients back to care in the public sector
- In the case of Nurse Practitioners, failure to recognise and respect their status as such.

3. Clinics and Rehabilitation Facilities

There are a number of distinct interests within this category: private clinics, public clinics treating a general opioid dependent population (some with specialist services such as the Medically Supervised Injecting Centre), and those providing residential and rehabilitation (including abstinence or therapeutic community models) services. Their concerns included:

- Over-regulation of their activities, primarily by NSW Health

- Some confusion between Commonwealth and State requirements, reporting and accountability
- General reduction in government funding for their services
- Lack of co-ordination between NSW Health with other relevant State Government departments and organisations such as Centrelink.

4. Health Administration Organisations

These were primarily the Local Health Districts, Specialty Health Networks (Justice Health, NSW Kids and Families), Aboriginal Medical Services, and OTP Managers within the public hospital/clinic environments and the NSW Mental Health Commission. Their issues included:

- Uncertainty of guaranteed long term funding for the OTP at both the Budget level and in relation to allocations within Local Health Districts.
- Frustration at being unable to meet perceived demands and provide places or manage waiting lists
- Feeling under pressure to provide places in OTP when resources already stretched (eg sudden arrival of new patients from Justice Health or MERIT program)
- Perceived lack of clarity about the aims and (measurable) outcomes of the OTP
- Lack of a co-ordinated approach between NSW Health and other state departments and agencies
- Problems in accessing workforce development opportunities
- A sense of bewilderment at where pillars such as CEC or ACI relate to OTP activities
- Their legal responsibilities in areas which touch on matters of discrimination, reporting and managing “difficult” patients.

5. Professional Associations

These included the Australian Medical Association, Royal Australasian College of General Practitioners, Pharmacy Guild, Pharmaceutical Society, Chapter of Addiction Medicine, Drug and Alcohol Nurses (DANA), specialist Nurse Practitioners, and specialist pregnancy and ante-natal services. Not surprisingly their concerns tended to focus on:

- Institutional and financial arrangements with NSW Health and with aspects of Commonwealth payments and rebates
- Control of entry and recognition of professional qualifications
- Lack of undergraduate education about aspects of OTP in relevant university courses.

6. Others

Consultations with various research organisations (ANCD, NDARC), numerous individuals, other Australian jurisdictions and overseas contacts, and other NSW Government departments and agencies yielded comments on a number of matters including:

- General lack of co-ordination across the whole of NSW Government leading to the establishment and maintenance of a silo-approach to a state-wide challenge
- Lack of co-ordination in Commonwealth and State funding arrangements and in the provision of a coherent and co-ordinated national framework for dealing with a nation-wide challenge
- The difficulty of access, analysis and interpretation of meaningful data upon which to base further developments in OTP policies and strategies.

Not all of the issues raised were necessarily well grounded in fact and many resulted from a simple misunderstanding of, or lack of information about, critical policy and administrative matters. This of course, is a concern in and of itself if information is not readily available or is not well understood by the people for whom it is intended.

Nevertheless there was a consistency about many of the issues raised.

Arising from consideration of these issues, ten clear areas were identified as being worthy of specific consideration and the development of appropriate recommendations.

These were:

1. Stigma and discrimination
2. Pharmacy-related issues
3. General Practitioner issues
4. The interface between the provision of public and private health services

5. Whether in fact a “one-size-fits-all” was an appropriate model for the future development of OTP services given the changing nature of the OTP population, or whether this offends the principle of equity in the provision of health services

6. The role of the NSW Ministry of Health as policy maker and regulator

7. The opportunities for NGOs to play a more active role in the provision of and support for OTP

8. Exit strategies and possibilities for exiting being more proactively promoted as an integral part of the OTP in line with the Terms of Reference

9. Issues of workforce and personal development, training and education, together with access to professional and peer support

10. Issues related to national policy responsibility in this area, national policy co-ordination and changes in structural and financial arrangements related to the OTP.

A briefing note outlining this summary of issues was sent by the Consultant to all those who had participated in the consultations with a request that they comment further on any or all of these issues so that their final input could be considered in the preparation of a final report. Response to this initiative was very positive and a number of useful final comments were available for consideration in the preparation of the final report and recommendations.

It is in relation to each of these issues that this report now proceeds.

PART THREE: ADDRESSING THE ISSUES

Having identified the principal issues which have arisen both in terms of the consultations and from the observations of the Consultant, it is proposed to address each of them and make any recommendations which seem appropriate.

1. Stigma and Discrimination

No issue figured more prominently in the responses of patients, families, carers and their organisations than the enormous extent of stigma and discrimination experienced, directly and indirectly, overtly and subtly against patients in the OTP.

Numerous examples were given, for instance:

- Clients in pharmacies being made to wait for (treatment) services until everyone else in the pharmacy had been served or until the pharmacy was empty
- Pharmacies or health centres where OTP patients were required to enter and exit by separate doors from the general patient population
- Patients were told that they would only be attended to at certain times of the day
- Disparaging remarks made by service providers about OTP clients, often reflecting on their status or perceived lack or moral strength/worth
- The frequent use of terms such as “dirty” urines (where urinalysis tests have shown positive for continuing illicit substance use), or even the term “dosing” (instead of a term such as “treatment provision”) may be seen as redolent with prejudicial overtones
- Lack of respect for, or understanding of, the privacy rights of OTP patients.

These instances reflected a study published by AVIL (Australian Injecting and Illicit Drug users League) in 2010[26], indicating that little had changed in the last few years.

Stigmatisation and discrimination has been a regular feature of the operation of health services provided to people whose illness is perceived as having some aetiology in transgressive acts such as drug taking or sexual behaviours. Previous reports from the NSW Anti-Discrimination Board dealing with HIV[27] and Hepatitis C[28] have drawn this matter to the attention of government authorities in NSW and there are numerous works which describe the impact of stigmatisation on reducing health outcomes for those suffer from it.[29]

This problem, or threat, is not unique to Australia. A review of the history of the OTP in New Zealand noted:

> "Although changes in approach have occurred over … time, influenced by various sociopolitical events and changing ideologies, opioid substitution treatment has still not 'come of age'. ***It remains undermined by stigma.***"[30] (emphasis added)

(a) Stigmatisation in the pharmacy

Among the many reasons why pharmacists may be reluctant to participate in the OTP, the issue of stigmatisation and misunderstanding of the nature of the OTP client population arises on a regular basis. There have been several studies touching on this issue, including the AVIL Report mentioned above.

Adam Winstock and colleagues examined some of the problem experienced by community pharmacists in delivering OTP services and concluded that many of these arose from problems which pharmacists had in communicating with and managing clients perceived to be 'difficult' or unstable.[31] They drew attention to situations where pharmacy staff felt threatened by patients perceived to be unstable or aggressive and noted that in many instances younger female staff often found it difficult to engage with such clients and that pharmacists or pharmacy managers expressed particular concern for the welfare of such staff.

A 2013 study into factors influencing pharmacists' participation in provision of OTP services in the community pharmacy setting in NSW found that:

> *"Factors influencing non-providers were mainly stigma and fear, the nature of an opt-in scheme, professionals' moral responsibilities, lack of awareness and knowledge, disproportionate distribution of clients and lack of financial support for OTP clients".*[32]

The Pharmaceutical Society of Australia publishes a *Code of Ethics for Pharmacists* which lists as its first item:

> *"A pharmacist recognises the health and wellbeing of the consumer as their first priority"*

and goes on to enjoin members to respect 'the dignity and privacy of the consumer." It also requires recognition of:

> *"consumers who are particularly vulnerable and (that pharmacists must) tailor the provision of care accordingly."*[33]

Regrettably, the consultations revealed that these fine aspirations and aims in the Code are not always observed and followed.

(b) Stigmatisation in General Practice

Although the AMA's *Code of Ethics* specifically enjoins its members to:

> *"refrain from denying treatment to your patient because of a judgment based on discrimination",* there is nevertheless ample evidence that this occurs on a regular basis.[34]

Numerous studies have suggested that General Practitioners have an essentially negative, a priori view of potential clients of the OTP[35], that they express concerns that other patients will find it threatening or unpleasant to share a waiting room[36] with them, and that they fear being thought less of by their professional colleagues if they entertain an extensive practice with OTP patients on their books.

One author writes:

> *"As well as committing economic suicide by working harder, GPs entering the drug and alcohol field will work in the dark with ongoing denigration of their practices and beliefs."*[37]

Despite the evidence that such negative attitudes towards OTP patients are unfounded and unjustified and that evidence that other patients will be concerned about proximity to OTP patients (even if they could identify them), discriminatory practices abound. A further provision of the AMA *Code of Ethics* which permits a doctor to "*decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one*"[38] provides a neat, if somewhat tendentious excuse.

Further factors which appear to influence GPs against participation in the OTP include: significant economic concerns related to Medicare payments; a general lack of education in their undergraduate years about drug and alcohol issues generally and OTP in particular; and lack of specialist support and advice if they do decide to participate.

It will be argued (below) that discrimination against OTP patients, on the basis that they are people with a "disability" as defined in the *Anti-Discrimination Act (NSW) 1977* and as provided in the *Disability Discrimination Act (Cw) 1992,* constitutes a breach of these Acts rendering the perpetrator potentially liable for action to be taken against them. In the event that such perpetrators are employees of the State of NSW then it is the State (or the relevant Department) which would be held vicariously liable for the actions of its employees, agents or servants.

It would, of course, be much better that no such action would be required in order to ensure that OTP patients are treated with the same degree of respect and dignity as any other patient of the health system, or indeed any other person in the community.

In the course of the consultations almost all service providers were asked about their knowledge of formal anti-discrimination requirements and obligations. The same questions were asked of major organisations such as the AMA and the Pharmacy Guild and of Government Departments and Agencies (including the Ministry of Health). They were asked of clinics and of individuals. In almost every instance there was simply no knowledge of legal obligations related to non-discriminatory behaviour, no evidence that any anti-discrimination training or information had been provided, and a general lack of understanding of the entire issue.

When practices which were discriminatory were drawn to attention, the general response was that ”custom and practice” in this area had always been observed and that such issues had never been raised.

Lest it be thought that the environment was uniformly bleak in this regard, it should be noted that a number of community based organisations and the overwhelming majority of private clinics were far more aware and alert to this issue and far more proactive in addressing it.

It is of course, hardly surprising that clients of the OTP are unlikely to be strong or well informed advocates in their own behalf. Many of them (perhaps a majority) are among the most vulnerable, most marginalised, most disempowered and often uneducated members of the community. They are effectively mendicants within a system which dominates their lives on a daily basis. They feel vulnerable and act accordingly.

There were certainly no programs either in the educational courses (especially university undergraduate courses in medicine or pharmacy) or offered by leading professional organisations, which sought to address this issue.

When patients of the OTP become almost acculturated to acceptance of their treatment in a less than best practice fashion, the whole system becomes self-replicating and self-perpetuating.

Discriminatory or stigmatising practices have no place in any decent health system. They should not be tolerated and steps should be taken to reduce and eventually eliminate them.

As Commissioner Garling stated more generally in relation to NSW Health:

> *“To start with, a new culture needs to take root which sees the patient’s needs as the paramount central concern of the system and not the convenience of the clinicians and administrators.”*[39]

NSW Health has already taken major steps to bring about the degree of culture change which Commissioner Garling advocated, but there is still further to go in relation to the way in which OTP patients are treated. Professional organisations such as the AMA and the Pharmacy Guild lag even further behind in relation to education and training of their members.

It is thus recommended that:

R1: NSW Health consult with the NSW Anti-Discrimination Board to develop specifically focussed training and educational modules which should be promoted to and used by all sectors of NSW Health which are involved in the provision of OTP services, and

R2: NSW Health should engage with the major medical and pharmaceutical professional organisations to ensure that such training and educational modules are promoted to and used by their members who have any responsibility for the provision of OTP services.

2. Pharmacy- related Issues

(a) The Pharmacy Incentive Scheme

NSW is unique among Australian jurisdictions in having a Pharmacy Incentive Scheme (the Scheme) which in effect, pays individual pharmacists to dispense OTP medications. The Scheme emerged as a result of initiatives taken at the NSW Drug Summit in 1999 and although originally scheduled as only a four year program, has been maintained ever since.

The essential features of the Scheme are:

- An initial payment of $1,000 is offered to each pharmacy practice to enrol in providing treatment or dispensing services for OTP medication
- A further payment of $100 per patient (up to a maximum of 20 patients) is paid for each OTP enrolment – patients must be dosed continuously for two months and payments are made twice each year
- Pharmacies may dose up to a maximum of 50 patients (although patients who are dosed only once each week are excluded from the cap)
- Pharmacists are free to charge a 'dispensing' fee to OTP patients with this fee being set at the determination of the individual pharmacy.

The Scheme is uncapped in terms of costs to NSW Health and in 2013/14 a total of $1,529,162 was allocated for payments.

As at 30 September 2014, there were 704 community pharmacies registered as participating in the Scheme and community pharmacies provided treatment/dispensing services for just over half of the total OTP population.

There are elaborate provisions in the both the *Poisons and Therapeutic Goods Act* and the related *Regulations,* covering the operation of the dispensing and treatment processes, including the detailed requirements about the way in which prescriptions are written by prescribers, transmitted to pharmacies and recorded. State regulations are supplemented by further regulations and requirements imposed under Commonwealth authority which relate to the control and management of Schedule 8 drugs.

During the course of the consultations three regulatory matters were raised on a number of occasions:

- The cap on pharmacies limiting their OTP client base to 50[40]
- The requirement for OTP medication prescriptions to be "*in the handwriting of the person by whom the prescription is issued"* [41]and
- The requirement that prescriptions be transmitted by the prescriber to the pharmacy by use of fax machine.

Despite the existence of the Scheme, NSW in 2013 had a level of pharmacy participation (at 32%) which is lower than the national average (36%) and significantly lower than States such as Western Australia (46%) and Victoria (38%) where no such financial incentives are provided.[42] Although recent data suggest this State is now closer to the national average with 704 of 1901 NSW pharmacies participating, rates still remain below other jurisdictions.

Similarly, while NSW has a cap on patients per pharmacy, this is not the case in other States and in some, such as Victorian pharmacies, may be providing services for several hundred clients – with no indication that this service is of a lesser quality or standard than NSW provides.[43]

In discussions with NSW Health, the Pharmacy Guild has apparently indicated that 23% of participating pharmacies may no longer participate in the OTP if the Scheme was removed; that 42% indicated that the Scheme was a major incentive in their decision to dispense and that 74% would increase their dispensing fees in the absence of the Scheme.

However, a study by IAB Services in 2008 suggested that most pharmacists participated in the OTP as a result of their feelings of "social obligation" or to provide support for existing patients/clients and their families. It appears that incentive payments make up only about 10% of gross income for a pharmacist dispensing 25 patients at $35 per week and that incentive payments make only a small contribution to overall program revenue.

Reinforcing this view, in all the consultations, when visiting pharmacies, the clear majority of them indicated that in the absence of the Scheme, they would continue to participate in the OTP as they saw this as an ethical responsibility on their part.

Each of the three issues identified above is capable of being addressed by amendment of parts of the *Poisons and Therapeutic Goods Regulation* (the Regulations). These regulatory changes would not need formal parliamentary approval although are, of course, subject to parliamentary disallowance.

In relation to the cap issue, particular attention has been drawn to the operations of Newcastle pharmacist Nicholas Bakarich who has responded to the 50 cap restriction by opening multiple separate pharmacies within that city, or by splitting one premises into two separate dispensing operations. His practices now service in excess of 230 clients. Mr Bakarich provided access to his premises during the consultation, met with the Consultant, and subsequently made written submissions.

Mr Bakarich draws attention to the fact that section 92 (1A) of the *Regulations*, introduced in 2013, prohibits the provision of OTP services unless they are provided "*at the premises of, and in the course of carrying on the business of, a retail pharmacy*" and further that the retail pharmacy is located on a premises which has approval to supply pharmaceuticals under section 90 of the Commonwealth *National Health Act 1953*. In effect this means that a policy decision has been made by NSW Health that OTP can only be supplied in a retail pharmacy by a pharmacist who is PBS accredited.

There appears to be little clear rationale for this policy.

If the aim and intent of the OTP is to increase the number of clients able to access OTP services, there appears no reason why, if the dispensing pharmacist is qualified, this should not be done from a premises which does not necessarily operate as a retail pharmacy but is otherwise compliant with the ethical and security standards expected by NSW Health and the pharmacy profession and authorities.

Similarly, obtaining PBS accreditation simply in order to be able to supply OTP medication is prohibitively expensive for any individual who wishes, in effect, just to conduct an OTP medication service as a stand-alone facility.

The actual cap number similarly has no clear rationale and indeed NSW appears to be unique, not just in Australia but internationally, in having such a restriction. There is an unmet demand and there are people willing, able and qualified to address that unmet demand that are prevented from doing so by this policy.

In relation to the issues of prescription writing and transmission; these requirements are set out in the *Regulations* which also provide flexibility for their amendment or prescription of alternatives. Section 80 (2) (a) specifies that prescriptions must be handwritten, but Section

80(2) (b) allows the Director General of Health to approve prescriptions written in "*such other manner*" as she decides.

Similarly Section 81 (1) provides that directions whereby "*an authorised practitioner may direct the supply of a drug of addiction orally, by telephone, by electronic mail or by facsimile*" but only in the case of an emergency.

The *Fifth Community Pharmacy Agreement* entered into between the Commonwealth Government and the Pharmacy Guild of Australia provides specific mechanisms for the *Electronic Recording and Reporting of Controlled Drugs,* and developments in NSW to move to a more electronically-based system of prescription management are in development.

It might also be added that this *Fifth Agreement* carries over a commitment to the implementation of a Community Service Obligation Funding Pool from the *Fourth Agreement* (2006) which claims to ensure that:

> *"all Australians have timely access to the PBS medication they require, regardless of the cost of the medicine, or where they live."*

A recent survey conducted by the Pharmacy Guild in NSW and provided to the consultation on a confidential basis (still in draft awaiting publication) provides a number of important and relevant statistics. These include:

- That among the 378 pharmacies responding to the Guild's survey, 335 dispensed methadone; 253 dispensed buprenorphine and 263 dispensed buprenorphine-naloxone
- A total of 5,062 patients were treated in responding pharmacies which had an average of 14 patients per pharmacy
- 82% (n=297)of responding pharmacies reported that they had additional capacity to treat patients and that their average additional capacity was 28 patients
- The average weekly fee for dispensing was $34.34 for methadone; $31.96 for buprenorphine and $ 29.55 for buprenorphine-naloxone. A further 3% (n=10) charged extra for takeaways
- 445 (n=160) were carrying outstanding fees from patients at an average level of $606.50 after a two week or more period
- Geographically, pharmacies in the Hunter New England region had the highest proportion of their patients on OTP (16%) compared with South Western Sydney (13%) and South Eastern Sydney (13%), with Central Coast, Western Sydney and Northern Sydney at 7%. Both South Eastern Sydney and Hunter New England pharmacies reported that the additional number of patients for whom OTP could be provided was considerable at 826 and 606 respectively.[44]

To fulfil the Review's aim of increasing the level of participation in, and access to OTP services, a combined approach is needed which both increases the number of participating pharmacies per se and increases the number of patients being treated in existing participating pharmacies. There might be greater benefit in metropolitan areas in expanding the number of participating pharmacies, whereas in more regional/rural/remote areas the key may be to increase numbers in existing providers. Clearly, both objectives should be pursued.

In the light of these developments and considerations, the following recommendations should be considered:

R3: The cap on pharmacies limiting their OTP patient load to 50 should be removed with consideration given to lifting the cap immediately to 100, progressively to 200 over the next one year period and thereafter, following further evaluation, be removed entirely.

R4: Section 92(1A) of the *Regulations* should be repealed and a regime developed to allow the provision of OTP medication from non-retail pharmacy outlets which operate as stand-alone OTP medication supply facilities and which do not require PBS authorisation to operate.

R5: A review be undertaken of all aspects of the writing, transmission, recording and managing of scripts for OTP medications with a view of developing a system which is streamlined, seamless and entirely electronically based.

(b) Dispensing Fees

As noted, the Scheme allows for pharmacists to set their own dispensing fees.

There is probably no more contentious issue in the current management of the OTP than the impact which dispensing fees has in relation to patient participation. Consultations revealed that the lowest dispensing fee reported was at $3.00 per occasion of service – equivalent to about $21.00 per week (at a community pharmacy in Broken Hill) to a high of $90.00 per week (at a private clinic in metropolitan Sydney). The average, to the extent it could be ascertained, was in the order of $35.00 per week.

Fees as reported during the consultations appear to be uniform for either methadone or buprenorphine, although there is rarely any differentiation between fees charged for supervised treatment and the mere handing over of prepared take-aways, despite there clearly being a differential cost to the pharmacist in providing such services.

It should also be noted that from advice given in the consultations and by direct observation in pharmacies visited, the extent to which individual pharmacists interacted with individual clients by way of engaging them in any sort of therapeutic role was highly variable – from

nothing (the patient enters, is identified, dosed, and leaves, all with two minutes) to more thoughtful conversations and engagement over a five or ten minute period. Much of this is also dependent upon the time of day of the interaction, most of which tends to take place first thing in the morning or last thing in the evening.

This needs to be set against the fact that a majority of OTP clients are not in full time employment and are (largely) dependent on social security payments of one type or another. The current Newstart Allowance for a single person with no dependents is $257.80 and for a partnered couple with no dependent $232.75 per week. The current maximum allowance under the Disability Support Pension is $388.35.

The impact of dispensing fees has been studied by various researchers.

A paper from the Australian National Council on Drugs (ANCD) indicated that dispensing fees in NSW tended to be generally higher than those in Victoria.[45]

A summary of all the reviews undertaken concludes that;

> *"All reviews have highlighted that fees are a significant barrier to treatment retention."*[46]

This however, is qualified by a further ANCD report which reports that:

> *"there appears to be some international research supporting the view that fees discourage entry into treatment, but little evidence to support the view that fees have an impact on retention."* [47]

The Centre for Research Excellence into Injecting Drug Use concludes its study:

> *"The evidence indicates that MATOD (methadone assisted treatment for opioid dependence) dispensing fees are a major barrier to treatment retention and represent a significant financial burden particularly for 65-75% of pharmacotherapy clients on fixed incomes or welfare support."*[48]

Chalmers and Ritter (2012) report that:

> *"A study of income support recipients in pharmacotherapy treatment in Melbourne reveals the financial hardship associated with dispensing fees. Patients would rather pay their dispensing fees and go without food or go to emergency organisations for food and accommodation, commit crimes and/or obtain loans from Centrelink."*[49]

They further note that:

> *"in health care generally, users fees are considered to be 'the most regressive form of healthcare financing available; they contribute to the unaffordable cost burdens imposed on poor households; and they represent one facet of the social exclusion experienced by these households.'"*[50]

A very recent paper by the Pennington Institute reports on a 1996 study showing that "outstanding fees were associated with almost half of treatment dropouts" and "urges further consideration of more "equitable ways of funding ORT services."[51]

Pharmacists themselves report that among the impacts of dispensing fees are that:

- many of them carry bad debts for their OTP clients which may impact their decisions to continue as OTP participants, and
- chasing OTP patients for outstanding debts compromises their therapeutic relationship with such clients.

It should be noted that the proposal from the Commonwealth for co-payments for access to certain medical services (eg doctor's consultations) has the potential to exacerbate these concerns.

In the Australian Capital Territory, the health authorities have come to an agreement with the local pharmacies whereby the pharmacies cap their dispensing fees to patients at $14.70 per week, with the ACT Health Department paying the balance of such fees directly to the pharmacists.

There are a variety of exceptions which should be noted, including the provision in Victoria for free dispensing for juveniles, fee relief provided for newly released prisoners in a number of jurisdictions, and special arrangements for pregnant women. In the United Kingdom similar fees are paid by the government for people in receipt of income support, and in Germany the national social health insurance scheme covers such costs.

Calculations (based on Pharmacy Guild data) have been made that the average cost of dispensing a daily dose of methadone is in the order of $3.27 and $3.29 for buprenorphine. The provision of take-away doses is considerably less.

In the response to concerns about dispensing fees a number of studies have addressed the alternative whereby dispensing fees are paid by the government and the Pharmacy Incentive Scheme is terminated.

The Consultant is in no position to make any assessment of the costs of such a proposal. It is understood that there are number of studies which have attempted to undertake this task, including those prepared for both the NSW Government and the Commonwealth.

The NSW study is:

- Jenny Chalmers, Kari Lancaster, Trevor King and Alison Ritter: *Pharmacy Participation in the NSW Opioid treatment Program: Options paper* (A report prepared for NSW Health, Drugs Policy Modelling Program, March 2011)

The Commonwealth study is:

- Feyer, A et al (2010): *A national pharmacotherapy model for pharmacotherapy treatment for opioid dependence in community pharmacy* (Australian Department of Health and Ageing).

There are two ANCD Reports:

- *Polygon – the many sides to the Australian pharmacotherapy maintenance system* (ANCD Research Paper no. 18, 2009)

- *Modelling pharmacotherapy maintenance in Australia – exploring affordability, availability, accessibility and quality using systems dynamics* (ANCD Research paper no 19, 2009)

A further study of significance is:

- Jenny Chalmers and Alison Ritter: "Subsidising patient dispensing fees: the cost of injecting equity into the opioid pharmacotherapy maintenance system, *Drug and Alcohol review* (November 2013), 31, 911-917.

The current system has its own in-built disincentive for people to move from a clinical (usually public) setting, into management within the community pharmacy environment. Dispensing fees mean that in making this transition the patient is moving from a free service to one in which they are required to make a financial contribution. There is thus a limited incentive to move, although the provision of take-aways, possible greater interaction with one regular health professional and possible geographic convenience, may be relevant factors encouraging transition. Failure to move out of the public clinic environment also reduces the opportunities for new clients to be taken into the public programs or may increase waiting lists for such access.

It is axiomatic that moving towards any scheme of paying the dispensing fees involved will involve an increase in expenditure for NSW Health, although whether some of the cost would be borne by the Commonwealth is unclear. Nevertheless there is a widespread feeling and considerable evidence that the Pharmacy Incentive Scheme has failed.

- It has failed to attract pharmacists to participate in the OTP resulting in lower rates of pharmacy enrolment in NSW than in other States where no such scheme exists, and lower than the national average.

- There is little evidence that its removal would diminish the number of participating pharmacists if they were instead guaranteed that dispensing fees (on a standard and uniform basis negotiated by NSW and the Pharmacy Guild) would be paid so that they would carry no bad debts and not jeopardise their therapeutic relationship with clients.

- The Scheme was originally intended to be of a limited duration (4 years) and has persisted without any clear statement that it has achieved its stated objectives.

On the other hand there is clear evidence that dispensing fees have a major impact on the ability of OTP patients to either access the program in the first instance, or remain on it, especially where those patients are in receipt of various forms of income support.

Inability to afford potentially life-saving medication the cost of which is provided for by the Commonwealth, because of the imposition of dispensing fees, should be unacceptable to the NSW Government and NSW Health in particular.

That having been said, there is an equally important argument to consider, namely that things which are free are often not valued whereas those in which an individual/patient has a more direct and immediate (financial) investment may be taken more seriously and valued. Similarly, where a patient makes a contribution (even a modest one) towards a service this is an indication of their preparedness to take a higher degree of responsibility for the management of their own life and affairs – something which should be a key goal of the OTP per se.

A compromise position between the wholesale take-over of dispensing costs by the State and the risk of financial disincentives preventing people from accessing or remaining on treatment can be achieved.

R6: That the Pharmacy Incentive Scheme in its current form be discontinued by July 2015 and replaced with an arrangement whereby the State pays the dispensing fees of:

***all patients whose sole or principal means of financial support is a pension or social security payment while they are in receipt of such payments**

*** all juveniles and pregnant women**

*** all other patients for the first twelve months of their participation in the OTP (this would be about one-third of the total cohort)**

Thereafter all OTP patients would be required to pay a dispensing fee which should be a capped uniform fee (taking into account different fees for different services) negotiated between NSW Health and the Pharmacy Guild. Pharmacists should be free to charge less than the agreed fee which should be subject to renegotiation every three years.

The same fee would be the basis upon which the State makes payments to the pharmacist.

Getting More Pharmacists Involved

Given the view that the Pharmacy Incentive Scheme has failed to induce a significant number of pharmacists to participate in the OTP, the question arises of what will.

In large part the precursor to this question lies in the area of pharmacy training and education. Consultations with the Pharmaceutical Society and others indicated that there was very little if any, attention given to OTP related matters in under-graduate training for pharmacists and not much more at general post-graduate level. It is clear that a start must be made in the earliest stages of training and education. Apart from education related to purely pharmacological issues related to OTP dispensing, managing and evaluation, an opportunity arises at this stage for such education to include matters of stigmatisation and prejudice which have already been identified as inhibitors of success within the OTP.

At the next level, there was clear evidence that a greater level of pharmacy participation was achieved where LHDs, local GPs, Medicare Locals and others set out on an active recruiting strategy to find and then support local pharmacists as part of an overall strategic approach, not just to OTP management but to a holistic attitude towards drug and alcohol management generally.

Key elements which helped attract pharmacists were:

- Ease or difficulty in completing NSW Ministry of Health registration requirements
- Education about the aims and objectives of the OTP and accurate advice about the nature of the potential client population
- Clear statements of support from the public health system guaranteeing that difficult or decompensating clients would be automatically and seamlessly re-accepted into public treatment facilities
- The establishment of peer groups and networks to support pharmacists starting out with OTP clients and the further development of support and advice networks amongst themselves
- Mentoring arrangements with established and experienced pharmacists available to those interested in commencing as OTP participants
- Advice about managing amenity issues related to the fear of becoming a “honey-pot” for a potentially difficult or marginalised population addressing matters such as the prevention of loitering, accessibility of police support services in emergencies, management of the physical arrangements within the pharmacy (eg treatment places, concerns about shop-lifting etc.), training of pharmacy staff participating in the program, and the management of relationships with neighbouring businesses.

- One pharmacist reported that his business had been the subject of on-going and vicious attacks on social media commenced by neighbouring businesses in a high street mall who objected to "the type of people" he was "attracting" to the area

- Several pharmacists whose businesses were located in shopping centres indicated that they would have been prepared to become OTP participants but had been prevented from doing so by order of the Centre Management

- Advice related to the financial issues involved, especially the management of bad debts and the start-up costs.

Lead responsibility in his area should lie with each Local Health District where it should be the responsibility of a specifically designated officer.

R7: NSW should engage with the relevant training, educational and professional authorities to ensure that education about OTP is included in all relevant undergraduate programs and that no pharmacist should be registered unless evidence was presented that they had completed such training.

R8: NSW Health in association with the Pharmacy Guild, and representatives of both client/user groups and Medicare Locals, should develop a Pharmacy OTP Development and Resources Kit which should cover at the least the items identified above, together with others which would successfully encourage the participation of more pharmacists in the OTP.

R9: Each LHD in NSW should designate an officer to be responsible for the proactive promotion of the Kit to pharmacists within the LHD and each Ministry/LHD Service Level Agreement should set targets for new pharmacy enrolments on an annual basis with such targets set taking into account the particular features of each LHD and the potential OTP population.

3. General Practice Issues

Many of the issues raised in relation to pharmacists, especially those of stigma and discrimination, negative attitudes about or towards patients, reluctance to participate in the provision of OTP services, and concerns about financial remuneration are shared in relation to general practice issues.

Negative (often false) perceptions by general practitioners and concerns about the potential attitude of “other” or “normal’ patients to the presence of OTP patients in waiting rooms, have been discussed above.

The reluctance of general practitioners to become OPT prescribers generally revolves around one or more of the following issues:

- Actual negative experiences dealing with OTP patients
- Anticipated concerns about the attitude likely to be taken by other patients or by practice colleagues or staff if a practitioner seeks to become a prescriber and develop an OTP client base
- Lack of confidence about personal skills, training, competence or peer support in the management of OTP patients
- Financial concerns re such matters such as inadequate Medicare rebate not reflecting the greater complexity and labour intensiveness of properly managing OTP and the (often) concomitant psychosocial support; together with concerns about potential bad debts.

The first two of these issues have already been discussed and so it remains to address the remaining questions.

Current regulations provide that General Practitioners without accreditation are limited to the prescribing and management of up to a maximum of five stable OTP patients who have been transferred from an accredited prescriber. Only an accredited prescriber is able to initiate a patient onto the Opioid Treatment Program. If a GP wishes to prescribe for more than five patients they must complete the Opioid Treatment Accreditation Course (OTAC) provided through the Faculty of Medicine at the University of Sydney. The course is offered both online and face-to-face. Data supplied by the OTAC providers indicates that there is a higher reported level of satisfaction with the face-to-face course (93% against 84%) but that there is a higher rate of completion/accreditation for participants in the online course (71% to 62%). There is no data as to why initial participants do not complete the course.

Data from the Ministry indicates that since 2012 there has been a decline in the number of prescribers accredited to provide OTP from 47 in 2012 to 47 in 2013, and 19 (to date) in 2014. In the same period the number of registrars[52] accredited fell from 39 in 2012 and 41 in 2103 to 21(to date) in 2014.

There appears to be no particular rationale as to why five patients should be the limit set. If each patient is regarded as fully equal there should no difference between the skill/capacity of a prescriber to prescribe and manage one patient as there is for five or six. Either specialist training takes place on entry and relates to the care and management of the first patient, or it should be no longer required. It is generally accepted that when a practitioner

delivering any medical service increases the number of procedures which he or she provides, the better they become and the better their patient outcomes. One assumes that the same would be true with the management of OTP patients.

Nor does there appear to be any evidence about the value/utility/effectiveness of the OTAC as such. In consultations there appeared to be a general level of satisfaction with the OTAC but no clear view about the extent to which it really enhanced the skill of the average general practitioner.

In the United Kingdom the Royal College of General Practitioners runs a six-month modular program for Substance Misuse Management in General Practice (SMMGP) which consists of seminars, online training modules, written assignments, site visits and an examination/assessment. The program website also provides detailed updates on developments and access to further information, course and peer support networks.

There is thus a dilemma as to whether or not the level of training for OTP general practitioners should be upgraded to ensure potentially better treatment of OTP patients as against the imposition of additional registration requirements which might be seen as burdensome, costly (in both time and money) and hence adding to the disincentives for participation in an already unpopular and marginalised area of general practice.

General Practitioners themselves (see above) express concern about both a lack of training, a lack of incentive (including incentives for CPD in this field), a lack of access to data, and a lack of peer support for OTP prescribers.

There is also a continuing view among many in the health system that OTP is a "specialist" area of practice and that it is unsuitable for integration into primary health care or general practice.

The SMMGP model cited above appears to address many of these concerns, as does a very positive initiative being undertaken by the Hunter New England LHD with the development of their *HealthPathways – Opioid Substitution Treatment – Methadone and Buprenorphine* website. This is a most impressive interactive site providing not only clinical and regulatory advice but also establishing links to peers and specialists which are easily accessible to any participant.

The level of prescription and over-prescription of opioids, primarily for pain management, is a vexed question and outside the scope of the review, except to the extent that an increasing number of people are presenting to OTP services as a result of their addiction to prescribed opioids. The management of this issue is the responsibility of other authorities although it is germane to this discussion in many ways.

A paper provided to this Review by Dr Simon Holliday (a notable expert and practitioner in the field of OTP) advised that:

"[A]n analysis of 2,949 opioid scripts written by 645 GP registrars (showed that) the vast majority were for repeat scripts. In terms of risk-mitigation strategies, only 2 urinary drug screens were ordered and there were no contacts with the Prescription Shopping Information Service. Opioid analgesics were significantly more likely to be prescribed to Aboriginals, males and from practices located in disadvantaged and more rural areas. These are exactly the same demographics predominantly presenting for OTP services."[53]

A number of suggestions have been made to address this problem, and the growing problem of prescribed opioid diversion, including the registration of OTP patients with one practice only at any one time (akin to the tradition UK-NHS model), while there are also cautionary warnings about moving to an overly-prescriptive regime which might force people back into the use of illicit drugs.

Similar comments should also be noted about the growing impact of over-the-counter products in leading to addiction problems.

The question of adequate Medicare rebates being available for complex OTP consultations and services was raised on numerous occasions. A similar point was made about the lack of availability of appropriate Medicare item numbers for services in addiction medicine generally. Such matters are outside the scope of this Review but it is recognised that this is a serious problem and one which ought to be brought to the attention of the Commonwealth which in March 2013 received a report from consultants on behalf of the then Department of Health and Ageing analysing this issue, but about which no decision has yet been made.[54]

The Involvement of Nurse Practitioners (NPs)

Despite denials from official spokespersons for various parts of the medical profession there is a distinct lack of respect for and support of the role of Nurse Practitioners in the provision of primary health services. While it is true that in many areas, notably Justice Health (which is predominantly a nurse-led model of care) or in areas such as at the Canterbury Drug Health Service where there is considerable reliance on Nurse Practitioners, the role of Nurse Practitioners is undervalued, underappreciated and underutilised.

Evidence indicates that of the 99 NPs who had been authorised in NSW, only 3 were practicing in the drug and alcohol area[55]. In the consultations, information was provided to the effect that there were only 10-12 such D&A NPs nationally. A study examining the barriers to NP participation in OTP concluded that one of the principal barriers was a "lack of internal support from management and colleagues"[56] along with disincentives involved in the considerable investment in time and effort to graduate from an RN to a NP without any adequate financial recognition of the value of such enhanced skills and services.

The greater utilisation of NPs in this area would have particular impact in remote/regional/rural parts of NSW where expansion of general practice services is more problematic.

Courses are offered by the Drug and Alcohol Nurses of Australasia (DANA) including those specifically designed to enhance skills within the OTP.

R10: Discussions should be initiated with the relevant medical education authorities to ensure that appropriate advice, education and training is provided in undergraduate medical and nursing courses to make students familiar with the issues in OTP, to address issues of stigma and discrimination against OTP patients, and to promote greater support for personal involvement in OTP after graduation.

R11: A kit, similar to that advocated in R8, be developed to assist in the recruitment and CPD of General Practitioners into the OTP and that initiatives such as the Hunter New England LHD *HealthPathways* be given active support by NSW Health. Emphasis should be given to the development and support of peer support and advice networks particularly to assist new entrants into the field of OTP prescribing.

R12: The *Regulation* restricting GP prescribing to five patients without specialist OTP training be re-examined to determine whether this number continues to be appropriate in the light of greater experience being available about the management of OTP patients and the availability of more online information to GPs who wish to prescribe for a greater number of OTP patients.

R13: The OTAC be subjected to external review to determine if it could be improved and the extent to which more GPs might be attracted to seek OTP registration were any such course more easily accessible as an online training module. Such a review should also consider the extent to which any such registration course should be mandatory, and if so, at what level for GP prescribers and how further CPD in this area could be enhanced or incentivised.

R14: Strategies to address the over-prescription of pharmaceutical opioids, risk-mitigation strategies associated with such prescribing, prevention of diversion, and proper control of pain management regimes should be developed in association with the relevant authorities.

R15: Positive steps should be taken by NSW Health to attract NPs to engage with the OTP, and their role in the provision of OTP services should be recognised and encouraged. Regulatory barriers to their capacity to prescribe OTP medication should be reviewed.

R16: NSW Health should seek Commonwealth support to address issues related to

inadequate Medicare rebates for complex OTP consultations and management and the provision of appropriate Item Numbers to recognise the provision of specialised addiction medicine services. The attention of the Commonwealth and all other jurisdictions might be drawn to the desirability of having the National Guidelines augmented and supported by a more co-ordinated national approach to recognition of prescriber registration, on-going professional development and the desirability of both OTP practitioners and OTP patients to move more seamlessly between jurisdictions. NSW may care to consider listing this as an item for a future meeting of the Standing Committee on Health.

4. The Public/Private Interface

NSW provides OTP services from both public and private clinics as well as from community pharmacies, although (in line with Victoria, Western Australia and South Australia) the majority of OTP patients are treated by private prescribers. Figures for 2013 indicate that approximately 57% of OTP patients received their pharmacotherapy from a private prescriber, 33% from a public prescriber, 1.5% from a public/private prescriber, and 8.5% from custodial facilities. By contrast, Victoria has no public or private clinics – all clients are either treated by private prescribers or in correctional settings.

A number of NSW public clinics have established reputations as centres of excellence in the provision of OTP services, most being associated with major hospitals (both public and private). In addition there are unique services provided at the Medically Supervised Injecting Centre.[57] Of the 39 public clinics in NSW, 19 are located within the Sydney metropolitan region. Most major country cities/towns have access to some public facility; however, Albury/Wodonga is managed by Vic Health and Wagga Wagga has no public clinic.[58]

Equally there are number of private clinics in NSW which have operated for many years and which have been an important part of the whole OTP. There are currently 12 such private clinics licensed (eleven in metropolitan Sydney and one in Wollongong). Several of them place considerable emphasis on encouraging their patients to exit from the OTP over a period of years, using either the Therapeutic Communities model or more direct abstinence programs.

In addition, there are a number of facilities operated by Non-Government Organisations which receive support from both Commonwealth and State governments and provide high quality, often residential care covering a variety of programmes. Several of these operate in

regional/rural NSW, often catering for the specific needs of the Aboriginal community or offering places to patients from interstate.

During the course of the consultations, visits were made to a number of these clinics and discussions were held with representatives of most of them – as they were with public clinics and their representatives.

It is important to maintain a system in which both public and private clinics operate and remain viable. Not only does this enhance the variety of services available, but competition also raises the standards across the entire sector and encourages learning and innovation. It is often the case that private clinics are able to be more flexible in such matters as their hours of opening.

It was however, a strong observation from the site visits that while some of the clinics (both in the public and private sectors) were open, attractive and welcoming, a number were small, dingy, prison-like and unattractive. Similarly, levels of patient-staff interaction varied considerably from a level of effective engagement to a level of dismissive unconcern.

Private Clinic Expansion

What private clinics appear to be able to do more effectively is to manage programs designed to lead patients to abstinence. There exists however, no data which would allow an assessment to be made of the extent to which patients leaving such clinics remain abstinent over a longer period of time, nor the cost-per-patient of such intervention services. It is also the case that access to private clinics may be affected by the capacity of the patient to pay the fees which are charged especially in residential settings.

In practice, private clinics tend to have more issues to manage related to questions of community amenity, especially as there is often resistance to such clinics being established in residential areas, both from local residents and from Councils. Where such clinics have been established they tend to place a very high premium on the management of amenity issues, and most appear to have been successful in this regard.

Nevertheless there is a strong case for the expansion of the number of private clinics throughout the State both to address issues of geographic disadvantage, to respond to the particular needs of Aboriginal communities, and to enhance the number of places available for people seeking to progress through structured programmes to abstinence.

There are currently regulatory restrictions on the approval of new private clinics by virtue of a regulation under the *Poisons and Therapeutic Goods Act.* Specifically, section 166 of the *Regulations* provides:

Part 8 Division 3

166 Consideration of applications

(1) After considering an application under this Division, the Director-General may issue the licence for which the application is made or may refuse the application.

(2) In particular, the Director-General may refuse an application if of the opinion that the applicant is not a fit and proper person to hold the licence for which the application is made.

(3) A licence may not be issued unless the Director-General is satisfied that the premises to which the application relates are appropriate for the manufacture or supply of drugs of addiction

4) The Director-General is not empowered to issue a licence under this Division for the supply, under the program known as the New South Wales Opioid Treatment Program, of methadone or buprenorphine to drug dependent persons (as defined in section 27 of the Act) unless:

(a) the licence is a replacement licence, or

(b) the application for the licence is made by or on behalf of an agency that:

(i) provides drug treatment services at premises under that Program to no more than 50 drug dependent persons who are resident at the premises while they are being treated, and

(ii) is a member of the Network of Alcohol and Other Drug Agencies Incorporated.

(5) To avoid doubt:

(a) subclause (4) does not affect the validity or operation of any licence to supply methadone or buprenorphine that was in force immediately before 30 June 2006, and

(b) the Director-General may:

(i) add conditions to, or vary or revoke the conditions of, such a licence, or

(ii) vary the premises to which such a licence relates, on the application of the licensee.

(6) In this clause:

replacement licence means a licence to supply methadone or buprenorphine that replaces such a licence which is in force immediately before the replacement licence is issued.

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The initial reasoning behind the introduction of the restrictions in s. 166(4) was apparently to try to disperse patients throughout the system and to deal with issues related to private clinic amenity concerns. This reasoning of course, fails to consider what is in the best interest of the clients, focussing rather upon what was perceived as best for the system and to avoid potential political issues.

There appears to be no continuing reason why this restriction should exist, and indeed, if the OTP is to be expanded and greater emphasis given to the availability of abstinence-based programs then it should be repealed. Its repeal and the establishment of more private clinics is in the best interests of patients.

Throughout the consultations most private clinic operators indicated an interest in the possible expansion of their existing programs. There was also evidence of a willingness of new participants to enter the program. There were concerns expressed at some of the public clinics about the expansion of private facilities – largely on the basis of their being available only to persons who might be able to afford their services or for reasons connected with ethical/ideological considerations. On the other hand a majority of consultation participants accepted that there was a need to maintain both public and private clinical options for OTP patients.

Public Clinic Responsibilities

Public clinics have the primary responsibility for assessing new entries to the OTP, managing them to a point at which they become stabilised, and where possible, facilitating their transfer into the community and their management in community settings. This will not be possible for all patients, either through lack of facilities/services to which patients can be referred, or due to the particular problems associated with their personal management, or because patients are reluctant to leave public clinics, especially for reasons of financial disincentive.

What is of paramount importance to the overall success of the OTP, is that it be accepted that there will always be an obligation on public clinics to provide a safety net for patients who are having difficulty or cannot be managed effectively outside public clinic settings.

On numerous occasions, when general practitioners or pharmacists were asked about their unwillingness to or concerns about participating in the OTP, the most frequently raised issue was what would be the case if a patient became “unmanageable” or decompensated in a way that the private provider no longer felt able to manage them.

There is only one answer to this – an acceptance that the public clinic system has an obligation to take back such “unmanageable” or severely decompensating patients and

ensure that they remain in treatment until they can be stabilised or until other arrangements can be made for their continuing and on-going management.

Although this imposes a burden upon the public sector, the provision of a 'safety net' with guaranteed entry for people in need, is clearly its responsibility, although it is accepted that this imposes major resource burdens, especially on LHD budgets. Appropriate financial arrangements between the LHD and the Ministry need to be in place to address this.

A New Approach

However, if it is accepted that the role of private clinics should be expanded, this should be done only within a strategic framework developed by the Ministry of Health which indicates areas in which it would be desirable for new private clinics to be established to meet assessed needs and with programs which are supportive of the policy objectives of the Program and/or the Minister. Consideration should also be given to benefits of supporting existing abstinence models or developing and funding new models.

R17: In order to enhance support for the OTP from private providers (including pharmacists, General Practitioners and private clinics) it should be accepted as a matter of policy that public OTP clinics will always act as "safety nets" and be prepared to manage or take back patients who cannot be managed outside the public sector or who have become "unmanageable' or have decompensated while in external treatment and can no longer be managed in that environment.

R18: As part of the Review of the OTP, NSW Health develop and publish a policy and strategic framework for the expansion of OTP services, including their expansion through private clinics, with particular emphasis upon the support therein of abstinence programs which have proven therapeutic and cost effectiveness. Once such a Strategic Plan is developed, consideration should be given to the variation or repeal of restrictions on new licences set out in section 166 of the *Regulations*.

5. One Size Fits All

Attention has been drawn to the changing demographic of the OTP patient cohort. They are getting progressively older and remaining in treatment for longer periods of time. Increasingly people on the OTP are less likely to be 'traditional' illicit drug/heroin users and just as likely to now derive their addiction problems from prescribed opioid or over-the-counter medications.

The question thus arises as to whether there should continue to be basically just one standardised approach to the provision of OTP? Does the increasing differentiation within the OTP cohort justify treating some of the patients differently from others.

To a certain extent this happens already. For example, stable patients who have been 'compliant' with the requirements of the program gain by their behaviour and adherence, access to take-away privileges. In practice they may be less frequently required to undertake urinalysis.

One view put to the Review was that the real differentiation was between 'traditional' illicit drug user OTP patients and prescribed opioid patients (in that both are involved in either illegal activity or manipulative practices such as gaming the prescription system/doctor shopping) on the one hand, and the over-the-counter medication OTP patient who is not involved in any illegal activity. They are in that respect more akin to people with tobacco or alcohol problems – misusing legal substances. This is a legitimate point.

A counter argument is that to differentiate in any fashion between categories of people who are facing the same basic problem – addiction – would serve only to marginalise an already marginalised population further. This is a debate familiar to those who were involved in the early days of HIV/AIDS management where a distinction was often drawn between those who had 'acquired' HIV as a result of blood transfusions[59] and those who had 'acquired' it as a result of their own behaviour. This was a divisive and unhelpful debate and an unnecessary distraction from addressing the basic problem – infection with the virus.

It would, in the opinion of the Consultant, be much better to continue to manage the OTP patient cohort on the basis that the level of stability and controlled behaviour on the part of each individual was the sole basis upon which any variations in OTP management were based. A 'reward' system based on recognition of 'progress' to desirable goals of stability and reintegration is well justified, whereas variations based upon the aetiology of the addiction are not.

However, one large metropolitan public clinic notes strong resistance to treatment on the part of some patients who acquired their addiction through use of legally prescribed pharmaceutical opioids (especially those who maintain employment and stable living conditions), when treatment must be accessed through the public waiting area. The Clinic permits discreet entry to a separate waiting area, solely as an expedient to better response and retention in treatment. This clinic has no waiting lists and therefore there is no discrimination on priority of access. The real equity issue remains not so much one of treatment, as of access, and the uneven distribution of access to OTP continues to fail the test of equity in the provision of public health services.

6. Role of the NSW Ministry of Health

The OTP has been a success in very large part due to the support which it has continued to enjoy from the NSW Ministry of Health. Despite issues with funding and regulation the Ministry has sustained a commitment to the OTP which has allowed it to develop and improve over time. There are still however, a variety of challenges which need to be addressed at Ministry level.

(a) Over-regulation

There has already been considerable discussion in this report of the level of regulation and supervision exercised by the Ministry over aspects of the OTP. Many of these oversight mechanisms derive from historical practices which were instituted in the earliest days of the OTP when far less was known and success far more problematic. Both experience and time have moved on.

Other regulatory controls derive from legislation, parliamentary decisions and compliance with Commonwealth or national requirements.

Generally however, there is perceived by almost all consultation parties to be too much regulation, too much control, too much paperwork and too much form-filling and bureaucracy.

The consultant was not in a position to examine the entire regulatory framework but must faithfully report the overwhelming view of the consultation parties. A number of proposed changes to the regulatory environment, which it is believed would free up the system and open it to more participating pharmacists, General Practitioners and private clinics have been discussed already. It is not necessary to add anything further.

(b) Data and Data Quality

Another criticism which appears to have some validity is that in many areas data is either absent or problematic and this inhibits best decision making. It has already been noted that there is considerable uncertainty about the critical question of measuring or determining unmet need which is vital if effective planning for further developments is to be well informed.

Similarly, strong data on the changing demographic of the OTP population is not available. In another area, the success of people exiting from the OTP and remaining drug free/non-dependent, and the best strategies to achieve such outcomes is hardly robust despite a plethora of publications in this area.

More comprehensive data on OTP patient co-morbidities would be useful, especially in the planning of integrated care, particularly for people intersecting with the mental health

system. Another area would be the development of tools which might allow for a better evaluation of how to tailor strategies to better meet the needs of individual patients using such tools as the ADAPT – Addiction Dimensions for Assessment and Personalised Treatment.[60]

This is not to deny that there are many useful studies, including publications from the Australian Institute of Health and Welfare, and commissioned reports from ANCD and NDARC, but rather that there has not been a clear identification of what data is needed by NSW Health upon which to make fundamental decisions about the future of the OTP.

(c) Integration with other State Health Policies and Departments

(d) Issues of co-morbidity, in particular access to mental health and oral health services

Since the election of the Coalition Government there have been a significant number of new State health policies developed and published. Among these, key policies include:

- NSW State Health Plan Towards 2021
- Pain Management Plan 2012-2016
- Palliative Care in NSW
- Advance planning for Quality Care at End of Life
- Blueprint for eHealth in NSW
- Health Professionals Workforce Plan 2012-2022
- NSW HIV Strategy 2012-2015 A New Era
- NSW Hepatitis C Strategy 2014-2020 and NSW Hepatitis B Strategy 2014-2020
- NSW Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016.

There are continuing Plans such as:

- NSW Youth Health Policy 2011-2016
- Smoke-Free Health Care Policy

and newly released plans closely associated with OTP issues such as,

- Living Well: Putting People at the Centre of Mental Health Reform in NSW: A report (Mental Health Commission).

In addition there are plans or strategies which cover areas such as oral health.

All of these are supposed to be set within an environment of "Integrated Care" and based upon Minister Skinner's CORE values of collaboration, openness, respect and empowerment.

Objectively it has to be said that the OTP finds itself almost entirely on the outer of all of these excellent programs. To give just a few examples:

- The Pain Management Plan contains no recognition of the real problems of over-prescription of pain management medication as it impacts on the OTP
- There is no evidence that the OTP is in any way seen as integrated with strategies such as oral health, tobacco cessation or mental health services
- It can hardly be said that all the CORE values are reflected in the operation of the OTP in its present iteration
- The assumptions about the needs being addressed in both the Workforce Development Plan or the eHealth Plan take no notice of the special needs of this most marginalised of the public health programs run by NSW Health.

There is overwhelming evidence that patients in the OTP suffer from issues of co-morbidity with mental health problems and that their oral health is severely compromised. In addition their co-morbidity with excessive tobacco use is well established.

It is hardly necessary to continue to elaborate on this theme, but rather to point out the fact that because the OTP is so marginalised as a public health policy within the whole suite of NSW public health policies, not only is it generally overlooked, but its interests are in fact seen as compatible with those of the system as a whole.

Yet every aspect of the OTP is directed towards the same ends as all the other health policy initiatives – improving community health through improving the health of individuals; ensuring fairness and equity in access to health care; providing non-discriminatory treatment which places the patient at the centre of all clinical and other decision making with respect for patient autonomy, dignity and privacy. Almost none of these are reflected in the way in which the OTP operates at present.

Patients are not at the centre – systems are. Care is not integrated – it is fragmented. Respect is not always shown – it is frequently absent.

If the OTP is to realise its potential then NSW Health must take proactive measures to move it from the embarrassing shadows to a place closer to centre stage and treat it and its patients with the respect it deserves.

A more complex issue arises in relation to taking a more whole-of-government approach to OTP-related issues. As part of the consultation process a specific round-table panel was convened with representatives from a significant number of government departments and

agencies (including the Police) to discuss cross-departmental issues related to OTP. As noted earlier, it was not possible during the Consultation to meet with the Ministry of Aboriginal Affairs.

[Interestingly, the NSW Police have a set of Guidelines which also offer guidance on "dealing with public criticism of OTPs" which demonstrates a considerable degree of insight into a key question relevant across the board.[61]]

What this phase of the consultations revealed was that there are a number of programs throughout the NSW Government which are positive in relation to their support of the OTP and the program's clients, but that there is a general lack of awareness of what is going on across the whole of government, a lack of co-ordination and information sharing, and a lack of any central focus for addressing these issues.

Clearly in matters such as housing, welfare services, child protection, law enforcement and education there are policies being pursued which are of relevance to the OTP, particularly in terms of psychosocial and welfare support for people newly entering or exiting from the program.

It is beyond the scope of this report to analyse all such State policies, and it is appreciated that the issue of policy co-ordination (whole of government) and support is a vexed one in a number of areas. What can and should however, be improved, is simply the exchange of information about relevant programs across agencies.

(e) Treatment Guidelines

NSW Health is responsible for the development and publication of guidelines for the management of OTP operations. The Guidelines are just that – guides to best practice, and unless they are referring to statutory requirements, they are advisory and not prescriptive.

The last set of Guidelines was published by NSW Health in 2006. A new set of national guidelines were published in November 2013. Revised NSW Guidelines are now in preparation and are awaiting finalisation after government has given consideration to any recommendations and changes arising from this Review. It would be fair to say that they are eagerly awaited.

What the Consultations identified on a regular basis was a hope that the new NSW Guidelines would be relatively brief in terms of supplementing the national guidelines; that they would be written in plain English; and that they would clearly reflect contemporary best practice.

The 2006 NSW Guidelines ran to 170 odd pages, the 2013 National Guidelines to over 200. It is hardly surprising that extensive familiarity with them in pharmacy, general practice and most clinics is not immediately apparent.

Obviously Guidelines need to be comprehensive but they need also to be accessible. They need to be more than published, they need to be read.

(f) Role of the Local Health Districts/Speciality Health Networks and Public Health Networks

In association with the LHD/SNs themselves, through Service Agreements and other mechanisms, the NSW Ministry helps define the role of the LHD/SNs and then uses that as the basis for funding their operations through a variety of arrangements, most recently Activity Based Funding (ABF). There is at present no clear statement of the role of the LHD/SNs in the provision, management, development or supervision of the OTP. Different LHD/SNs approach their responsibilities in different fashions, primarily in response to the perceived needs of their area.

Some take a more proactive role in appointing an individual to co-ordinate activities between their public facilities (where they exist) and the local pharmacists and General Practitioners. Others see this as a more passive management responsibility – they expect the initiatives to come from elsewhere.

It would be useful if the Ministry had a more uniform and coherent approach to what it expects from the LHD/SNs and made this clear in each of the Service Agreements. The OTP will not grow from the bottom up – it is required to be a top-down initiative and must be initiated at Ministry or senior LHD level.

Much the same can be said for Public Health Networks (Medicare Locals). Those which are well integrated and play a positive role in the development and promotion of OTP are those which were approached in the first instance by their own LHD. The realignment of PHNs which is currently underway gives the LHDs a perfect opportunity to engage with them in relation to the expansion of OTP services and this needs positive encouragement from the Ministry.

(g) Justice Health and OTP in prisons *

On any one day, the largest single concentration of people in NSW on the OTP, are in custodial care. This service is provided through Justice Health and Forensic Mental Health Network (Justice Health) which is a speciality network within the NSW Ministry of Health.

In general terms, about 8.7% of people on OTP are being treated within correctional facilities. This is not as high as Western Australia (9.8%) and the ACT (9.5%) but much higher than Victoria (6.2%) and Queensland (only 0.9%).

OTP is provided at 21 metropolitan and rural correctional centres with only eight of the smaller facilities not providing such a service.[62]

Between July 2012 and June 2013 Justice Health managed 3,298 OTP patients in custody. All of the 1,614 who were on OTP when they entered custody were prioritised so that they

remained on OTP and 608 patients were commenced on OTP when they entered custody. A total of 1,843 patients have post-release arrangements co-ordinated with Justice Health and so were placed in appropriate public or community facilities on release. Very few adolescents (usually fewer than 3) are on OTP at any time.

When people come into custody, if they are already on OTP they are automatically continued, although patients on Suboxone may request to be transferred to methadone. Some do so because it is harder for inmates to be stood-over or forced into diversion of medication with methadone than with Suboxone. Those who elect to remain on Suboxone are permitted to do so; however inmates who have not previously accessed opioid substitution treatment are automatically put and maintained on methadone. Suboxone treatment is more difficult and time-consuming to manage within correctional environments.

Any patient on entry into custody is automatically assessed for all health conditions and may request placement into the OTP. All requests are prioritised and any pregnant/HIV positive or adolescent patient will be automatically enrolled, as are any Drug Court patients. Any patient with a serious co-morbidity is further assessed by senior drug and alcohol clinicians (this includes HCV patients and patients with liver disease), and generally commence OTP within a few weeks.

Other patients are placed on a waiting list as the total number of OTP places in Justice Health is capped at 1,400 at any one time due to resource and financial constraints. As places become available, people are moved from the waiting list into OTP. The waiting list at the current time stands at about 5 months from initial screening.

Up to half of all persons in custody who make an initial request for OTP do not commence as they either change their minds or were primarily users of stimulants for whom opioid substitution is not a suitable treatment. An alternative approach is taken whereby some patients are referred, through the Department of Corrective Services, to the Intensive Drug and Alcohol Treatment program (IDATP) in Windsor.

In some respects the most difficult issue in the management of custodial patients on OTP comes at the time of their release. Justice Health negotiates with relevant LHDs to find places in their programs for ex-prisoners to access immediately upon release. However this is not always an easy negotiation, as LHDs often claim that their own programs are full and there is a degree of resentment, from time to time, at having to prioritise ex-prisoners ahead of others who may be on local waiting lists. Such arrangements are generally made under the terms of Memoranda of Understanding entered into between Justice Health and relevant LHDs under the auspices of the *Connections Program* which is a broadly-based post-release psychosocial and welfare program. It is understood that about 200 OTP patients are released from custodial care each month. Almost all need to be placed in contact with some form of continuing OTP support.

An equally unfortunate situation arises from time to time when a prisoner on OTP is suddenly released by the Bail Court or a Bail Magistrate and finds themselves no longer returning to custody (and hence to their OTP treatment), but free on the streets with nowhere to go and no immediate access to their next day's treatment. This may occasionally result in considerable distress and health compromise to these individuals.

Not surprisingly, it is common for people who are opioid dependent to be in contact with the criminal justice system, although exact data on what proportion is not available. However, within that overall cohort it is a small minority (5.6%) who account for the overwhelming majority (24.3%) of the associated costs. To this extent, while by definition people who are dependent upon illicit opioid use are committing offences, it tends to be only a small minority of them who feature in the public discussion related to crime and criminality[63].

Regardless of that demographic, what is important for these purposes is the extent to which the evidence is overwhelming that the mortality rates of opioid dependent prisoners is significantly lower while they are in OTP[64] and that treatment in an OTP has a positive effect of reducing incarceration rates.[65]

The principal problem arises however on release, as the data in one study indicate that where ex-prisoners are released without being placed into continuing OTP their mortality rate is considerably higher (0.7%) in the first six months compared with those released onto an OTP (0.3%)[66]. A more detailed study showed that the lowest rate of post release mortality at 6.4 per 1000 person years (PY) was for people continuously retained in OTP post-release, compared with 36.7 per 1000 PY for those with no continuing OTP.[67] There is a heightened degree of vulnerability for ex-prisoners in the first two weeks after release, especially if they return to injecting illicit substances after a period in which they have become desensitised to doses at a rate as high as those which they were using prior to incarceration.

This places a considerable premium on Justice Health to ensure that its ex-prisoners are connected into an OTP on release, and it is frustrating that this is not always possible for a variety of reasons. Even where ex-prisoners are placed into an OTP on release they may not sustain this contact for a variety of reasons including costs, which is why Victoria ensures that all such individuals have their OTP dispensing costs covered by the State for the first six months after their release.

Another important characteristic of the prison OTP is that Indigenous people first commence on OTP in prison at a rate three times higher than that of non-indigenous people (30.2% v 11.2%). Indigenous opioid-dependent people in contact with the criminal justice system are charged with a greater number of offences and spend longer in custody, compared with non-Indigenous opioid-dependent people. 'Hence, contact with the criminal justice system provides an important opportunity to engage indigenous people in OTP."[68]

Much the same may be said of HCV positive prisoners. They have some priority in terms of access to OTP within the prison system, and, as has been noted above, there is now clear evidence that participation in OTP has beneficial effects for people with HCV.

All of the evidence clearly indicates that prison OTPs are highly effective in reducing post-release deaths, engaging Indigenous people in OTP‘ reducing reincarceration rates (and thus costs), and in promoting better health outcomes for people with co-morbidities such as HCV infection.

R19: Although it is appreciated that there are differences between groups of patients within the OTP, the only basis upon which there should be differential treatment of any of them should be related to their degree of stability and adherence to the OTP.

R20: A thorough review of the statutory and regulatory framework of the OTP should be undertaken in order to reduce compliance burdens on OTP providers and to reflect the maturing of the OTP since its inception.

R21: The Ministry of Health should define more clearly the data which it believes should be available to it and others to assist in planning the further development of the OTP and should commission an appropriate research facility to obtain it. More generally, the OTP should include a component of support for on-going quality research in this field.

R22: The Ministry of Health should establish a small working party to review the inter-relationship between the OTP and other significant NSW Health policies in order to achieve greater co-ordination between them, with special focus on policies related to pain management; the provision of mental health services; the provision of oral health services and the promotion of smoking cessation among OTP patients.

R23: Priority should be given to the speedy finalisation of the NSW Guidelines for the management and operation of the OTP but these should be made as simple, clear and easy to read as possible.

R24: The Ministry of Health should consult with Local Health Districts, Speciality Health Networks and Public Health Networks (Medicare Locals) and more formally define the role and responsibilities of each in providing and supporting OTPs.

R25: Prison-based OTP should be expanded in order to allow all eligible patients to join the program as soon as possible on entry into custody and enhanced support should be provided by the Ministry of Health to ensure that the maximum number possible of people being released from custody are transferred into a community based OTP. This support should include the payment of any OTP dispensing fees for the first six months after release.

7. Developing and Enhancing an NGO presence

Increasing NGO participation in the OTP was defined as one of the objectives of the Review in its Terms of Reference and particular care was taken during the consultations to address this issue both with the NGO sector itself, individual NGOs and existing OTP providers.

The consultation participants were also aware of the new funding model proposed for NGO support as from 2015 following the review of this program which reported in November 2012[69].

It would be fair to say that there were sharply divided opinions about both the desirability and the capacity of the NGO sector to become more involved in the provision of OTP services.

- A number of NGOs expressed their concern that they did not believe it was the role of the NGO sector to be so involved in the management of complex primary health care needs and that very few, if any of them, possessed or were likely to be able to acquire, the services of qualified personnel which would be needed
- A number expressed concerns that the provision of OTP services was such "core" business for the Ministry of Health that it should not be "outsourced" to the NGO sector
- Most expressed a view that any expanded involvement of the NGO sector would need to be accompanied by significant increase in resourcing (this point was made particularly forcefully in the consultations and elsewhere[70] by Larry Pierce, CEO of NADA);
- However, a select few believed that they were both interested and capable of expanding their operations into the provision of some, if not all, of the services required within a more comprehensive OTP.

There are two distinct areas in which the NGO sector could become involved:

(a) The provision of direct treatment services

A number of existing NGOs, especially those related to the Aboriginal Medical Services, and to a lesser extent, Family Planning Australia, already run clinics which are staffed by health professionals and often have pharmacists either within or attached to the service. These have the capacity to provide treatment services to stabilised and experienced OTP patients.

Treatment at an Aboriginal Medical Service (AMS) may in fact have significant advantages for members of the indigenous community if they are more likely to be attracted to and attend at an AMS for treatment, where they feel they will be dealt with in a more culturally sensitive fashion, and thus provide an opportunity for other health and welfare

interventions to take place. It would be possible to construct a model of service whereby daily treatments (doses) or take-aways could be prepared, on or off-site, by a registered pharmacist and then administered or handed over within the AMS. Exactly the same point may be made about any other of the Aboriginal Community Controlled Health Services, many of which include residential rehabilitation services.

This might also have the advantage of attracting more pharmacists to become dispensers, if in practice their responsibility was the preparation of treatments (doses) which would not have to be delivered within their own retail environments. The preparation of treatments (doses) off-site and delivery to an approved clinic for actual provision to patients is already a common feature in some clinics. An alternative is that the pharmacist attends at the clinic and prepares the treatments (doses) each morning before the clinic opens. There are obviously issues related to the secure delivery and storage of the OTP medications and a need for robust systems to be in place to prevent diversion or misuse. Supervision of the treatment would need to be by appropriately qualified and skilled personnel but at this level that may well be by a nurse.

Nevertheless, it must be recognised that there are a variety of attitudes apparent within the AMSs themselves with some taking a more positive view of their potential role as treatment providers and others taking a much more negative view, not only of this option but of the OTP as a whole. There are also particular issues of privacy within the Indigenous community which need to be considered and add a layer of complexity to decision making in this area.

Discussion with Family Planning Australia indicated a potential willingness on their part to participate in the OTP and in some of their facilities there are pharmacy services being provided already. They may need to be upgraded for security purposes but this would not be a major undertaking. A view was expressed that there may be many OTP patients who would value the opportunity to receive treatment in a Family Planning clinic rather than one known and identified as an OTP clinic.

(b) The provision of a variety of psychosocial and welfare based support services

It is in this area that the greatest opportunity exists for NGOs to play a valuable role in enhancing the outcomes of the OTP by the provision of a variety of psychosocial and welfare-based support services.

A number of NGOs are well experienced in the management of some parts of the OTP patient cohort. For example, the Community Restorative Centre has a 25-year history of providing support services to people who are exiting from custody, including connecting them with employment, housing, transport, identity management, welfare and family services.

Similar experience exists in organisations such as WIPAN (Women in Prison Advocacy Network); faith based organisations such as Uniting Care and the Salvation Army; peak NGO

bodies such as NADA (Network of Alcohol and Drug Agencies); ACON (AIDS Council of NSW); Hepatitis NSW; and the Ted Noffs Foundation.

There is also expertise along these lines available through organisations such as WHOS (We Help Ourselves), United Gardens Clinic and other existing OTP/residential service providers. Most of the 14 NGOs that currently admit patients for rehabilitation or detoxification have some experience in this area. None of these 14 NGOs when taking OTP patients actually provide treatment services to them, patients are treated off-site. Only WHOS, which in relation to its 45 inpatients is specially licensed to provide treatment, has direct experience as a treatment provider.

It should be possible to ascertain the extent to which the NGO sector would be interested in undertaking either of these activities as part of the further development of the OTP.

The NGO sector is ideally placed to undertake the latter, especially as the expertise to deliver such services does not exist within the Ministry of Health itself, and is certainly not core business for the Ministry.

It would be possible to draw up a tender seeking the provision of services for both

- Treatment provision, and
- Welfare support.

Some organisations may feel they are capable of providing both services; most would be likely to look at providing only one of them.

A contract for the former might specify that the service required is the provision of daily treatment services in an approved clinical setting under the control and supervision of appropriately qualified personnel. An appropriate outcome measurement might be that a fixed proportion of OTP clients assigned to that facility were managed successfully for a specified period of time.

A contract for the latter might specify that payment would be made for the provision of psychosocial and welfare support services for a specified number of OTP patients over a period of time with the outcome measurements focused upon such issues as placement in secure and stable housing; entry into gainful employment and diversion from any (or further) contact with the criminal justice system. Such contract could be offered on a State-wide basis by the Ministry or on a local level by the relevant LHD with whom there would be a close involvement.

[As noted above, in each case there would need to be a clear undertaking that any patients who were unable to be managed in this alternative environment would be covered by the safety-net of guaranteed return to the public sector system.]

R26: The Ministry of Health should undertake a scoping exercise (perhaps by round-table discussions) to ascertain formally the extent of interest within the NGO sector in providing support services for the OTP at the level of both treatment provision and the provision of psychosocial and welfare-based support services within the tender-based framework for NGO support being introduced in 2015.

8. Exiting from the Program

Without qualification, it can be said that no single issue was more contended or contentious than that related to the Term of Reference which specifies that a purpose of the Review *"is to guide program change to better support recovery*." The specific use of the term 'recovery' is discussed at length below.

To demonstrate how widely divergent the views on 'exiting' from the OTP were, two sources can be quoted:

- "Addiction is a chronic relapsing disorder in the majority of people who present for help"[71]

This view is strongly advocated by many practitioners with extensive experience and expertise in the field. One article in the influential *Journal of the American Medical Association* describes addiction as a 'chronic relapsing disorder' involving drug-dependency which should be regarded in the same light and compared with drug-dependency in three chronic medical illnesses: Type 2 diabetes, hypertension and asthma[72]. Others add reference to the long-term management of epilepsy.

One experienced Australian clinician wrote to the Consultant, in relation to strategies for potential cessation:

> *"Unfortunately addiction does not work that way. When a person begins using heroin or other opioids on a regular basis, these drugs bring about a "re-wiring" in the brain. This means that for a majority of the addicted persons, that addiction will last long term. … Addiction is like high blood pressure. We are not clever enough to cure addiction."*

Similarly, an experienced clinician in London used the same term when talking with the Consultant. He said:

> *"Drug addiction re-wires the brain. It stays re-wired. You can't get another brain."*

Addiction is a choice and you can choose to stop being an addict

At the other extreme is the view taken by Gene Heyman in his book *Addiction: A Disorder of Choice*. Heyman adopts the choice model of addiction rejecting the disease model. Heyman posits that most addicts eventually quit their addiction and that what tends to be the most important factor keeping them in treatment is not their addiction but rather comorbidities of a psychiatric or medical nature needing attention and intervention. This essentially binary model reflects a particular view on the question of free will and personal responsibility, which may be divorced from the social reality of the lived lives of drug-dependent persons. He does however, concede that drug addiction is a result of alteration in the neurotransmission system of the brain (hence the "re-wiring" analogy) and that genetic and developmental factors have to be taken into account.[73]

Most people spoken to in the consultations fell somewhere between these two views with a clear majority favouring the former, although some highly respected and experienced clinicians believed the latter view to be more correct. There was simply no consensus on the point.

When turning to the evidence about what "works" in terms of helping people to end their heroin addiction, the overwhelming weight of that evidence is that the answer is long-term treatment programs. The most recent Australian Treatment Outcome Study (ATOS) in NSW demonstrated that the greatest benefit in terms of individual health and in reduction in criminal behaviour occurred in people who had been on OTP for a period of 11 years or more.[74]

One of the co-authors of the report (Professor Shane Darke from NDARC) was quoted as saying:

> *"What works, is long term. Either maintenance therapies where people are given substitutes like Methadone or Buprenorphine or residential rehabilitation or drug free rehabilitation. I think it's important to understand that short term treatments like detoxification is actually risking the increase of death. In fact, we know for a fact it increases the risk of death."*[75]

What then becomes important is the question of what maintains people on treatment for a longer rather than a shorter period of time. In this respect there is agreement with an earlier British study which found that "to a remarkable degree relapse to drugs is independent of conscious freewill and motivation" and that

> *"premorbid social stability, especially stable employment history, proved a more effective predictor of long-term outcome that the severity or chronicity of addiction."*[76]

This conclusion – that it is the employment/housing/relationship environment of the patient which encourages long-term participation (and hence higher chances of ceasing heroin dependency) is reinforced by more recent extensive work in Israel[77].

That said, there is nevertheless broad agreement that to date most OTPs fail to provide sufficient support for withdrawal. The ANCD comments that:

> *"Little attention has been paid to exit strategies for long-term clients who want to reduce their dose and ultimately cease treatment."*[78]

The other major research centre in this area, NDARC comes to a similar conclusion:

> *"… there appears to be little attention to exit strategies for long-term clients who want to reduce their load and ultimately cease treatment."*[79]

All the NGO-based rehabilitation services made the same point to the Consultant, one of them writing:

> *"On reflection one missing link in the original concept (for our service) was the absence of any pathway to abstinence. It seems to be wholly focussed on maintenance by using a legal substitute. Although I acknowledge that only a small percentage of addiction sufferers will want to or be able to progress to abstinence unless they know it is possible they won't do it."*

This is clearly reflected in the fact that the only significant publication which could be sourced which provides a comprehensive guide to withdrawal written specifically for clients: *Coming Off Methadone,* was written in 1996 and indeed had to be sourced from an interstate library.[80]

Recent work undertaken by Professor Adrian Dunlop in the Hunter New England region found that in relation to a series of questions asked of current OTP patients, when asked if:

- There should be a limit on how long I am allowed to remain on treatment, 72% disagreed (62% strongly) while 18.5% agreed (13.5% strongly)
- I could come off methadone/buprenorphine in the next six months, 60.6% disagreed (48% strongly) while 29.7% agreed (13.5% strongly)
- I would like to come off treatment, 51.3% disagreed (43.3% strongly) while 21.8% agreed (14.3% strongly)
- I would worry about relapse if I came off, 65.1% agreed (50.4% strongly) while 23.2% disagreed (17.8% strongly)
- If I did come off my treatment I would worry about getting back onto treatment if I needed it, 69.6 agreed (54.2% strongly) while 20% disagreed (17.4% strongly).[81]

These are important findings and confirm two major issues related to treatment withdrawal, namely that it will be hard and that chances of relapse are great and that an unsuccessful withdrawal will make it hard(er) to get back onto treatment.

It also raises the very complex issue of dose-reduction. The consultation was informed of numerous cases where individual patients had been brought down from high-dosing regimens to exceptionally low-dosing regimens (in the order of 0.2 mgs) but that people remained at that level for exceptionally long periods of time. They were happy to participate in a gradual reduction regime but often seriously concerned about taking that last step and casting off the "liquid handcuffs" for the last time.

Institutionalisation on the program is a major concern and a question arises as to whether it is better to allow people to remain on such incredibly small doses and feel secure, than to pressure them into an exit situation in which they do not. Importantly, the critical factor at this stage may be, as noted above, the presence of the employment/housing/relationship environment into which they are then existing or moving.

Nevertheless, sustaining people indefinitely on any drug-based treatment regime is undesirable if there are alternate drug-free options and alternatives available.

It is difficult to assess how many OTP patients might be classified as "suitable" for withdrawal. Estimates are in the range of 10–17 %.[82] Whatever it is, it is relatively small. Nevertheless it is important and it is clear, that OTPs should be more proactive in emphasising the possibility of withdrawal, provided that the necessary support mechanisms can be put in place. Equally, there must be concerns about the indefinite maintenance of people on treatment, many of whom it appears, have never been properly assessed as potential clients for withdrawal and have been maintained, at least in part by the clinical lethargy or institutional convenience of the treatment providers. This is an area clearly ripe for review.

It may be that after a patient has been either on the OTP for a considerable period of time or on the same low-dose level of treatment for a prolonged period of time, they should be subject to independent external assessment and evaluation to check and see whether further maintenance in this condition is justified and/or desirable or whether they should be moved to lower dosing or to program withdrawal.

A decision to move to withdrawal must be that of the patient themselves and cannot be imposed unilaterally. Nor should patients be coerced into meeting predetermined treatment timelines[83]. However, appropriate counselling, management and support may make this easier once all options have been exposed and explained. The advantages of complete withdrawal need to be articulated for each patient.

Equally, if a patient is assessed as being unsuitable for withdrawal, not only should they never be forced out of the programme, they should be encouraged not to exit voluntarily until they are better prepared to manage without program support.

The National Guidelines give excellent advice in this area, stressing the need for flexibility (rather than time mandated) in arrangements; supportive of long-term treatment as a better indicator of successful eventual withdrawal; encouraging of the provision of psychosocial and welfare support interventions and emphasising that final decisions must be left entirely to the patient and their clinicians.[84]

It is important that a distinction be drawn between withdrawal and abstinence. Although their ultimate aim is the same – to live without resort to or dependence on drugs - the images which they conjure in the minds of both patients and providers are somewhat different.

Clearly there is an important place for abstinence-based programs and therapies and these need to be expanded but equally they should not be conflated with withdrawal strategies and support services.

It must also be anticipated that there are few successful withdrawals on the first attempt (just like giving up tobacco). Of the 7,904 patients who entered OTP in 2013, 6,321 (or 80%) were re-engaging and only 1,583 (20%) were commencing treatment for the first time – of whom 158 (10%) came in through the justice sector. Those who simply drop out of treatment (especially in the first year) have a very high rate of relapse.

Thus the critical factors which predispose towards success in treatment withdrawal and abstinence are:

- Patient choice advised by appropriate clinical advice, including advice not to attempt withdrawal/abstinence until genuinely suitable and ready
- High levels of “recovery capital” (see below)
- Proactive offering of such support services by OTP providers
- Longer-term experience on the OTP
- Provision of psychosocial and welfare support services
- A capacity to attempt successful withdrawal/abstinence on more than one occasion
- Flexibility in timing arrangements both in relation to when to start the process and the time taken to complete it.

Aiding withdrawal must be a central feature of any good OTP but expectations of “success” must be realistic, patience must be in full abundance; advice and support must be readily

available; coercion must be absent and above all the wishes and autonomy of the patient must be respected.

It should also be recognised that this is an area where as much expertise and interest lies in the NGO and private clinic sector as anywhere else.

R27: In any revamped NSW OTP the opportunities for exit/withdrawal from treatment need to be given greater prominence and support bearing in mind the qualifications mentioned above, especially being realistic in anticipated outcomes and at all times respecting the decisions and autonomy of each individual patient.

R28: Recognition must be given to the data which demonstrates that long-term participation in treatment leads to better outcomes for the majority of patients and that some patients will need to be maintained on therapy for an indefinite period of time.

R29: Where patients have been on the OTP for a prolonged period of time (say ten years) or maintained on the same small level of dosing, there should be an external evaluation of their clinical management and treatment to assess whether it continues to be optimal.

R30: The proposed NSW Guidelines should be specific and supportive in their coverage of this issue.

R31: The capacity of the NGO and private clinic sector to make a major contribution to outcomes in this area should be recognised and supported.

9. Workforce development

This Report has already drawn attention to a number of matters related to workforce development, both in terms of original relevant undergraduate education issues; prescribing qualification issues; and courses available for medical and nursing practitioners.

Throughout the consultation process there was a recurring complaint that workforce development in this area was very limited (a general criticism within the whole drug and alcohol area) and that there were few opportunities for continuing personal development or skills upgrading.

A matter of real concern is not only the ageing of the OTP population but also the ageing of the OTP provider workforce. There are a significant and worrying number of OTP providers who have large patient loads and are approaching retirement age and there are very few new addiction medicine trainees being recruited. Figures provided in a submission to the Commonwealth indicated that there were only 6 addiction medicine trainees in NSW in 2013 (of a national total of 18) but that only 1 had commenced as a trainee in 2012 and none had commenced in either 2010 or 2011. This ageing of the specialist workforce poses a

real threat to the long term viability of the OTP and leaves it particularly vulnerable to even small changes in personnel.

The report cited above concludes:

> *"The Addiction medicine workforce is in decline, a significant proportion of current Fellows are nearing the age of retirement and an insufficient number of trainees are currently being recruited to redress workforce shortages."*[85]

Indeed a majority of OTP practitioners with large patient loads, especially outside the metropolitan area, who were part of the consultation process, impressed this point on the Consultant, citing their own cases by way of example.

Anecdotal evidence presented indicated that the youngest OTP prescriber in Wollongong was aged 57 years and was planning to retire. He treats about 80 patients and since he became a prescriber ten years ago there have been no new private prescribers in that city. Another private prescriber in Wollongong with 30 patients is aged 70 and also contemplating retirement. Similarly, the two prescribers at the Denison Street private clinic (also in Wollongong with about 200 OTP patients) are both between 67 and 70 years old. The only private prescriber in Nowra is also aged approximately 70 years.

Representatives of the Australasian Chapter of Addiction Medicine (within the Royal Australasian College of Physicians) made the same point very strongly in both consultation and written submissions and cited a general lack of support for and recognition of the speciality of addiction medicine both generally and within the remunerative arrangements under Medicare.

NSW has a *Health Professionals Workforce Plan 2012-2022* which has a table listing "Medical Speciality Workforce Projected Growth to 2025" under headings of "priority for further growth", 'moderate further growth" and "supply in balance". In all, 34 items are listed – *not one of them refers to either drug and alcohol or addition medicine services* – and the closest the list comes, is to list "anaesthetic and pain management" as being a "supply in balance" item.[86]

Workforce development is not listed as an item anywhere in the Ministry's briefing paper *Review of the NSW Opioid Treatment Program April 2014*.

This just demonstrates the extent to which drug and alcohol services are always at the bottom of the list (if they make the list at all) when it comes to priorities, and addiction medicine/OTP services are at the end of the drug and alcohol list itself. This it should be noted, at a time when the community is becoming increasingly aware and concerned about the impact of alcohol (in particular) in the destruction of indigenous communities, rising levels of domestic and other violence and the impact upon crime and community costs.

Unless there is a serious commitment on the part of the Ministry to address workforce development issues in this area it will not be long before a crisis point is reached, when the demands for increased services cannot be provided because of workforce shortages.

This report has already made comment upon the need to recruit more participants among pharmacists and general practitioners and takes the opportunity here to re-state the need to address an enhanced role for suitably qualified nurses as participants. Once prescribing has been done by registered practitioners (including Nurse Practitioners) there is no reason that there should not be a more active role for qualified nurses in the provision of OTP treatment, especially as in most instances, the provision of that treatment is not particularly complicated from a medical point of view.

The excellent initiative of the Hunter New England LHD with the development of their *HealthPathways* on-line resource dealing with OTP needs to be supported, replicated and extended across the whole of NSW.

R32: The Ministry of Health should give consideration to the development, in association with the Australasian Chapter of Addiction Medicine, of a plan to increase the recruitment of additional Addiction Medicine Specialists and provide them with access to on-line support in terms of both peer networking and continuing professional education and development.

R33: The Ministry of Health specifically endorse the greater role of nurses, and Nurse Practitioners in particular, in the provision of OTP services and work with their representative to overcome structural barriers to this greater participation and to attract more of them to work in this field.

10. Matters for the Commonwealth

This report has already alluded to the repeated concerns of many consultation practitioners regarding aspects of both the PBS and the Medicare Item Number schedule, which constitute continuing disincentives for participation by health professionals in the OTP, and Recommendation 16 addresses this issue.

However, there is also a compelling case that along with National Guidelines, there should be some greater national uniformity or co-ordination in the regulation of OTP services such that it would be easier for both practitioners and patients to move seamlessly between jurisdictions. This is a matter which NSW might consider placing on the agenda of the Standing Committee on Health for discussion between all Health Ministers.

PART FOUR: REDEFINING THE OBJECTIVES AND THE METHODOLOGY OF THE NEW SOUTH WALES OPIOID TREATMENT PROGRAM

While the OTP currently enjoys a considerable amount of support among those members of the community, including the health professions who know that it exists, it has few if any public champions. It is still regarded by many as a politically-charged and sensitive issue – one best avoided in terms of public discussion and where it is thought best that things should continue to fly under the radar.

Any significant expansion of the OTP, which is taken to be an objective of the Review, needs to address the question of building a wider and deeper constituency for its growth.

The Consultant believes that this can best be achieved by three initiatives being taken.

1. A clearer statement of the aims and objectives of the OTP should be given, which focusses not on the processes of the OTP but on the goals of the OTP in an entirely patient-centred fashion

2. There should be greater public exposure of the successes of the OTP as a major public health initiative

3. A more direct involvement of both existing and former patients/clients and their organisations/representatives in the development of a State-wide Strategy for the OTP should be embraced.

Redefining the Aims and Objectives

The aims and objectives of the OTP, as presently stated in the 2006 NSW Guidelines, focus primarily upon the concept of modifying behaviour by reducing or eliminating heroin and other illicit drug use (see page 4 above) and improving the personal health of those in the OTP.

The 2013 National Guidelines proceed directly into a discussion of the structure and delivery of treatment without any overarching description of the aims and objectives of OTP.

The Consultant believes that these approaches are both flawed and that the approach that should be taken is that advocated by the NSW Minister for Health (Hon Jillian Skinner MP) who has always insisted that health policies should be based around the concept of putting the patient first – front and centre.

To this extent, there is a powerful case that the stated aims and objectives should focus first on what it is expected that the OTP will achieve for each of its patients and that the methodologies used to achieve those aims, and the consequences which flow from that for the broader society should be subsidiary concerns.

Similarly, there is a tendency in the rhetoric of NSW Health to talk about "recovery" from addiction. As discussed above, the term "recovery", derived and copied from American and British models is freighted with meanings – most of which remain unarticulated. However when unpacked, they reveal an approach which is based upon the assumption that somehow the OTP client has strayed into the realms of unacceptable behaviour and needs to be assisted to "recover". Exactly what it is that the patient is expected to recover **to** is never stated.

The Consultant believes that this rhetoric should be laid to one side and the term '**reintegration**' embraced as the central ideology of the OTP.

Reintegration may cover a wide spectrum of activities:

- A person may be reintegrated into the physical and emotional support network of their families or of their network of personal relationships
- A person may be reintegrated into the world of paid and stable employment
- A person may be reintegrated into the world of secure and stable accommodation
- A person may be reintegrated into a community where they have no continuing contact with environments involving crime and criminality.

There are an endless variety of possibilities – just as there are an endless variety of OTP patients.

A person may not have "recovered" from their use of drugs or their dependence on methadone – but if they are reintegrated into a community of relationships, employment and housing and separated from the communities of criminality and violence, then it could certainly be argued that the program by which that has been achieved (ie the OTP) has succeeded.

A "successful" OTP client may well be one who continues to be methadone-dependent and even an occasional user of illicit substances, but if they live fulfilling and productive lives, reintegrated into their communities with stable relationships, employment and housing, surely this is enough.

Nailing one's colours to the mast of "reintegration" allows a far clearer focus within the OTP of what it is that the program is expected to provide to its patients.

"Recovery" is a largely meaningless and essentially political word. It says virtually nothing because it fails to define what a "recovered" person looks likes or how they act.

"Reintegration" by contrast is a process – a continuum of activity along which progress can be made and along which goals can be set and measured.

How does one measure when a person is "recovered"? Does it mean that they are no longer on any form of treatment? That is hardly good enough if the reasons for absence from treatment are not that the individual is now abstinent, but rather that they are unable to continue. For how long does a person have to be off treatment before they are declared recovered? Six weeks? Six months? Six years?

Reintegration is easier to observe and measure – it is immediate and it is obvious. It allows for tracking over time and for direct observation of the success of particular interventions. It allows for a standardisation of both outcomes and reporting mechanisms. Because it is more objectively based, it makes it more likely that external service providers such as those in the NGO sector would be prepared to accept it as a benchmark against which contractual obligations could be entered into and measured.

The noted American legal scholar Alan Dershowitz has remarked on several occasions that

> *"Justice is a process – not an outcome."*[87]

So is addiction management for the vast majority of clients. So is the OTP.

By giving the OTP a patient-centred focus rather than a process focus it is more likely that it will become better integrated into the whole suite of public health policies and interventions, all of which are being recast to emphasis the patient-centred approach.

Recovery v Reintegration

During the course of the consultations there was a very strong resistance to the use of the term "recovery", especially as this is perceived as being used as a code word for "force people out" and eventually wind down/close down the program. The Review's Terms of Reference refer to the outcomes being used "*to guide program change to better support clients to recovery*." The NSW Opioid Treatment Program Priorities Expert Reference Group which met in 2011, agreed that the definition of "recovery" should be that provided by the UK Drug Policy Commission Recovery Consensus Group, namely

> *"The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society".*[88]

Interestingly this definition would define people as "recovered" if they were still using substances (presumably including illicit ones) but their behaviour demonstrated "control over" them.

That report itself noted:

> *"Part of the issue behind the debate appears to be a lack of clarity and agreement about what treatment is trying to achieve and what we mean by the term 'recovery'. Without greater clarity about the goals of treatment and rehabilitation and the dimensions of benefit, it is obviously hard to commission or deliver the individually tailored packages of care that are required to meet the very varied needs of individuals with different presenting and underlying problems."*

In both the United States and the United Kingdom "recovery" has now increasingly come to mean something where policy directs or mandates emphasis on program-exit and where full abstinence is the ultimate marker of success.

This in itself is contrary to a statement quoted by the UK Commission that:

> *"As US expert on recovery William White has commented: "How recovery is defined has consequences, and denying medically and socially stabilized methadone patients the status of recovery is a particularly stigmatizing consequence"."*

That a new "recovery" paradigm is in place is evident in the newly released National Drug Strategy of the United Kingdom: *Drug Strategy 2010 – Reducing Demand, Restricting Supply, Building Recovery: Supporting People to live a Drug Free Life*. The strategy clearly seeks to downplay the previous centrality of harm minimisation as a key element in national drug policy.

In her *Foreword* to the strategy, Home Secretary Rt Hon Theresa May MP writes:

> *"A fundamental difference between this strategy and those that have gone before is that instead of focusing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency. …….. The solutions need to be holistic and centred around each individual, with the expectation that full recovery is possible and desirable."*[89]

The Strategy document mentions methadone only once and that by way of inclusion in a table of illicit drug use, and emphasises throughout the cost savings to the budget of getting drug-dependent people off welfare payments.

For the UK, "recovery" is defined as comprising three elements – "*wellbeing, citizenship and freedom from dependence*". However, the Strategy does acknowledge a point made above when it declares:

> *"It (recovery) is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore put the individual at the heart of any recovery system and commission a range of services at the local level to provide tailored packages of care and support."*[90]

In relation to the UK equivalent of OTP, the Strategy states:

> *"Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. Medically-assisted recovery can, and does, happen. There are many thousands of people in receipt of such prescriptions in our communities today who have jobs, positive family lives and are no longer taking illegal drugs or committing crime."*[91]

After then agreeing to consider the potential of prescribing diamorphine (heroin) "for a small number who may benefit", the Strategy goes on:

> *"However, for too many people on a substitute prescription, what should be the first step on the journey to recovery risks ending there. This must change. We will ensure that all those on a substitute prescription engage in recovery activities…."*[92]

The Strategy recognises that the best predictor of "recovery" being sustained is what it calls the individual's recovery capital – the resources needed to commence and sustain recovery from dependency. "Recovery capital" consists of four elements:

- Social capital – based on relationships
- Physical capital – including money and housing
- Human capital – based on skills, employment and physical health
- Cultural capital – based on beliefs, values and attitudes.

In its analysis of the new Strategy, a leading article in *The Lancet* notes:

> *"Long-term extended treatment using methadone or other substitute prescribing, without a definite endpoint is now out of favour……. Recovery is a term redolent of 19th-century temperance, with the pledge as creed and the reformed drunkards as the saved. …… Now the post-AIDS consensus in the UK around harm reduction is questioned and recovery is the definition of the moment …. Conservative politicians….had questioned continuing drug prescription and advocated abstinence well before the Coalition government came to power. Mental health had adopted the term and the language of 'recovery 'seems to have percolated through to the drugs*

field. The influence of the significant American focus on abstinence can also be detected."[93]

It is quite clear that the aims and objectives of the new national drug strategy in the United Kingdom are those which resonate with the present government in New South Wales and that there would be little in the new Strategy with which there would be significant disagreement.

However, the issue is one of terminology and the Consultant believes that there is a strong case not to use the term "recovery" because of its associations with particular strategies in the United Kingdom and the United States and the (implied) threat of coercion to get people "off the program and into recovery."[94] Rather, the term "reintegration" carries, it is suggested, a far more positive and proactive overtone which is genuinely centred on the placement of the individual back into mainstream society with appropriate support and encouragement mechanisms.

It is also suggested that since "recovery" is seen in large part, as a formal rejection (or at the very least serious downgrading) of the principle of harm reduction/minimisation, this term should be avoided unless it is the intention of the government to follow down that same path. The potential abandonment of harm reduction/minimisation as a central part of any drug strategy in NSW would need far more comprehensive groundwork being prepared than has been undertaken at this stage – the risk would be that a reversal of policy – real or perceived – would reopen a debate on drug strategy which, at this stage, would be singularly unhelpful.

Evaluating Outcomes : The key to explaining success

The Consultant is not aware of any studies undertaken by the Ministry of Health to satisfy itself that all the stated objectives of the OTP are being met and that they are being met in a cost-effective and efficient manner. It is assumed that this is occurring as part of the current Review as reflected in the "Overview" paragraph of the Terms of Reference. It is axiomatic that this must be done so that the benefits of the OTP can be more clearly in the public domain.

Any further investment of resources in programs as politically sensitive and problematic as OTP, are more likely to gain public approval once it can be demonstrated that stated objectives have been achieved and that public money has been well spent in achieving positive personal and public health outcomes.

The lessons of the Medically Supervised Injecting Centre and the now almost universal support for the Needle and Syringe Program were based on showing by objective measurement of outcomes, such as lives saved and infections reduced, that public money

was being well spent and that initially controversial schemes had lived up to their promises[95].

There is already ample evidence that the OTP works in improving personal and public health outcomes, and (of more interest to some elements in the community) in reducing crime. It is by any measure, a successful public health program, and in order to establish the groundwork for its expansion, steps should be taken to publicise this.

Engaging with the Patients

It would be hard to identify any area of public health policy where the end-users, patients or clients are less engaged in discussions about the policy than when it comes to matters related to OTP. There is an underlying assumption about the level of competence and ability of such patients to make useful contributions, although a number of representative organisations (such as NUAA, AIVL, WIPAN and others) have regular seats at the table.

Basically much of the current attitude towards consideration of policy improvement in this area reflects the issues of stigma and discrimination highlighted at the very outset of this report. These patients are regarded as having a "credibility deficit"[96] when it comes to the potential to make useful contributions. It leads to a pervasive sense of disengagement and disenfranchisement among consumers.

In conversations with many patients/clients at clinics and a variety of settings through the consultation process, it became apparent that many of them have sound and practical suggestions about how the services provided might be improved. Not taking their views into account risks the loss of valuable insights and analysis.

One analysis of the benefit of such openness to client participation reported that in relation to a series of such patient-based initiatives, noting an improvement in 'service quality and health outcomes':

> *"Participants consistently recounted positive experiences of a change as a result of the consumer participation initiative, particularly with regards to relations between service users and staff. Both sets of participants described a diminution of adversarial relations: an unsettling of the "them and us" treatment divide."*[97]

The same thing must be said about the involvement of patient's families. As was pointed out on numerous occasions, especially by people such as Tony Trimingham (Family Drug Support) and the Ted Noffs Foundation, the involvement of patient families is a crucial element in seeking any improvement in the nature and delivery of OTP and support services.

Finally, peer-based groups should be recognised as having particular value and expertise to contribute to this process and should continue to be promoted and supported.

R34: That in any further announcements about the future of the OTP and in the forthcoming NSW Guidelines, clearer aims and objectives for the OTP be stated and these focus primarily on being patient-centred and relating to patient wellbeing with all process issues being made subservient to this.

R35: That where possible the term "recover" be eschewed in favour of the more positive term "reintegration".

R36: Consideration should be given to making more widely known the success of the OTP in improving personal and public health outcomes and in reducing crime and that its cost-efficiency and effectiveness should be emphasised.

R37: That any initiatives undertaken by the Ministry of Health or LHDs to develop further their services to OTP clients, consultation directly with clients (past and present), and their families and carers, along with their representative organisations, be regarded as a crucial part of any such process.

PART FIVE: THE PACHYDERMS IN THE PADDOCK

There are two significant issues which are relevant to this Report and which are almost never the subject of discussion or consideration. They must be addressed.

Pharmacy Ethics

The first question is – what ethical or legal right do individual pharmacists have to refuse to dispense a lawfully written prescription?

Pharmacists cannot operate without a licence from Government. Community/private pharmacies are provided with exclusive geographic areas in which to operate, thereby establishing, by government fiat, a small monopoly. In effect community pharmacists cannot operate without the support and authorisation of government.

What then are their obligations in return? Above all, they appear to be primarily that they will deliver professional services, key among which is the dispensing of lawful prescriptions in accordance with the relevant laws and regulations.

While it has always been accepted that some pharmacists may have ethical objections to dispensing particular types of drugs such as abortifacients, these objections are based upon the outcome of (and purpose of) taking the medications, namely to procure a termination of pregnancy, which is clearly an ethical issue about which there are legitimate, significant disagreements. Many years ago it was not uncommon for some pharmacists to refuse to supply the contraceptive pill or condoms – such behaviour is no longer regarded as acceptable.

In relation to OTP medications there can be no such objections. The aims of OTP medication are entirely beneficial and positive. They are supported by public policy and government authority. The drugs themselves are no more dangerous than many others which they dispense, and indeed are not as difficult to manage as many other drug regimes, such as those used for HIV management.

No such refusals to dispense would be tolerated for other drugs which are supplied to people who may have been involved in activities such as injecting drug using, for example those dispensed for the management of hepatitis C infection.

Here are no other “opt-in” arrangements about dispensing. Lawfully prescribed drugs must be dispensed unless there are government-based regulations about their control (as there are in relation to Section 100 drugs), reflecting public policy decisions. In relation to OTP

medication, the public policy is clear that the medications should be made as widely accessible as possible.

Indeed, the pharmacies themselves sell, and make a profit from selling, over-the-counter medications which may themselves lead to problems of addiction. They also dispense lawfully written scripts for opioid pain killers (primarily oxycodone) which are becoming a major problem in the creation of addiction.

There is also no clear evidence that clients of the OTP as a whole, constitute a population who are difficult to manage, aggressive, inclined to engage in anti-social or criminal behaviour (eg shop-lifting), nor indeed that they are even clearly identifiable as OTP patients prima facie. Individuals may be difficult as patients/clients but this is the case with many other sub-groups of the general population, for example people with mental illness or alcohol-related issues.

The only basis upon which this decision not to dispense can be based is where a pharmacist has decided deliberately to act in a discriminatory fashion by identifying one sub-group of the population to whom they will not provide a generally available service.

The question of whether this is in breach of anti-discrimination legislation is canvassed below, but as a matter of ethics such behaviour would appear to be intolerable.

It is certainly contrary and inimical to best practice in terms of the protection of public health.

Why then does the Government of NSW allow those whom it has licensed, to act in such a manner?

This question was asked frequently by the Consultant during the course of this enquiry. No satisfactory answer was ever provided.

It is time that such a question was asked and answered.

NSW Anti-Discrimination Amendment (Drug Addiction) Act 2001 and Commonwealth Disability Discrimination Act 1992

In November 1996 a certain Mr Marsden was expelled from the Coffs Harbour and District Ex-Servicemen's and Women's Memorial Club after a number of incidents (reaching back to 1994) as a result of Mr Marsden appearing to be intoxicated on the Club's premises and being involved in loud altercations with Club staff. In August 1996 Mr Marsden had disclosed to a Club official that he was on the methadone program and had previously been addicted to heroin.

Mr Marsden complained to the Federal Disability Discrimination Commissioner claiming that he was the victim of unlawful discrimination based on his disability, namely opioid dependency or addiction to methadone. In the first instance he was unsuccessful, but on appeal in the Federal Court (Branson J), the case was remitted back to the lower court after the Federal Court found that the definition of "disability" in section 5 of the *Disability Discrimination Act 1992 (Cth)* had not been properly applied and should be read as to encompass a disability based on the person's addiction to drugs – including prohibited drugs[98]. The matter was never finalised in court because the parties settled. However the leading author on discrimination law notes that:

> *"Indeed the definition [in the DDA] is so wide that it has been interpreted to include illicit drug addiction."*[99]

The response of the Commonwealth was to propose a new provision in the *Disability Discrimination Act:*

> ***54A Addiction to prohibited drug***
>
> (1) This Part does not render it unlawful for a person to discriminate against another person on the ground of the other person's disability if:
>
> (a) the disability is the other person's addiction to a prohibited drug; and
>
> (b) the other person is addicted to the drug at the time of the discrimination.
>
> Note: This does not affect the operation of this Part in relation to a disability that is a medical condition (such as HIV infection or hepatitis C) that may be related to drug addiction.
>
> (2) Subsection (1) does not apply to discrimination by a person against another person on the ground of the other person's disability if:
>
> (a) the other person's use of the drug is authorised by a law of the Commonwealth, a State or a Territory; or
>
> (b) the other person is undergoing a program, or receiving services, to treat the addiction to the drug.
>
> (3) In this section:
>
> ***prohibited drug*** means a drug within the meaning of regulation 5 of the *Customs (Prohibited Imports) Regulations 1956*.

However this Bill was never passed and as a result, the situation thus remains that:

> *"Addiction to a "prohibited drug" is a disability under the DDA."*[100]

The response of the NSW Government was similarly to introduce and pass the *Anti-Discrimination Amendment (Drug Addiction) Act 2001* which amended the original *Anti-Discrimination Act 1977* (NSW) to insert a new provision, section 49PA:

"49PA Persons addicted to prohibited drugs

(1) This section applies to the provisions of Division 2 (Discrimination in work), other than sections 49H, 49I and 49J.

(2) Nothing in those provisions renders unlawful discrimination against a person on the ground of disability if:
(a) the disability relates to the person's addiction to a prohibited drug, and
(b) the person is actually addicted to a prohibited drug at the time of the discrimination.

(3) However, nothing in this section makes it lawful to discriminate against a person on the ground of the person having hepatitis C, HIV infection or any medical condition other than addiction to a prohibited drug.

(4) In this section:

"prohibited drug" means a prohibited drug within the meaning of the *Drug Misuse and Trafficking Act 1985* , but does not include:
(a) methadone or buprenorphine, or
(b) any other drug that is declared by the regulations not to be a prohibited drug for the purposes of this section."

In 2002 Mr Stephen Carr lodged a complaint under the NSW Anti-Discrimination Act claiming that he had been discriminated against by his employer, the City of Botany Bay Council on the basis of his addiction to methadone and his opioid dependency. When the case came before the Administrative Appeals Tribunal[101], it found, inter alia that:

"45. We are satisfied that the Applicant's disability is methadone addiction."

It noted in relation to the precedential value of *Marsden* that:

"50 …. Thus, the fact that a person who suffers from a disorder feels "normal" and is able to lead "a normal life" while taking appropriate treatment does not mean that he or she is no longer has a disability within the meaning of the DDA." [Disability Discrimination Act – Cth].

In reviewing the legislative history of the new 49PA provisions, the Tribunal stated:

61 In the circumstances of the present case, where the Applicant is addicted to methadone, there is no confusion caused by the language of s49PA. The provision in s49PA (4) means that the exception set out in s49PA (2) does not apply, as methadone is not a "prohibited drug" for the purposes of the exception.

62 There is nothing unclear about the operation of s49PA. Methadone and buprenorphine, which are both used in the treatment of heroin addiction, are expressly excluded from the definition of a "prohibited drug" for the purposes of the exception. There is nothing to suggest that the operation of the section on its clear terms produces an absurd or unreasonable result. We are of the view that no permissible basis has been established for the Tribunal to have regard to the Second Reading Speech.

63 If this view is wrong, in either event we accept the Applicant's submission that the Speech itself provides no basis for the Tribunal to do anything other than apply the provisions of s49PA in the manner set out in [56] above.

64 The Speech commences with a clear recognition of the impact of the Marsden decision on the definition of disability under the Act, and a statement from the Attorney General that the Government of the day does not believe that drug addiction should be treated as a disability. However, the Bill itself then goes on to make no effort to legislate to remove the impact of the Marsden decision, or to exclude substance-related disorders such as opioid dependence from the definition of disability.

65 The Government could have introduced a Bill which amended the definition of disability in s4 (1) to state that disability does not include drug addiction or dependence disorders. However it chose not to do so.

66 The inclusion of s49PA as an exception, which applies only to direct employment relationships and not to all of the relevant areas protected against disability discrimination, confirms that despite the Attorney's comments, there was no express intention to legislate Marsden out of application. Marsden was a case of disability discrimination in the area of membership of a club. The disability was opioid dependence, and the drug of addiction was methadone. Branson J's decision in Marsden would have been entirely unaffected by the amendments included in the NSW Bill."

The New South Wales legislation regarding methadone addiction/opioid dependency relates only to discrimination in relation to Division 2 of that Act, namely discrimination in work.

However section 24 of the Commonwealth Act goes further by prohibiting discrimination against a person on the basis of their disability in the provision of "goods and services" It states:

24 Goods, services and facilities

It is unlawful for a person who, whether for payment or not, provides goods or services, or makes facilities available, to discriminate against another person on the ground of the other person's disability:

(a) by refusing to provide the other person with those goods or services or to make those facilities available to the other person; or

(b) in the terms or conditions on which the first-mentioned person provides the other person with those goods or services or makes those facilities available to the other person; or

(c) in the manner in which the first-mentioned person provides the other person with those goods or services or makes those facilities available to the other person.

This raises the fundamental question:

If a person who is opioid dependent and/or addicted to methadone seeks a "service" from a pharmacist, namely that they dispense his/her methadone/buprenorphine prescription, and the pharmacist declines to provide that service, would the affected person have the right, under the Commonwealth *Disability Discrimination Act* to seek redress for unlawful discrimination based on their disability?

R38: That in order to satisfy itself that the non-participation of pharmacists in the OTP would be secure from legal challenge as an act of discrimination on the basis of disability (particularly under the Commonwealth Disability Discrimination Act), this matter be examined by the Legal Branch of the Ministry of Health.

PART SIX: THE NEED FOR A COMPREHENSIVE NSW OTP STRATEGY

All the above discussion and recommendations need to be considered within an overall cohesive and comprehensive framework.

In 2010, an Expert Reference Group within the Ministry of Health produced a draft of a Strategic Plan for the NSW OTP to run from 2011 to 2016. For a variety of reasons, including a change of Government, this Plan was never published.

If the OTP is to be taken seriously it is appropriate that it should be seen as part of the armamentarium of the Ministry of Health, operating alongside the many other strategic plans which have been published.

A patient-centred approach, consistent with the statements by the Minister for Health that this must always be central to health policy development in NSW and reflective of the CORE values which she has articulated, must be the basis upon which such a Plan should be developed. It must recognise that it is all about changing behaviour and not judging people.

It should have a focus on assisting all those who participate in the program to reintegrate into their various communities and recognise that they, their families and carers are valued members of our society.

Publication of such a Plan would also serve to enhance public and community awareness of the importance and success of the OTP to date and should serve to refute many of the unfounded but continuing criticisms of the program. It would also allow the current Government to spell out clearly its redefined goals and objectives along the lines stated in the Terms of Reference for this Review.

R39: That a comprehensive Strategic Plan for OTP in NSW be developed and published with the endorsement of the NSW Minister of Health.

SUMMARY OF RECOMMENDATIONS

R1: NSW Health consult with the NSW Anti-Discrimination Board to develop specifically focussed training and educational modules which should be promoted to and used by all sectors of NSW Health which are involved in the provision of OTP services, and

R2: NSW Health should engage with the major medical and pharmaceutical professional organisations to ensure that such training and educational modules are promoted to and used by their members who have any responsibility for the provision of OTP services.

R3: The cap on pharmacies limiting their OTP patient load to 50 should be removed with consideration given to lifting the cap immediately to 100, progressively to 200 over the next one year period and thereafter, following further evaluation, be removed entirely.

R4: Section 92(1A) of the *Regulations* should be repealed and a regime developed to allow the provision of OTP medication from non-retail pharmacy outlets which operate as stand-alone OTP medication supply facilities and which do not require PBS authorisation to operate.

R5: A review be undertaken of all aspects of the writing, transmission, recording and managing of scripts for OTP medications with a view of developing a system which is streamlined, seamless and entirely electronically based.

R6: That the Pharmacy Incentive Scheme in its current form be discontinued by July 2015 and replaced with an arrangement whereby the State pays the dispensing fees of:

*all patients whose sole or principal means of financial support is a pension or social security payment while they are in receipt of such payments

* all juveniles and pregnant women

* all other patients for the first twelve months of their participation in the OTP (this would be about one-third of the total cohort)

Thereafter all OTP patients would be required to pay a dispensing fee which should be a capped uniform fee (taking into account different fees for different services) negotiated between NSW Health and the Pharmacy Guild. Pharmacists should be free to charge less than the agreed fee which should be subject to renegotiation every three years.

The same fee would be the basis upon which the State makes payments to the pharmacist.

R7: NSW should engage with the relevant training, educational and professional authorities to ensure that education about OTP is included in all relevant undergraduate programs and that no pharmacist should be registered unless evidence was presented that they had completed such training.

R8: NSW Health in association with the Pharmacy Guild, and representatives of both client/user groups and Medicare Locals, should develop a Pharmacy OTP Development and Resources Kit which should cover at the least the items identified above, together with others which would successfully encourage the participation of more pharmacists in the OTP.

R9: Each LHD in NSW should designate an officer to be responsible for the proactive promotion of the Kit to pharmacists within the LHD and each Ministry/LHD Service Level Agreement should set targets for new pharmacy enrolments on an annual basis with such targets set taking into account the particular features of each LHD and the potential OTP population.

R10: Discussions should be initiated with the relevant medical education authorities to ensure that appropriate advice, education and training is provided in undergraduate medical and nursing courses to make students familiar with the issues in OTP, to address issues of stigma and discrimination against OPT patients, and to promote greater support for personal involvement in OTP after graduation.

R11: A kit, similar to that advocated in R8, be developed to assist in the recruitment and CPD of general practitioners into the OTP and that initiatives such as the Hunter New England LHD *HealthPathways* be given active support by NSW Health. Emphasis should be given to the development and support of peer support and advice networks particularly to assist new entrants into the field of OTP prescribing.

R12: The *Regulation* restricting GP prescribing to five patients without specialist OTP training be re-examined to determine whether this number continues to be appropriate in the light of greater experience being available about the management of OTP patients and the availability of more online information to GPs who wish to prescribe for a greater number of OTP patients.

R13: The OTAC be subjected to external review to determine if it could be improved and the extent to which more GPs might be attracted to seek OTP registration were any such course more easily accessible as an online training module. Such a review should also consider the extent to which any such registration course should be mandatory, and if so at what level, for GP prescribers and how further CPD in this area could be enhanced or incentivised.

R14: Strategies to address the over-prescription of pharmaceutical opioids, risk-mitigation strategies associated with such prescribing; prevention of diversion and proper control of pain management regimes should be developed in association with the relevant authorities.

R15: Positive steps should be taken by NSW Health to attract for NPs to engage with the OTP and their role in the provision of OTP services should be recognised and encouraged. Regulatory barriers to their capacity to prescribe OTP medication should be reviewed.

R16: NSW Health should seek Commonwealth support to address issues related to inadequate Medicare rebates for complex OTP consultations and management and the provision of appropriate Item Numbers to recognise the provision of specialised addiction medicine services. The attention of the Commonwealth and all other jurisdictions might be drawn to the desirability of having the National Guidelines augmented and supported by a more co-ordinated national approach to recognition of prescriber registration, on-going professional development and the desirability of both OTP practitioners and OTP patients to move more seamlessly between jurisdictions. NSW may care to consider listing this as an item for a future meeting of the Standing Committee on Health.

R17: In order to enhance support for the OTP from private providers (including pharmacists, general practitioners and private clinics) it should be accepted as a matter of policy that public OTP clinics will always act as "safety nets" and be prepared to manage or take back patients who cannot be managed outside the public sector or who have become "unmanageable' or have decompensated while in external treatment and can no longer be managed in that environment.

R18: As part of the Review of the OTP NSW Health develop and publish a policy and strategic framework for the expansion of OTP services, including their expansion through private clinics, with particular emphasis upon the support therein of abstinence programs which have proven therapeutic and cost effectiveness. Once such a Strategic Plan is developed, consideration should be given to the variation or repeal of restrictions on new licences set out in section 166 of the Regulations.

R19: Although it is appreciated that there are differences between groups of patients within the OTP the only basis upon which there should be differential treatment of any of them should be related to their degree of stability and adherence to the OTP.

R20: A thorough review of the statutory and regulatory framework of the OTP should be undertaken in order to reduce compliance burdens on OTP providers and to reflect the maturing of the OTP since its inception.

R21: The Ministry of Health should define more clearly the data which it believes should be available to it and others to assist in planning the further development of the OTP and should commission an appropriate research facility to obtain it. More generally, the OTP should include a component of support for on-going quality research in this field.

R22: The Ministry of Health should establish a small working party to review the inter-relationship between the OTP and other significant NSW Health policies in order to achieve greater co-ordination between them, with special focus on policies related to pain management; the provision of mental health services; the provision of oral health services and the promotion of smoking cessation among OTP patients.

R23: Priority should be given to the speedy finalisation of the NSW Guidelines for the management and operation of the OTP but these should be made as simple, clear and easy to read as possible.

R24: The Ministry of Health should consult with Local Health Districts, Speciality Health Networks and Public Health Networks (Medicare Locals) and more formally define the role and responsibilities of each in providing and supporting OTPs.

R25: Prison-based OTP should be expanded in order to allow all eligible patients to join the program as soon as possible on entry into custody and enhanced support should be provided by the Ministry of Health to ensure that the maximum number possible of people being released from custody are transferred into a community based OTP. This support should include the payment of any OTP dispensing fees for the first six months after release.

R26: The Ministry of Health should undertake a scoping exercise (perhaps by round-table discussions) to ascertain formally the extent of interest within the NGO sector in providing support services for the OTP at the level of both treatment provision and the provision of psychosocial and welfare-based support services within the tender-based framework for NGO support being introduced in 2015.

R27: In any revamped NSW OTP the opportunities for exit/withdrawal from treatment need to be given greater prominence and support bearing in mind the qualifications mention above, especially being realistic in anticipated outcomes and at all times respecting the decisions and autonomy of each individual patient.

R28: Recognition must be given to the data which demonstrates that long-term participation in treatment leads to better outcomes for the majority of patients and that some patients will need to be maintained on therapy for an indefinite period of time.

R29: Where patients have been on the OTP for a prolonged period of time (say ten years) or maintained on the same small level of dosing, there should be an external evaluation of their clinical management and treatment to assess whether it continues to be optimal.

R30: The proposed NSW Guidelines should be specific and supportive in their coverage of this issue.

R31: The capacity of the NGO and private clinic sector to make a major contribution to outcomes in this area should be recognised and supported.

R32: The Ministry of Health should give consideration to the development, in association with the Australasian Chapter of Addiction Medicine, of a plan to increase the recruitment of additional Addiction Medicine Specialists and provide them with access to on-line support in terms of both peer networking and continuing professional education and development.

R33: The Ministry of Health specifically endorse the greater role of nurses, and Nurse Practitioners in particular, in the provision of OTP services and work with their

representative to overcome structural barriers to this greater participation and to attract more of them to work in this field.

R34: That in any further announcements about the future of the OTP and in the forthcoming NSW Guidelines, clearer aims and objectives for the OTP be stated and these focus primarily on being patient-centred and relating to patient wellbeing with all process issues being made subservient to this.

R35: That where possible the term 'recover' be eschewed in favour of the more positive term 'reintegration'.

R36: Consideration should be given to making more widely known the success of the OTP in improving personal and public health outcomes and in reducing crime and that its cost-efficiency and effectiveness should be emphasised.

R37: That any initiatives undertaken by the Ministry of Health or LHDs to develop further their services to OTP clients, consultation directly with clients (past and present), and their families and carers, along with their representative organisations, be regarded as a crucial part of any such process.

R38: That in order to satisfy itself that the non-participation of pharmacists in the OTP would be secure from legal challenge as an act of discrimination on the basis of disability (particularly under the Commonwealth Disability Discrimination Act), this matter be examined by the Legal Branch of the Ministry of Health.

R39: That a comprehensive Strategic Plan for OTP in NSW be developed and published with the endorsement of the NSW Minister of Health.

APPENDIX A

REVIEW OF THE NSW OPIOID TREATMENT PROGRAM

TERMS OF REFERENCE FOR KEY STAKEHOLDER CONSULTATION

Overview

In January 2014, the Minister for Health and the Minister for Mental Health directed that there be a review of all components of the NSW Opioid Treatment Program to ensure the most effective and cost effective operation of the program with consistency state-wide. The review is to guide program change to better support clients to recovery and covers:

- strengthening the NSW Opioid Treatment Program;
- ensuring it is operating effectively and efficiently; and
- better supporting individuals to move through the various stages of treatment for opioid dependence.

Key considerations include:

- expanding GP participation and community pharmacy dispensing;
- expanding private clinic participation;
- increasing NGO participation;
- providing better psychosocial support; and
- ensuring regular, proactive engagement between clinician and client regarding potential cessation.

The framework to guide the overall program review in relation to the community based program may contain the following key components:

- an assessment of current OTP operation in each Local Health District;
- building the evidence base for what works;
- an up to date and consistent clinical approach;
- improved integration of the program with other care and support services;
- legislative adjustments, if appropriate;
- increased participation by GPs and community pharmacists; and
- a structured process to facilitate implementation of recommendations.

The review will be informed by a comprehensive, targeted consultation process with key stakeholders to be conducted by an external consultant.

Scope of Stakeholder Consultation

- Targeted stakeholder consultation by invitation to include institutional and professional groups, clinical service deliverers, NGOs including those outside D&A, peak bodies, program clients and others impacted by injecting drug use. A list of relevant stakeholders will be provided by MHDAO.

Conduct of Consultation

- Consultations to be separated by cohort and interests and may be conducted as roundtables or one-on-one meetings;
- Consultations to include a balance of both metropolitan and regional areas;
- Where possible to help inform and customise each consultation, key issues should be identified in relation to each stakeholder group, as well as alignment with any proposed service and/or legislative redesign.
- Administrative support to the approved consultant will be provided by the Opioid Priorities and Partnerships team within the Mental Health and Drug & Alcohol Office, NSW Ministry of Health

Timeframe

- The consultation process to commence from 7 June 2014;
- A report on findings of the consultation to be provided to the Mental Health and Drug & Alcohol Office, NSW Ministry of Health by 7 November 2014.

Deliverables

- An advisory report on findings of the stakeholder consultation to be provided to the Mental Health and Drug & Alcohol Office, NSW Ministry of Health by 7 November 2014, for inclusion in the final review report that will be provided to the Minister for Health.

APPENDIX B

OTP Review - Key Stakeholders Consulted

Stakeholder
Institutional Bodies
Australian Medical Association
Hunter Medicare Local
Family Planning Association
Clinical Excellence Commission (CEC)
Agency for Clinical Innovation (ACI)
NSW Mental Health Commission
Medical
Royal Australian & New Zealand College of Psychiatrists (RANZCP) Addiction Psychiatrists
Chapter of Addiction Medicine
Drug and Alcohol Nurses Australasia (DANA)
General Practitioners – Royal Australian College of General Practitioners (RACGP) (special interest group for D & A)
Allied Health Professionals Australia (AHPA)
Local OTP dispensing GPs - both metropolitan and regional
Pregnancy and Ante-natal services
Pharmacy
Pharmaceutical Society of Australia (PSA)
Pharmacy Guild of Australia
Pharmacist Guild VIC Chairman, Harm Minimisation Cmtee
Nick Bakarich – ABC Pharmacy
Local community pharmacies – both metropolitan and regional
Research
NDARC (National Drug & Alcohol Research Centre)
ANCD (Australian National Council on Drugs)
Consumers/Families
Family Drug Support
WIPAN (Women in Prison Advocacy Network)
NUAA (NSW Users and AIDS Association)
SWOP (Sex Workers Outreach Project)
Indigenous
Aboriginal Medical Service (Redfern)
Maari Ma (Broken Hill)
Aboriginal Drug & Alcohol Network (ADAN) & Aboriginal Health & Medical Research Council (AHMRC)
Clinical Service Delivery
Private OTP Clinics (12)
Local Health Districts – Public Clinics
Kirketon Road Centre
OTP Managers Group
Nurse Practitioners
Government
NSW Department of Justice
NSW Corrective Services
NSW Police Force
Family and Community Services
NSW Kids and Families
Justice Health & Forensic Mental Health Network
NSW Health Pharmaceutical Service Unit
NGOs and Peaks
ACON (AIDS Council of NSW)
NADA (Network of Alcohol and Other Drugs Agencies)
WHOS (We Help Ourselves)
The Buttery

Stakeholder
Phoebe House
Jarrah House
Odyssey House
Wayback
Watershed D & A Recovery Centre
Salvation Army
MSIC (Medically Supervised Injecting Centre)
Community Restorative Centre
Hepatitis
Hepatitis NSW
Prof. Greg Dore
NSW Health Centre for Population Health
High profile
John Ryan – Penington Inst.
Peter Dwyer SC
Dr Alex Wodak
Prof. Ian Webster
Peter Dwyer – Chair of Pharmacy Tribunal
Maudsley Hospital OTP London including: Strang, Bell and Winstock
Prof. Robert Batey
Education/Training
OTAC – U of Syd
Other Jurisdictions
Western Australia
South Australia
ACT
Queensland
Victoria
Commonwealth – Siggins Miller Consultants

Regional Site Visits included: Lismore, Wollongong, Newcastle, Orange and Broken Hill

END NOTES:

*DISCLAIMER : The Consultant is also the Chair of the Justice Health and Forensic Mental Health Network Board.

1 For example the National Centre in HIV Social Research produced its review *Methadone Injection in New South Wales* in 2001.

[2] The entirely negative impact of such (politically motivated) decisions to close down a controversial but successful public health initiative in 1998 was analysed in Erica Southgate, Deborah Blair and Max Hopwood: *The Closure and Relocation of the St Marys Needle and Syringe Program – Social and Health Impact Study* (National Centre in HIV Social Research, University of NSW, Monograph 5 / 2000).

[3] At para 1.9

[4] April 2104 version at page 3

[5] For example: Caplehorn J and Drummer O: "Mortality associated with NSW methadone programs in 1994: lives lost and saved", *MJA 1999; 170: 104-109;* Gibson A et al: "Exposure to opioid maintenance treatment reduces long-term mortality", *Addiction*, 103, 462-468 (2008); Degenhardt, L et al : "Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: Risk factor and lives saved", *Drug and Alcohol Dependence* 105 (2009), 9-15; Shanahan M et al: "The cost effectiveness of OST and impact on criminal offending and mortality", *NDARC Symposium* September 2014

[6] John Capelhorn and Olaf Drummer: "Mortality associated with the NSW methadone programs in 1994: lives lost and saved", *MJA (1999) 170: 104-109* provides data showing that in 1994 there were ten deaths associated with iatrogenic methadone toxicity and diverted methadone syrup being involved in 26 fatalities, nevertheless there were at least 68 lives saved as a result of participation in the OTP.

[7] White, B et al : "Opioid substitution therapy protects against hepatitis C virus acquisition in people who inject drugs; the HITS-c study", *MJA* 201(6) 15 September 2014; Tsui, J et al: "Association of Opioid Agonist Therapy With Lower Incidence of Hepatitis C Virus Infection in Young Adult Injection Drug Users", *JAMA Intern Med* published online 27 October 2014

[8] Methadone originated in Germany in 1941 used for pain relief. It was first used to counteract heroin addiction in New York in 1964 and was introduced for that purpose in Australia in 1969. Together with a framework of harm minimisation which was accepted as an underlying principle of Australia's drug policies in 1985 the combination of this approach and OTP was first formalised in the National Drug Strategy of 1997.

[9] NSW Government: *NSW 2021 – A Plan to make NSW Number One* Goal 11

[10] Details of the various jurisdictions and their practices are outlined in Australian Institute of Health and Welfare: *National opioid pharmacotherapy statistics 2013* (Drug treatment Series no 23) at section 5

[11] Guidelines are precisely that – recommendations related to best practice. They are not mandatory in terms of the practice of individual practitioners. Policy Directives are mandatory for adherence by employees of NSW Health.

[12] This is provided by the Justice Health and Forensic Mental Health Network which is a specialist network within the NSW Ministry of Health

[13] NSW Ministry of Health: *Treatment Agreement – Conditions of methadone/buprenorphine treatment*, Reprint May 2012 (SHPN (MHDAO) 120144

[14] Figures derived from Jenny Chalmers and Alison Ritter: *Modelling alternative opioid treatment service delivery configurations*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, August 2013.

[15] Alison Ritter, Matthew Sunderland, Jennifer Chalmers: *Estimating the Unmet Need and Demand for Opioid Treatment in NSW,* Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, 23 October 2012.

[16] See Degenhardt, L et al (2014): "The global epidemiology and burden of opioid dependence: results from the global burden of disease 2010 study", *Addiction* 109(8): 1320-33. Australian Institute of Health and Welfare (2014); *National opioid pharmacotherapy statistics 2013.*

[17] Peles, E, Schreiber, S and Adelson, M : "Opiate-dependent patients on a waiting list for methadone maintenance treatment are at high risk for mortality until treatment entry", *J. Addict Med.* 2013 May-June 7(3) 177-182

[18] AIVL: *Double Jeopardy –Older Injecting opioid users in Australia: Discussion Paper* (July 2011)

[19] Frei, M et al: "Serious morbidity associated with misuse of over-the-counter codeine-ibuprofen analgesics: a series of 27 cases", *MJA I 93(5), 6 September 2010.*

[20] Blanch, B., Pearson, S., and Haber PS: "An overview of the patterns of prescription opioid use, costs and related harms in Australia", (in press)

[21] Suzanne Nielsen et al : "Pharmaceutical Opioid Dependence; Baseline characteristics from a cohort of treatment entrants", (NDARC, nd)

[22] Senate Community Affairs Legislation Committee: Estimates Hearings, *Hansard¸2 June 2014*

[23] See for example Health Care Complaints Commission v Ahmad Dabboussi [2007] NSWPB 1; Health Care Complaints Commission v Larden [2009] NSWPT 1; Health Care Complaints Commission v Daniel Cahill [2013] NSWPT 4.

[24] Eliza Gray: "Heroin gains popularity as cheap doses flood the US", *Time*, *4 February 2014. "Heroin healthcare", New Scientist*, 6 September 2014

[25] "A new opium pipe", *The Economist, 30 August 2014* p. 64. "Yeast to take on the opium farmers", *ibid* p. 17

[26] AVIL (2010): *Summary report – findings and future actions from AVIL's anti-discrimination market research* (Canberra)

[27] Anti-Discrimination Board of NSW : *Discrimination – The Other Epidemic; Report of the Inquiry into HIV and AIDS Related Discrimination* (April 1992)

[28] Anti-Discrimination Board of NSW : *C Change: Report of the enquiry into hepatitis C related discrimination* (November 2001)

[29] The classic work is Erving Goffman: *Stigma : Notes on the Management of Spoiled Identity* (Touchstone, New York, 1963)

[30] Daryle Deering, J Douglas Sellman and Simon Adamson: "Opioid substitution treatment in New Zealand: a 40 year perspective", *New Zealand Medical Journal* 4 July 2014, vol 127 no 1397 p. 57

[31] Winstock, A; Lea, T and Sheridan, J (2010) : "Problems experienced by community pharmacists delivering opioid substitution treatments in New South Wales and Victoria, Australia *Addiction* 105, 335-342

[32] Charr, B et al : "Factors influencing pharmacy services in opioid substitution treatment", *Drug and Alcohol Review*, (July 2013), 32, 426-434

[33] Pharmaceutical Society of Australia: *Code of Ethics for Pharmacists* (2011) at sections 1, 2 and 1.3 respectively

[34] Australian Medical Association *Code of Ethics* (revised 2006) at 1.1.j

[35] Simon Holliday et al: "An examination of the influences on NSW general practitioners regarding the provision of opioid substitution therapy", *Drug and Alcohol Review* (September 2013) 32, 495-503

[36] Simon Holliday et al: "Waiting room ambience and provision of opioid substitution therapy in general practice", *MJA* 196(6), 2 April 20123

[37] A R McQueen: "Why general practitioners might avoid drug and alcohol work", *Drug and Alcohol Review*, (1997) 16, 429-431

[38] AMA: *Code of Ethics* section 1.1.q

[39] Peter Garling SC: *Final report of the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals – Overview* (27 November 2008) at 1.24

[40] *Poisons and Therapeutic Goods Regulation 2008* section 92 (1)

[41] *Poisons and Therapeutic Goods Regulation 2008* section 80 (2) (a)

[42] These figures are drawn from an internal document prepared by NSW Health: *Review of the NSW Opioid Treatment Program, April 2014*. These figures are however sharply at odds with figures in an earlier Ministry paper *Pharmacy Incentive Scheme – NSW Opioid treatment Program Background* (H12/84073) which gave much higher participation rates for community pharmacies in WA and Victoria. This earlier paper should not be regarded as reliable.

[43] Anecdotally the Consultant was informed of a pharmacy in Victoria carrying a patient load of close to 900. No empirical data was available in support of this contention but numerous people in the consultation process referred to Victorian numbers in this order.

[44] Pharmacy Guild: *Pharmacy Participation in Opioid Pharmacotherapy Treatment Survey*, October 2014. Confidential Draft.

[45] ANCD : *Modelling pharmacotherapy maintenance in Australia* (Research paper no. 19, 2009) p. 24

[46] Jenny Chalmers et al: *Pharmacy Participation in the NSW Opioid treatment Program: Options Paper* – A report prepared for NSW Health, drug Policy Modelling Program, March 2011

[47] ANCD : *Polygon* (Research Paper no 18, 20090 p. 23

[48] Sarah Lord, Jenny Kelsall, Amy Kirwan: Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and *retention, Centre* for Research Excellence into Injecting Drug Use policy Brief no 88, September 2014

[49] Jenny Chalmers and Alison Ritter: "Subsidising patient dispensing fees; the cost of injecting equity into the opioid pharmacotherapy maintenance system", *Drug and Alcohol review*, (November 2012), 31, 911-917 at p. 912

[50] *idem*

[51] Pennington Institute: *Opioid replacement therapy (ORT) Fees – paper for consultation* (13 August 2014)

[52] Registrars receive only temporary accreditation and generally practice under supervision.

[53] Simon Holliday: "*Why the Drug and Alcohol Services review should recommend that services need to grow*", 25 September 2014 at p.2

[54] Apex Consulting: *Department of Health and Ageing – Analysis of proposed MBS items for Addiction Medicine, Final Report*, 8 March 2013

[55] Stephen ling; "Nurse practitioners in drug and alcohol: where are they?", *Australian Journal of Advance Nursing*, Vol 26 no 4, 62-64

[56] Stephen Ling et al: "An examination of barriers to Nurse Practitioner endorsement in senior rural drug and alcohol nurses in NSW", *Collegian* (2103)20, 79-86

[57] Ingrid van Beek: *Eye of the Needle – Diary of a medically supervised injecting centre* (Griffin Press, Adelaide, 2004). Uniting Care: *Cross Currents – the story behind Australia's first and only Medically Supervised Injecting Centre* (Uniting Care, Sydney, 2004).

[58] Jenny Chalmers et al: *treatment Pathways from the Client's Perspective: informing a Better Match between Service Provision and Service Need* (Drug Modelling program, National Drug and alcohol Research Centre, University of New South Wales), Final Report, 4 June 2013

[59] See Parliament of NSW legislative Council Standing Committee on Social Issues report : *Medically Acquired H.I.V.* (October 1991)

[60] John Marsden et al: "Development of the Addiction Dimensions for Assessment and Personalised Treatment", *Drugs and Alcohol Dependence xx (2014) xxx-xxx* (in press)

[61] NSW Police Force: *Methadone and Buprenorphine Treatment – the Opioid Treatment Program – Guidelines for Police* (March 2013) at p. 7

[62] Justice Health does not provide OST at Brewarrina, Glen Innes, Ivanhoe, Mannus, Oberon, St Heliers. Both Broken Hill and Tamworth have the ability to dose patients on OST however no medical D&A services are provided to these sites and in general patients do not remain for long periods in these centres if they are on OST. (there are currently 4 patients at Tamworth and 1 patient at Broken Hill receiving OST).

[63] Louisa Degenhardt et al " Engagement with the criminal justice system among opioid-dependent people: a retrospective cohort study", *Addiction* (2013) 108, 2152-2165

[64] Sarah Larney et al; "Opioid substitution therapy as a strategy to reduce deaths in prison: retrospective cohort study" *BMJ Open* 23014;4:o004666

[65] Louisa Degenhardt et al: "Imprisonment of opioid-dependent people in NSW, Australia, 2002-2012: a retrospective linkage study', *ANZ Journal of Public Health*, 2013 online

[66] Natasa Gisev et al: "A cost-effective analysis of opioid substitution therapy upon release in reducing mortality among prisoners with a history of opioid dependence", *NDARC Paper* 2014

[67] Louise Degenhardt et al: "The impact of opioid substitution therapy of mortality post-release from prison: retrospective data linkage study", *Addiction* (20140 109, 1306-1317

[68] Natasa Gisev et al 2014, 'Offending, custody and opioid substitution therapy treatment utilisation among opioid-dependent people in contact with the criminal justice system: Comparison of Indigenous and non-Indigenous Australians", *BMC Public Health*, vol. 14, no. 1

[69] NSW Health : *Grants Management improvement Program Taskforce Report* November 2012

[70] Larry Pierce: "A house of cards; funding, fatigue and fracturing in the treatment sector", *Of Substance*, vol 12 (no 3) November 2014 p. 12

[71] Doug Sellman: "The 10 most important things to know about addiction", *Addiction,* 105, 6-13 92009)

[72] G E Valiant: "What can long-term follow up teach us about relapse and prevention of relapse in addiction?", *Br J Addict* 1988: 83, 1147-57

[73] Gene M Heyman: *Addiction: A Disorder of Choice* (Harvard University Press, Cambridge, Mass., 2009). See also Don Ross' review of this book in *Journal of Economic Psychology* 31 (2010) 146-148

[74] ATOS Bulletin: *Long-Term treatment Outcome: What are the 11 year outcomes of treatment for heroin dependence?,* 7 September 2014

[75] "New heroin treatment study finds long term treatment offers best chance of recovery", *ABC News* 9 September 2014

[76] Valiant : loc cit

[77] E Peles et al: "Factors predicting retention in treatment: 10-year experience of a methadone maintenance treatment clinic in Israel", *Drug Alcohol depend.* (2006) May 20; 82(3): 211-17 and "15-year survival and retention of patients in general hospital-affiliated methadone maintenance treatment centre in Israel", *Drug Alcohol depend.* (2010) Mat 1 (107)2-3: 141-8

[78] ANCD : *Polygon Report op cit* p. 64

[79] Jenny Chalmers and Alison Ritter: *Modelling alternate opioid treatment service delivery configurations* (NDARC, August 2013) p. 15

[80] Adrian Dunlop et al: *Coming off Methadone* (Turning Point, Fitzroy, Victoria, September 1996). This document is commonly referred to in OTP circles as the "Orange Book".

[81] Data kindly supplied to the Consultant.

[82] M Lenne: "Withdrawal from methadone maintenance treatment: prognosis and participant perspectives", *Australian and New Zealand Journal of Public Health* 2001 25(2), 121-25

[83] NUAA : *Users News* no 58, Spring 09

[84] *National Guidelines for Medication-Assisted Treatment of Opioid Dependence* (November 2013) section 2.3.8

[85] Aspex Consulting: *Analysis of proposed MBS items for addiction Medicine* (Commonwealth Department of Health and Ageing), 8 March 2013 p. 54

[86] NSW Health: *Health Professionals Workforce Plan 2012-2022* p. 34

[87] See for example his remarks in Alan Dershowitz: "On the Philosophy of Law", Interview with Gil Lahav in *Harvard Review of Philosophy* Spring 1994 p. 61

[88] UK Drug Policy Commission Recovery Consensus Group: *A Vision of Recovery* (July 2008)

[89] HM Government: *Drug Strategy 2010 – Reducing Demand, Restricting Supply, Building Recovery* at p. 2

[90] *Ibid* at p. 18

[91] *idem*

[92] *idem*

[93] Virginia Berridge: "The rise, fall and revival recovery in drug policy", *The Lancet* vol 379, January 7, 2012 (Editorial) p. 72/3

[94] On the other hand it is of interest that more recently the UK government has started to provide free foil for heroin users to encourage them to inhale (via smoke) rather than inject class A substances and where the foil provided is free from the commercially available foil which contain vegetable oils which can be toxic when inhaled. Nigel Morris: "Free foil for heroin users under new government scheme", *The Independent* (UK) 8 August 2014

[95] Sede for example Department of Health and Ageing: *Return on Investment in Needle and Syringe Programs in Australia* (2002)

[96] M Fricker: *Epistemic injustice: Power and the ethics of knowing* (Oxford University Press, Oxford, 2007)

[97] Jake Rance and Carla Treloar: "'We are people too': Consumer participation and the potential transformation of therapeutic relations within drug treatment", *International Journal of Drug Policy* (in press) accepted 7 May 2014

[98] *Marsden v Human Rights and Equal Opportunity Commission* [20002] FCA 1619

[99] Chris Ronalds: *Discrimination Law and Practice* (Federation Press, Sydney, 2008) p. 25

[100] Australian Centre for Disability Law: *Using Disability Discrimination Law in NSW* (May 2011) at 9.1

[101] *Carr v Botany Bay Council & Anor* [2003] NSWADT 2009